

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2021

HEARINGS BEFORE A SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS SECOND SESSION

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**DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RE-
LATED AGENCIES APPROPRIATIONS FOR
2021**

WEDNESDAY, FEBRUARY 26, 2020.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WITNESS

**HON. ALEX M. AZAR, SECRETARY DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

Ms. DELAURO. The subcommittee will come to order.

Good morning, Mr. Secretary. Welcome to the Labor, HHS, and Education Subcommittee, I suppose I should say and related agencies as well. This is our first hearing on the President's fiscal year 2021 budget request.

However, I want to start with a matter of urgency, the novel coronavirus, COVID-19. Cases are growing, as is alarm. This is both domestically and internationally. The U.S. Government has responded to the COVID-19 outbreak with aggressive measures, significant travel restrictions, a mandatory 14-day quarantine for individuals returning to the U.S. from Hubei province.

Mr. Secretary, I support your declaration of a public health emergency. We are dealing with the likelihood of a global pandemic. It is interesting to note yesterday from the CDC that commented that with regard to the United States it is not a question of if but a question of when we will face this issue seriously here.

That said, I have serious concerns about the administration's responsiveness with respect to funding. I understand Senators of both parties expressed a similar concern to you at their hearing yesterday. I have repeatedly asked for information about expenditures thus far and about the balances remaining in the Infectious Diseases Rapid Response Reserve Fund. And yet, we have not received an adequate answer.

In addition, you submitted a letter late Monday night notifying the committee that you would begin transferring up to \$136 million from other HHS programs, including NIH and the Low-Income Energy Assistance Program. And on Monday, the administration finally submitted a request for an emergency supplemental funding, but there is no supporting documentation.

You must share that information immediately. In that request, the administration also asked permission to shift more than \$500 million from Ebola preparedness. That is a mistake, and we are not

robbing funding for other emergency activities to pay for this emergency.

There is another \$536 million–\$550 million of reprioritized funding and funding that was provided for fiscal year 2020, and that funding is coming from other HHS programs. We know of the—and we need to know specifically where that money is being cut from.

What the American people need is an emergency supplemental bill that answers these questions, supports development of therapies and a vaccine, funds State and local agencies and healthcare providers, and strengthens our public health infrastructure. And the American people, Mr. Secretary, need to know that now. As you know, there is great alarm and consternation in the country about this.

Another important issue, an issue that I, like many Americans, find deeply disturbing, is the administration’s ongoing and cruel treatment of asylum seekers and children entering the United States. In recent weeks, we learned that agents with ICE, Immigration and Customs Enforcement, are showing up at HHS-funded shelters to fingerprint 14-year-olds in the unaccompanied children program. That is outrageous.

They are allowing ICE agents to intimidate kids. I recognize that there is a statute, but it remains the responsibility of HHS to ensure the safest environment for the children. So I want HHS to make clear to its grantees that children are to have a representative present to allay their fears and ensure their understanding of the process, and I would, and I expect my colleagues on the subcommittee, would want to see a copy of that guidance.

We also learned that ORR took confidential notes from children’s therapy sessions and shared them with ICE for multiple years. I appreciate your comments on stopping this. It should not have happened. You and I know this, that it cannot happen again. There needs to be a firewall with DHS. ORR is not an immigration enforcement agency. Its mission is to provide for the care and the welfare of children.

Turning to your budget, Mr. Secretary, despite what you may try to say, this document would hurt millions of Americans, and you have to ask who is paying the price. It is not the wealthy or well off; no, it is the vulnerable who are the victims. It is the working people, middle-class families of this country, who would be forced to do less with less.

This is a time they need more help, but you are proposing to cut \$10 billion from the Department of Health and Human Services, an 11 percent cut. You are leaving people at risk of a potential pandemic by cutting \$700 million from the Centers for Disease Control and Prevention, and especially the Infectious Diseases Rapid Response Reserve Fund.

You are telling suffering families that we will not do all we can to help their ill loved ones by cutting \$3 billion from the National Institutes of Health. It is the world’s leading biomedical research institution, and you would want to hit the brakes on that research. It is unacceptable. You would leave people without enough trained doctors and nurses by cutting hundreds of millions of dollars for training for healthcare careers like nursing.

The health issues of this Nation require a trained healthcare workforce. You would force 6 million seniors to have to choose between eating, buying prescription drugs, heating or cooling their homes by eliminating LIHEAP, the Low-Income Home Energy Assistance Program.

And you would reject the bipartisan intention of this Congress to save lives and address the public health crisis by ending the \$25 million for gun violence prevention research. One hundred Americans are killed every day by guns, 36,000 per year, two-thirds of which are suicides, a particular concern for our veterans.

That is not all. On the mandatory side you would take away health insurance from 20 million Americans by cutting healthcare by \$1 trillion over 10 years and eliminating the Affordable Care Act and its Medicaid expansion. And you are still in Federal court to repeal the Affordable Care Act, endangering the health coverage for 130 million Americans with preexisting conditions.

To date, you have not come up with a comprehensive plan to help. I could go on, and I am not, but the consequences of your budget would leave us as individuals and as a Nation less healthy, less safe, and less able with respect to economic security.

And so we will not allow you to go after millions of Americans; instead, we will continue to invest in health workforce programs, medical research, and the public health, because it is what American people need and what the American people deserve.

I appreciate the administration's request for increased funding to reduce maternal mortality as well as additional funding to address tick-borne diseases like Lyme disease. Although, it is one step forward and three steps backwards as the growth in incidents of Lyme disease is related to climate change, and yet, you propose to eliminate the CDC's climate change program.

The administration is also requesting increased funding for the second year of an HIV initiative to reduce transmission of HIV by 90 percent over 10 years. We strongly share that ambitious goal. Again, I have to note the contradiction at the heart of this because the administration is simultaneously proposing to cut NIH's HIV research portfolio, USAID's PEPFAR program, eliminate the Affordable Care Act, and eviscerate Medicaid. These are programs essential to combatting HIV. In fact, Medicaid is the largest payer for HIV care in the United States.

So, much to discuss today. We appreciate your being here. And before we turn to you for your testimony, let me turn to our ranking member, Congressman Cole, for remarks that he would like to make.

Congressman Cole.

Mr. COLE. Thank you.

Thank you very much, Madam Chairman.

Thank you, Mr. Secretary, for being here. I have got some prepared remarks that I am going to read in just a second, but before I do, I want to begin by thanking you. I want to thank you, I want to thank the professionals at the Centers for Disease Control and the National Institutes of Health, the folks that you have supervising our strategic stockpile.

I think you guys have—your team, in working with other departments—I know you have worked very closely with Homeland Secu-

rity and Transportation. You have been up here briefing us on a very regular basis—have done a really remarkable job in responding to something that this committee has been preparing for for years, and this committee ought to be very proud of its work on a bipartisan basis providing the tools for you and your colleagues to respond.

And through you, I want to thank the President. The President has taken very strong and decisive action here in terms of protecting our borders and, you know, I am pleased to see this supplemental here, and, you know, I suspect we will change it in some ways.

My good friend, the chairman, makes some points that I agree with her on, and I wouldn't be surprised to see you back here. But you are doing the right thing. You have used the resources we have given you. You have come back for a supplemental. I have no doubt you will come back again if you feel like you need them or need additional support, and I have no doubt, frankly, the Congress will be forthcoming.

I have to tell you, I have heard a lot of stuff not on this committee and certainly it isn't—but particularly in the other body that I have got to tell you is just transparently political claptrap. And that is what it is. And when I hear people say, well, the President's done—it is too little and too late. I think, where have you been? We have been preparing for this honestly before this administration was here.

We had 5 years in a row of substantial NIH funding. I know my friend, the chairman, worked with me when I was chairman. I have tried to work with her as her ranking member. We have shared this goal all along the way. And we have done the same thing at CDC.

We have done the same thing with strategic stockpile with this subcommittee that came up with the Infectious Diseases Rapid Response Fund that gave you the initial money to not wait around on Congress or political theatrics but to start responding immediately, and I think you have done that exceptionally well.

So when I hear you criticized by people that in many cases didn't vote for the bills that gave you the tools then I regard that as political as opposed to substantive.

Last point I want to make on this is, I really appreciate the briefings that we have gotten, Congress as a whole has gotten. You have been—you know, had your representatives here before this committee. Our chairman did a wonderful job in bringing in folks. We had an honest and open dialogue.

So the idea that we haven't been kept well informed or people have not said, look, we are going to do our very best but this is an unpredictable disease, this could spread at any time, these are not warnings that I just heard in the last 24 hours. These are things that your team has been telling us from the very beginning. And it suggests to me that the administration has been on top of this, and, again, I appreciate the President in that regard from the very beginning.

So I know you are—I was going to open by asking you how has your last week been, but I was afraid I would get an honest answer, so I don't want to begin that way.

But I do want to commend you, and I mean that with all sincerity. You are one—I think one of the best cabinet officers that the President has, and I think you and your team serve this country very well. And I think this incident is proof of that, not a contradiction to it.

Mr. Secretary, let me, again, wish you good morning. I look forward to the hearing today. Department of Health and Human Services has broad responsibility covering almost every aspect of daily life. In the next year, you are projecting almost a \$1.4 trillion in outlay. You oversee healthcare for our seniors and Native Americans, and ensure both the quality and safety of the Nation's food and drug supply.

Your agency forms the backbone of the public health infrastructure and is responsible for the development of medical protections against infectious diseases and chemical, biological, radiological, and nuclear agents. Discretionary spending provided by this subcommittee amounts—you know, accounts for only a small fraction of your overall total, really, just 8 percent of your outlays.

In just the last 2 years—I was reflecting about your tenure as Secretary—you have responded to unprecedented storms leaving thousands of limited access to healthcare in Puerto Rico, humanitarian crisis at our southern border, and opioid addiction epidemic, and most recently, the spread of a new infectious disease from China. And I want to commend you and your leadership of this agency.

First, I want to address the aggressive budget you have put before us. We know the cuts proposed are deep and, quite frankly, unlikely to be sustained. And I also know who writes the budget. They are called the OMB, the, you know, Office of Management and Budget, and you get to submit things but you have to come out and defend the decisions that are made there. And I appreciate that, and you work for the President, and you have to do that.

But I want to stress, continued cuts to discretionary spending will not solve the Nation's fiscal problems, period. It is not possible to balance our national budget by chipping away at discretionary spending. We must look to broader entitlement reform to achieve the valued goal of a balanced budget. Nearly 90 percent of your agency is entitlement spending on autopilot. The authorizing committees of jurisdiction need to tackle the mounting problem of entitlement spending.

I know, Mr. Secretary, you know these figures, but I hope those listening will take heed and recognize the challenges with Federal spending are not within the discretionary spending controlled by the Appropriations Committee.

Second, I want to stress again that, while small compared to your total outlays, the discretionary component of your budget that we are going to talk about today plays a critical role for our country. Moreover, several programs we will discuss here today touch the life of every American. I usually start with the National Institutes of Health, but today I think it is fitting to highlight how important the Centers for Disease Control and Prevention is to protect the health of the American people.

In the span of just a few weeks, we have witnessed a massive interagency undertaking to respond to the novel coronavirus from

China. The CDC is built on lessons learned from past outbreaks and was positioned to respond, inform, deploy, and protect. Hundreds of staff were marshalled quickly to work on different elements of the response efforts.

While not everything has gone perfectly, the Agency has shown the value of preparing for the unexpected and having a transparent, proactive communication strategy. I urge this committee to increase its support for the Infectious Diseases Rapid Reserve Fund at the CDC. As I have said here before, the threat of a pandemic is far greater than a terrorist event. Having resources uncommitted and immediately available is vital.

I know many are disappointed to once again see proposed reductions for the National Institutes of Health. You and I have had candid conversations about this. I too agree with my chairman here that a reduction there is unwise. However, I do want to point out this budget actually is \$12 billion more for the NIH than the level proposed just 4 years ago. So it is not as if you haven't recognized the value there, and, frankly, I think you are going to catch up to us someday and you are going to be with us in continuing this bipartisan effort to increase this spending.

I ardently urge Congress to continue to maintain its commitment to sustained increases for biomedical research, and I am pleased to see that with each budget the total request for NIH continues to increase. I hope decades from now future legislators commend the work of this committee for showing its commitment to biomedical research and maintaining American dominance in basic science.

Recent news reports highlighting efforts by the Chinese Government to steal intellectual property and use financial incentives to manipulate researchers stresses the importance of our advantage. We should be proud the knowledge gained from hard work of our scientists is the envy of the world, but we must also understand protecting and safeguarding that information is necessary to ensuring the Nation's security.

I also want to highlight your commitment to emergency preparedness. However, I was disappointed to see the reduction in Project BioShield and the Infectious Diseases Rapid Response Reserve Fund and only flat funding of the Strategic National Stockpile and the Biomedical Advanced Research and Development Agency, or BART as it is known.

And, again, I will just be candid with you. I attribute that to OMB more than I do to people at HHS. And we can have that discussion later, because this whole Congress and administration needs a serious discussion on spending, but that has been true for a long time and under previous administrations as well.

Our country needs to be ready to respond to any event to protect the health of the Nation. These programs are the Nation's frontline of defense against a domestic chemical, biological, or nuclear attack or infectious disease outbreak. We know current funding levels are not enough to have the Nation prepared for a large-scale event; therefore, reductions there, in my view, are misguided.

I do want to recognize the \$50 million increase for pandemic flu. While the current flu season has been milder than in years past, it has still resulted in thousands of hospitalizations and hundreds of deaths, including children. And I am encouraged by the commit-

ment expressed in your budget to increase vaccination rates and efforts to develop more effective vaccines. We will save lives with those investments.

Your budget also proposes to provide an additional \$680 million for the unaccompanied children program. This program has been a difficult and—has had a difficult and unpredictable history resulting in a deficiency in highly contentious supplemental appropriation last year. Your agency's efforts to move the program to a more stable position to respond to increases in arrivals at the southern border is long overdue. Building a system that can accommodate unpredictable arrivals at the southern borders is both necessary and responsible management of Federal resources.

Finally, again, I want to personally thank you for your—the efforts that you have undertaken in your agency to protect the life of innocent children and respect a person's right to follow their religious beliefs. I support your efforts to align the Title 10 Family Planning Program with current law and ensure a separation between family planning services and abortion.

I also support your efforts to allow for the free exercise of conscience and health insurance coverage and enforce current law provisions, which prohibit discrimination based off of decision not to support an abortion.

Again, I appreciate the job you have done for the American people. I look forward to your testimony here today.

Ms. DELAUBRO. Let me now yield to the chair of the full Appropriations Committee, Congresswoman Nita Lowey from New York.

Mrs. LOWEY. Welcome. And I thank Chair DeLauro, Ranking Member Cole for holding this hearing.

Secretary Azar, thank you for joining us today. As you know, Chair DeLauro and I sent you a letter on February 4 requesting information on additional resources for the coronavirus. Despite urgent warnings from Congress and the public health community, it has taken weeks for the Trump administration to request these emergency funds while tens of thousands have become ill around the world. And I understand well, as my colleague Mr. Cole has said, this may not be attributed to you, but here you are today, and I thank you.

Where still the overall request is inadequate to effectively combat this threat, it is alarming that the administration is proposing to take money from one emergency to pay for another, which would leave us more at risk for emerging diseases and is an irresponsible approach to combatting what the WHO has said is a potential pandemic. House Democrats will move quickly to enact a robust package that will fully address this threat without jeopardizing other necessary programs.

Now to the budget. Mr. Secretary, you and I have been able to work together on important public health issues, and I value our relationship. That is why it is so disappointing when you come before us with a budget that is really devoid from reality and would seriously harm the American people.

President Trump's disastrous budget is filled with program cuts opposed by the public and bipartisan majorities in both chambers. It is unfortunate that instead of using the budget to build on the

historic investments secured in last year's appropriation bills, the President doubled down on partisan talking points.

To propose investing \$2 billion for the wall or steal it outright from our veterans and servicemembers while proposing to cut initiatives that improve the well-being of Americans exposes the Trump administration priorities to what they are, campaign promises over public health.

Among many reckless proposals your budget would cut CDC by nearly \$700 million, just as CDC is combatting epidemics on opioids, surging rates of youth vaping—we could use a whole hearing, again, on just the youth vaping issue. I have never seen anything expand in all our public schools, even down to fourth, fifth, sixth grade.

One of the worst flu seasons in decades and the coronavirus, cut NIH by \$3.3 billion jeopardizing lifesaving medical research, and eliminate preschool development grants which would stall the important progress dates made to build strong early education systems.

In addition, the irresponsible proposal to eliminate teen pregnancy prevention while assaulting Medicaid and attacking the foundation of Title 10 Family Planning with a domestic gag rule is a dangerous combination that will leave many women without access to quality care, result in more unplanned pregnancies. This is an assault on women's health and the rights of women and their doctors.

And I was dismayed—actually shocked—with the elimination of the Federal funding we included in the fiscal year 2020 spending bill for the first time in two decades for gun violence prevention research. While you have supported this research in the past—I want to say that again. I am aware that you have supported this research in the past—the budget makes clear that the President does not intend to do anything to combat the gun violence epidemic in this country.

In addition, rather than invest in the ability of State and local governments to combat the vaping epidemic, which has led to at least 64 deaths, nearly 3,000 hospitalizations, this budget would consolidate CDC's office on smoking and health, cut its funding at the very moment we need the CDC's expertise and resources.

So if a budget is a statement of values, that it is clear that President Trump has no intention of protecting our young people or improving the health of Americans.

So thank you so much for being here. I look forward to continuing the discussion.

Ms. DELAURO. Thank you.

I now want to yield to the ranking member of the full Appropriations Committee, Congresswoman Kay Granger from Texas.

Ms. GRANGER. Thank you so much.

Before I begin my prepared remarks on the crisis that we are dealing with right now, I want to associate myself with Ranking Member Cole's remarks having to do with your good job and the planning that has gone on in this committee for such a long time.

I would like to thank Chairwoman DeLauro and Ranking Member Cole, who also serves as the vice ranking member for the full committee, for holding this hearing.

I also want to thank you, Secretary Azar, for your efforts to protect our Nation from this new coronavirus. Your immediate actions have enabled us to get ahead of the virus and begin protecting our citizens.

At the beginning of the outbreak you told Members of Congress that you would let us know as soon as possible when more funding was needed, and you have done just that. I am confident that Congress will work with you to make sure you have the resources in hand to continue to respond rapidly to this dynamic situation.

All Americans should be reassured this morning that we have a robust public health system that is able to respond in every State to an infectious disease outbreak such as this. Congress has strengthened our State and local efforts with recent investments, including \$85 million in the most recent fiscal year 2020 appropriation for a rapid response to an infectious disease.

This is the very situation that led the subcommittee under the leadership of my friend Mr. Cole and Chair DeLauro to create such a fund, and I am pleased to see that it is enabling your agency to mount a quick and proactive effort to keep our Nation safe.

I look forward to working with you and my colleagues in Congress as we continue to prevent the spread of this and other diseases within our country. I thank you for being here to testify today, and I yield back my time.

Ms. DELAURO. Thank you very much.

Mr. Secretary, your testimony—and as you know, your full testimony will be entered into the record, and now you are recognized for 5 minutes. Thank you.

Secretary AZAR. Great. Thank you very much.

Chairwoman Lowey, DeLauro, and Ranking Members Granger and Cole, thank you very much for inviting me to discuss the President's budget for fiscal year 2021. I am honored to appear before this committee for budget testimony as HHS Secretary for the third time, especially after the remarkable year of results that HHS has produced in the last year.

With support from this committee this past year we saw drug overdose deaths decline for the first time in decades, another record year of generic drug approvals at FDA, and historic drops in Medicare Advantage, Medicare Part D, and Affordable Care Act exchange premiums.

The President's budget aims to move toward a future where HHS programs work better for the people we serve, where our human services programs put people at the center, and where America's healthcare system is affordable, personalized, puts patients in control, and treats them like a human being not like a number.

HHS has the largest discretionary budget of non-defense department agencies, which means that difficult decisions must be made to put discretionary spending on a sustainable path. This committee has made important investments over the years, and some of HHS's large discretionary programs, including the National Institutes of Health and we are grateful for that work.

The President's budget proposes to protect what works in our healthcare system and make it better. I will mention two ways we do that: First, facilitating patient-centered markets, and second, tackling key impactable health challenges.

The budget's healthcare reforms aim to put the patient at the center. It would, for instance, eliminate cost sharing for colonoscopies, a lifesaving preventive service. The budget would reduce patients' costs and promote competition by paying the same for certain services regardless of setting. And it endorses bipartisan, bicameral drug pricing legislation. The budget's reforms will improve Medicare and extend the life of the hospital insurance fund for at least 25 years.

We propose investing \$116 million in HHS's initiative to reduce maternal mortality and morbidity, and we propose reforms to tackle America's rural healthcare crisis, including telehealth expansions, and new flexibility for rural hospitals.

The budget increases investments to combat the opioid epidemic including SAMHSA's State opioid response program where we appreciate this committee's work with us to give States flexibility to address stimulants like methamphetamines. We request \$716 million for the President's initiative to end the HIV epidemic in America by using effective evidence-based tools, and this committee's support has enabled us to begin implementation already.

Today, I am pleased to announce that the Health Resources and Services Administration is dispersing \$117 million in grants to expand access to HIV treatment and prevention by leveraging successful programs and community partnerships, such as the Ryan White HIV/AIDS Program and community health centers to reach more Americans who need treatment or prevention services.

The budget reflects how seriously we take the threat of other infectious diseases such as the novel coronavirus by prioritizing funding for CDC's infectious disease programs and maintaining investments in hospital preparedness. We still have only 14 cases of the novel coronavirus detected in the United States involving travel to or close contacts with travelers.

We have three cases among Americans repatriated from Wuhan and 42 cases among American passengers repatriated from the Diamond Princess. The immediate risk to the American public remains low, but there is now community transmission in a number of countries, including outside of Asia, which is deeply concerning. We are working closely with State, local, and private sector partners to prepare for mitigating the virus' potential spread in the United States, as we expect to see more cases here.

On Monday, OMB Center requests to make at least \$2.5 billion in funding available for preparedness and response, including for therapeutics, vaccines, personal protective equipment, State and local public health support, and surveillance. I look forward to working closely with Congress on that request.

Lastly, when it comes to human services, the budget cuts back on programs that lack proven results while reforming programs like TANF to drive State investments in supporting work in the benefits it brings for well-being. We continue the fiscal year 2020 investments Congress made in Head Start and child care programs, which promote children's well-being and adults' independence.

This year's budget aims to protect and enhance Americans' well-being and deliver Americans a more affordable, personalized healthcare system that works better than just spends more,

and I look forward to working with this committee to make that commonsense goal a reality.

Thank you very much.

[The statement of Secretary Azar follows:]

Sec. Azar Written Budget Testimony

The President's Fiscal Year (FY) 2021 Budget (Budget) is built around a vision for HHS and a vision for American healthcare. We are building toward a future where HHS's programs work better for the people we serve; where America's healthcare system is affordable, personalized, and puts patients in control; and where our human services programs put people at the center.

The Budget reflects the Administration's commitments to delivering on this vision and other important themes of HHS's work: advancing a patient-centered healthcare system, protecting the lives of the American people, promoting independence, and making HHS the healthiest organization it can be.

Over the past year, under President Trump's leadership, the men and women of HHS have delivered remarkable results. Beginning in 2018 and through 2019, the number of drug overdose deaths in America began to decline for the first time in nearly two decades, thanks to huge expansions, assisted by HHS, in access to evidence-based addiction treatment. The Food and Drug Administration (FDA) approved a record number of generic drugs and biosimilars in FY 2019. We launched new payment models in Medicare that pay for health and outcomes, rather than sickness and procedures. We finalized a requirement, effective January 2021, that hospitals provide patients with useful price information, and proposed measures to give patients control over their own health data through interoperability. We launched President Trump's initiative to end the HIV epidemic in America within ten years, and worked with Congress to secure funding for it. The Department played a vital role in responding to an Ebola outbreak in the eastern Democratic Republic of the Congo and the humanitarian crisis in Latin America. We took unprecedented steps to expand access to treatment for Americans with serious mental illness and worked to help seniors remain in their homes. The latest data from the Administration for Children and Families shows a record number of adoptions with child-welfare-agency involvement, and reductions in the number of children entering foster care. The Budget proposes to continue work on these priorities, while also identifying new areas for action, such as maternal and rural health.

The Budget proposes \$94.5 billion in discretionary budget authority and \$1.3 trillion in mandatory funding. Within our discretionary programs, it prioritizes funding for programs that have demonstrated effectiveness, proposes to end programs that have not, and focuses on direct services provided to the American people. On mandatory spending, the Budget proposes commonsense reforms that will pave a path to fiscal sustainability and make these important programs work better for the people they serve.

FACILITATE PATIENT-CENTERED CARE

Providing Price and Quality Transparency

President Trump's Executive Order on *Improving Price and Quality Transparency in American Healthcare to Put Patients First* directs HHS to make healthcare prices transparent, laying the foundation for a patient-driven and value-based health system. HHS has acted swiftly to require hospitals to publish the prices they negotiate with insurers and is working to do the same for issuers, so patients can understand their own out-of-pocket costs. CMS has also required Part D

prescription drug plans to develop tools that allow beneficiaries to determine plan benefits and formularies.

The Executive Order calls for the development of a Health Quality Roadmap that aligns and improves reporting on data and quality measures across Medicare, Medicaid, the Children's Health Insurance Program, and other Federal health programs. The Roadmap will include a strategy for establishing, adopting, and publishing common quality measures; aligning hospital inpatient and hospital outpatient measures; and eliminating low-value or counterproductive measures.

HHS legislative proposals increase price and quality transparency in Medicare. For instance, the Budget would eliminate coinsurance or copayments for a screening colonoscopy when a polyp is found, saving lives and supporting the President's policy to reduce out-of-pocket costs for this common procedure.

The Budget also invests funding in programs that promote transparency. The Budget requests \$51 million for the Office of the National Coordinator for Health IT, which includes funding to develop, promote, and adopt common standards to integrate health information and product transparency while protecting privacy. In addition, the new National Institute for Research on Safety and Quality within the National Institutes of Health (NIH) supports the Administration's efforts to move healthcare organizations from volume to value by focusing on improving outcomes, reducing cost, and expanding choices for consumers. Research investments will focus on developing knowledge, tools, and data needed to improve the healthcare system.

Lowering the Cost of Prescription Drugs

The United States is first in the world in biopharmaceutical investment and innovation. But too often, this system has not put American patients first. We have access to the greatest medicines in the world, but access is meaningless without affordability. The Budget supports quick Congressional action to pass comprehensive legislation to address these flaws in our current drug pricing system and provide needed relief to the American people.

The Budget delivers on President Trump's promise to bring down the high cost of drugs and reduce out-of-pocket costs for American consumers by pursuing policies that align with the four pillars of the President's *American Patients First Blueprint*: increased competition, better negotiation, incentives for lower list prices, and lowering out-of-pocket costs.

The Budget includes an allowance for bipartisan drug pricing proposals. The Administration supports legislative efforts to improve the Medicare Part D benefit by establishing an out-of-pocket maximum and reducing out-of-pocket costs for seniors. The Administration also supports changes to bring lower cost generic and biosimilar drugs to patients. These efforts would increase competition, reduce drug prices, and lower out of pocket costs for patients at the pharmacy counter.

The Budget includes an allowance for savings of \$135 billion over ten years to support the President's commitment to lower the cost of prescription drugs.

Protecting and Improving Medicare for our Nation's Seniors

Over 60 million American seniors are in the Medicare program, and they are overwhelmingly satisfied with the care they receive through traditional Medicare and Medicare Advantage. The President is continuing to strengthen and improve these programs.

The Budget continues to implement the President's Executive Order on *Protecting and Improving Medicare for Our Nation's Seniors*, building on those aspects of the program that work well, while also introducing market-based approaches to Medicare reimbursement. The Administration seeks to protect and reform Medicare with proposals that strengthen fiscal sustainability and deliver value to patients. To drive reform, the Centers for Medicare & Medicaid Services (CMS) is modernizing the Medicare Advantage program, unleashing innovation, expanding telehealth options, and driving competition to improve quality among private Medicare health and drug plans. The Administration is expanding flexibility for these Medicare Advantage plans to maximize choices for seniors, and taking action to ensure fee-for-service Medicare is not promoted over Medicare Advantage.

President's Health Reform Vision Allowance

While Americans have the best healthcare options in the world, rising healthcare costs continue to be a top financial concern for many Americans. President Trump's Health Reform Vision will protect the most vulnerable, especially those with pre-existing conditions, and provide the affordability, choice, and control Americans want and the high-quality care that all Americans deserve.

The President's Health Reform Vision would build on efforts outlined in the Executive Order, "Improving Price and Quality Transparency in American Healthcare To Put Patients First" to provide greater transparency of healthcare costs and enshrine the right of a patient to know the cost of care before it is delivered. It focuses on lowering the price of medicine, ending surprise medical bills, breaking down barriers to choice and competition, and reducing unnecessary regulatory burdens. The Health Reform Vision will also prioritize Federal resources for the most vulnerable and provide assistance for low-income individuals. Medicaid reform will restore balance, flexibility, integrity, and accountability to the state-federal partnership. Medicaid spending will grow at a more sustainable rate by ending the financial bias that currently favors able-bodied working-age adults over the truly vulnerable.

The Budget includes savings of \$844 billion over ten years for the President's Health Reform Vision Allowance.

Paying for Outcomes

The Administration is committed to advancing a personalized and affordable healthcare system that puts the patient at the center by ensuring Federal health programs produce quality outcomes and results at the lowest possible cost.

In part, this will be achieved by our continued focus on paying for outcomes rather than procedures. For instance, the Budget seeks to improve Medicare primary care services by ensuring payments more accurately reflect clinician time, resources, and outcomes. The Budget also implements a value-based purchasing program for hospital outpatient departments,

ambulatory surgical centers, and post-acute care facilities, offering incentives to improve quality and health outcomes. Finally, the Budget proposes a set of reforms that improve the physician experience and participation in the Quality Payment Program by eliminating reporting burdens for clinicians participating in the Merit-Based Incentive Payment System, CMS's largest value-based care payment program.

The Administration issued proposed rules to modernize key regulations that advance the movement to value-based care and paying for outcomes. Specifically, the Administration proposed reforms to the Anti-Kickback Statute, the Physician Self-Referral regulations (Stark Law), and 42 CFR Part 2. These proposed rules are part of HHS's Regulatory Sprint to Coordinated Care, which aims to reduce regulatory barriers and accelerate the transformation of the healthcare system into one that better pays for value and promotes care coordination. These proposed rules reduce unnecessary regulatory burden on physicians and other healthcare providers while reinforcing their statutory intents of protecting patients from unnecessary services, and limiting fraud waste and abuse. This includes adding flexibilities with respect to outcomes-based payments and part-time arrangements. These rules would allow physicians and other healthcare providers and suppliers to design and enter into value-based arrangements that improve quality outcomes, produce health system efficiencies, and lower costs.

The CMS Center for Medicare and Medicaid Innovation (Innovation Center) launched a number of innovative payment and service delivery models to test ideas to shift our healthcare system toward payment for outcomes and health rather than sickness and procedures. This effort includes Direct Contracting and Primary Care First, a new suite of payment model options that will transform primary care to deliver better value for patients throughout the healthcare system. In addition, the Emergency Triage, Treat, and Transport Model provides greater flexibility to ambulance care teams to address emergency healthcare needs of Medicare beneficiaries following a 911 call, rather than delivering them to the hospital or emergency department for an unnecessary and expensive visit.

PROTECT LIFE AND LIVES

Combating the Opioid and Methamphetamine Crisis

In 2018, drug overdose deaths declined for the first time since 1990. A reduction in deaths from prescription opioid painkillers is almost entirely responsible for this decline. To maintain and build on this progress, HHS continues to advance the department's five-point 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 requests \$5.2 billion to address the opioid overdose epidemic and methamphetamine use, including \$169 million in new resources. Funding expands State Opioid Response grants in the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide treatment, recovery support services, and relapse prevention. The Budget provides funding to

the Health Resources and Services Administration (HRSA) for Addiction Medicine Fellowships to support approximately 60 fellows annually in underserved, community-based settings that integrate primary care with mental health and substance use disorder prevention and treatment services.

While opioids have been at the forefront of the drug landscape, the crisis continues to evolve and many public health experts believe we are entering into the fourth wave of the crisis, which is underscored by increases in overdose deaths involving cocaine and methamphetamine.

HHS is leveraging current efforts to address the opioid epidemic to combat the rising mortality and morbidity associated with methphetamines and other stimulants. To allow flexibility to most effectively combat substance use in whatever form it takes, SAMHSA's State Opioid Response grant program has the flexibility to also address stimulants. HHS would direct \$50 million within NIH for research to develop medication-assisted treatment and evidence-based psychosocial treatment for methphetamines and other stimulants.

Ending the HIV Epidemic: A Plan for America

In the 2019 State of the Union, President Trump announced a bold new initiative to reduce new HIV infections by 75 percent in the next 5 years and by 90 percent in the next 10 years, averting more than 400,000 HIV infections in that time period. This initiative focuses on four key strategies:

- Diagnose all individuals with HIV as early as possible after infection;
- Treat the infection rapidly and effectively after diagnosis, achieving sustained viral suppression;
- Protect individuals at risk for HIV using proven prevention approaches; and
- Respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.

The Budget invests \$716 million in dedicated funding for the second year of the *Ending the HIV Epidemic: A Plan for America* initiative, an increase of \$450 million from FY 2020. This funding expands activities in the 57 target jurisdictions to increase HIV testing and access to prevention and treatment services.

With \$371 million, the Centers for Disease Control and Prevention (CDC) transitions from planning to implementation and intensifies work begun in FY 2020 in the 57 target jurisdictions. CDC grants to affected communities will drive additional testing with the goal in the second year of doubling the number of new HIV diagnoses rapidly treated with antiretroviral therapy to maintain health and prevent additional HIV transmissions. Funded jurisdictions will use pharmacy data, telehealth, mobile testing, and new science-based networks to ensure individuals enter and adhere to care.

With \$302 million, HRSA expands HIV prevention services to all community health centers in the targeted initiative areas and serves 28,000 additional HIV positive people through the Ryan White Program. HHS also requests \$27 million for the Indian Health Service (IHS) to enhance HIV testing and linkages to care for American Indians and Alaska Natives.

NIH directs \$16 million to leverage pilot data from 17 Centers for AIDS Research to design and evaluate effective, sustainable systems to implement HIV prevention and treatment interventions and rapidly implement strategies at scale that will be most effective.

These investments build on ongoing HIV activities supported across the Department and an announcement in 2019 to make pre-exposure prophylaxis medication available free of charge for up to 200,000 uninsured individuals each year for up to 11 years. The donation by Gilead Sciences, in partnership with HHS, will help reduce the risk of HIV infections, particularly for individuals that may be at the highest risk.

Improving Maternal Health

Approximately 700 women die each year in the United States from pregnancy-related complications and more than 60 percent of these deaths are preventable. In fact, women in the United States have higher rates of maternal mortality and morbidity than in any other industrialized nation – and the rates are rising. In addition to rising mortality rates, severe maternal morbidity affects more than 50,000 women and adds significant costs to the healthcare system.

Cardiovascular disease is now the leading cause of death in pregnancy and the postpartum period, constituting nearly 30 percent of pregnancy-related deaths. Chronic hypertension – which is diagnosed or present before pregnancy or before 20 weeks gestation – may result in significant maternal, fetal, and neonatal morbidity and mortality. The rate of chronic hypertension increased by 67 percent from 2000 to 2009, with the largest increase (87 percent) among African American women. CDC points to hypertensive disorders, cerebrovascular accidents, and other cardiovascular conditions as some of the leading causes of maternal deaths, all potentially preventable conditions. It is imperative to identify risk factors prior to pregnancy in order to prevent poor pregnancy and postpartum outcomes.

HHS's *Improving Maternal Health in America* initiative is addressing this significant public health problem. This initiative focuses on four strategic goals:

- Achieve healthy outcomes for all women of reproductive age by improving prevention and treatment;
- Achieve healthy pregnancies and births by prioritizing quality improvement;
- Achieve healthy futures by optimizing postpartum health; and
- Improve data and bolster research to inform future interventions.

The Budget provides a total of \$116 million for this initiative across the National Institute for Research on Safety and Quality (NIRSQ), CDC, HRSA, and IHS. This includes \$7 million for NIRSQ to improve service data, advance data evaluation, and expand medical expenditure surveys to ensure policy makers have timely and accurate data. The Budget also invests \$24 million in CDC to expand the Maternal Mortality Review Committees to all 50 states and D.C. to ensure every case of pregnancy-related death is examined. The Budget provides \$80 million in HRSA to improve the quality of maternal health services, expand access to care, and reduce disparities in care. The Budget invests \$5 million in IHS to help improve health outcomes by standardizing care, increasing cultural awareness, and improving care for pregnant women.

Advancing American Kidney Health

Today's status quo in kidney care carries a tremendous financial cost. In 2016, Medicare fee-for-service spent approximately \$114 billion to cover people with kidney disease, representing more than one in five dollars spent by the traditional Medicare program. In July 2019, the President signed an Executive Order launching an initiative to transform care for the estimated 37 million Americans with kidney disease. The *Advancing American Kidney Health* initiative tackles the challenges people living with kidney disease face across the stages of kidney disease, while also improving the lives of patients, their caregivers, and family members.

The Budget includes \$39 million across multiple HHS agencies and requests new legislative authority in support of the initiative's three goals:

- Reduce the number of Americans developing End-Stage Renal Disease (ESRD) by 25 percent by 2030.
- Have 80 percent of new ESRD patients in 2025 receive dialysis at home or a transplant.
- Double the number of kidneys available for transplant by 2030.

This funding also supports transplantation activities for other organs.

To achieve these goals, HHS is scaling programs nationwide to optimize screening for kidney disease and educate patients on care options. HHS is also supporting innovation and groundbreaking research to inform the next generation of targeted therapies and accelerate development of innovative products such as an artificial kidney. New and pioneering payment models are also being developed to increase both value and quality of care for the patient.

The Budget also targets new funding towards HRSA's Organ Transplantation Program to remove financial disincentives for living organ donors. The Budget invests \$31 million in HRSA for the Organ Transplantation program, including \$18.3 million for the Organ Procurement Transplantation Network, Scientific Registry of Transplant Recipients, and public and professional education efforts to increase public awareness about the need for organ donation. In addition, the proposed rule to increase accountability and availability of the organ supply – announced in December 2019 – would improve the donation and transplantation rate measures, incentivize Organ Procurement Organizations (OPOs) to ensure all viable organs are transplanted, and hold OPOs to greater oversight, transparency, and accountability while driving higher OPO performance.

HHS is working to accelerate innovation in the prevention, diagnosis, and treatment of kidney disease through the Kidney Innovation Accelerator (KidneyX), a public-private partnership between HHS and the American Society of Nephrology. The HHS Office of the Chief Technology Officer will continue the KidneyX competition in FY 2021 by challenging individuals, teams, and companies to build and test prototype solutions, or components of solutions, that can replicate normal kidney functions or improve dialysis access.

The Budget proposes to establish a new program within the Office of the Assistant Secretary for Preparedness and Response (ASPR) that will advance kidney health. The Preparedness and Response Innovation program will support advanced research and development, prototyping and

procurement of revolutionary health security products, technologies and other innovations. The program's first project will focus on portable dialysis equipment for emergency response. This will ensure that individuals with kidney failure have access to dialysis during a disaster.

The Budget also advances legislative proposals to revolutionize the way patients with chronic kidney disease and kidney failure are diagnosed, treated, and supported. This effort includes extensions of both the NIH Special Diabetes Program and IHS Special Diabetes Program for Indians to address chronic conditions, such as diabetes, that can lead to kidney disease.

For patients who lose Medicare coverage at 36 months post-transplant and who do not have another source of healthcare coverage, the costs of continuing immunosuppressive drug therapy may be prohibitive. Without these drugs, the patient's body rejects the transplant, reverts to kidney failure, and requires dialysis. To prevent transplant rejection and reversion to dialysis, the Budget proposes to establish a new federal program that provides lifetime coverage of immunosuppressive drugs for certain kidney transplant recipients until they are otherwise eligible for Medicare coverage. The Budget also proposes to increase competition among, and oversight over, Organ Procurement Organizations to improve performance and increase the supply of organs for transplant. In addition, the Budget advances new innovative kidney care payment models to encourage home dialysis, increase access to kidney transplants, and incentivize clinicians to better manage care for patients with kidney disease.

Transforming Rural Health

There are 57 million Americans living in rural communities. Rural Americans face many unique health challenges, including hospitals that are closing or in danger of closing; difficulty recruiting and retaining physicians, nurses, and other providers; and increased likelihood of dying from many leading causes of avoidable death such as cancer and heart disease.

HHS's *4-Point Strategy to Transform Rural Health* builds on current HHS initiatives in the following areas:

- Build a Sustainable Health Model for Rural Communities;
- Leverage Technology and Innovation;
- Focus on Preventing Disease and Mortality; and
- Increase Rural Access to Healthcare.

The Budget supports rural communities through programs such as the Rural Communities Opioids Response Program and the Telehealth Network Grant Program at HRSA, which supports substance use prevention, treatment, and recovery services, and promotes telehealth technologies for healthcare delivery in rural communities. Project AWARE (Advancing Wellness and Resiliency in Education) will increase mental health awareness training in rural communities. In response to American Indian and Alaska Native communities' demand for telebehavioral services, IHS expands the Telebehavioral Health Center of Excellence with funding for new space, updated equipment, and additional behavioral health providers.

Telehealth services strive to make rural health programs more effective, increase the quality of healthcare, and improve health outcomes. The Budget seeks to remove barriers to telehealth services in rural and underserved areas through a proposal to expand telehealth services in

Medicare fee-for-service advanced payments models with more than nominal financial risk. This proposal broadens beneficiary access to Medicare telehealth services and addresses longstanding stakeholder concerns that the current statutory restrictions hinder beneficiary access. The proposal expands the telehealth benefit in Medicare Fee-for-Service and provides authority for Rural Health Clinics and Federally Qualified Health Centers to be distant site providers for Medicare telehealth services. It also permits IHS and tribal facilities to be originating and distant site providers, even if the facility does not meet the requirements for being located in certain rural or shortage areas, and allows for coverage across state lines. The Budget also proposes to modernize payments to Rural Health Clinics to ensure equitable payment for these health clinics and help rural communities maintain access to these crucial services. Finally, the Budget proposes to allow Critical Access Hospitals to voluntarily convert to an emergency hospital that does not maintain inpatient beds.

Addressing Tick-borne Diseases

Tick-borne diseases, of which Lyme Disease is the most common, account for 80 percent of all reported vector-borne disease cases each year and represent an important emerging public health threat in the United States. With 59,349 reported cases in 2017, the annual number of reported cases has more than tripled over the last 20 years; due to under-reporting, this number substantially under-represents actual disease occurrence. The geographic ranges of ticks are also expanding, which leads to increased risk for human exposure to the bites of infected ticks. Most humans are infected through bites from very small young ticks, hosted by deer or mice.

To address critical gaps in knowledge, diagnostics, and preventive measures for tick-borne diseases, HHS is proposing an action plan that will prioritize and advance the most promising candidates and technologies for diagnosing and preventing Lyme and other tick-borne diseases. This plan, led by the Office of the Assistant Secretary for Health in partnership with NIH, CDC, and FDA, will address four primary areas: innovations in diagnosis and advanced detection, developing vaccine-based prevention, ensuring robust domestic surveillance of vector borne diseases, and providing additional knowledge to advance the best treatment and prevention options. These efforts will improve outcomes for those affected by Lyme Disease symptoms. This plan builds on the Kay Hagan Tick Act, enacted through the Consolidated Appropriations Act for 2020, to improve research, prevention, diagnostics, and treatment for tick-borne diseases.

The Budget requests \$189 million, an increase of \$58 million, to address tick-borne diseases. This amount includes \$115 million for NIH to expand its research on of tick-borne disease, including in the prevention, diagnosis, and treatment; and \$66 million for CDC to address vector-borne diseases, focusing on tick-borne diseases, including tick surveillance, insecticide resistance activities, and development of improved diagnostics. FDA will ensure the safety and efficacy of products developed to prevent, diagnose, and treat vector-borne diseases.

Focusing on Influenza

Influenza is a serious disease that can lead to hospitalization and sometimes death, even among healthy people. In the United States, millions of people are sickened, hundreds of thousands are hospitalized, and tens of thousands die from influenza every year. In September 2019, the President signed Executive Order 13887, *Modernizing Influenza Vaccines in the United States to*

Promote National Security and Public Health. The Executive Order recognized influenza as a public health threat and national security priority, and directed HHS to prepare and protect the nation.

The Budget invests \$998 million to continue on-going influenza activities as well as targeted increases to support this directive. This amount includes \$306 million for ASPR to modernize influenza vaccine manufacturing infrastructure and advance medical countermeasure research and development. Activities include additional clinical studies on licensure of pre-pandemic recombinant-based influenza vaccine and the advanced development of novel diagnostics, respiratory protective devices, and alternative vaccine delivery technology. The Budget also funds the Office of Global Affairs to support US leadership of international efforts on pandemic influenza preparedness.

The Budget requests \$216 million for CDC's Influenza program, an increase of \$40 million. CDC will expand influenza vaccine effectiveness monitoring systems and develop and characterize candidate vaccine viruses for vaccine manufacturers, and efforts to improve the evidence-base on non-egg-based vaccines. CDC will support whole genome characterization of more than 10,000 influenza viruses. All of these activities help build domestic capacity. CDC will also increase influenza vaccine use by removing barriers to vaccination and enhance communication to healthcare providers about the performance of influenza vaccines.

The Executive Order also calls for the development of novel technologies to speed seed vaccine development, targeted development of vaccines that protect against multiple types of virus for multiple years, and to improve adjuvants. In support of this goal, the Budget includes \$49 million for FDA to support regulatory science research and clinical assessments to promote development and access to safe and effective influenza vaccines, and \$423 million for NIH to accelerate influenza research, including universal flu vaccine development.

Emergency Preparedness

HHS plays a key role in supporting domestic and international preparedness and response to ensure our nation's safety. The Budget invests \$2.6 billion in ASPR to expand efforts to prevent, prepare for, respond to, and recover from, the adverse health effects of public health emergencies. This amount includes \$562 million for the Biomedical Advanced Research and Development Authority to maintain a robust pipeline of innovative medical countermeasures that mitigate health effects of infectious diseases and chemical, biological, radiological, and nuclear agents. It also includes \$535 million for Project BioShield to support procurement of medical countermeasures against these threats, and \$705 million for the Strategic National Stockpile to sustain and increase inventory of high-priority countermeasures such as antibiotics to treat anthrax exposure and vaccine to prevent smallpox. These investments will help HHS advance progress towards national preparedness goals.

NIH supports a robust research portfolio to develop vaccines and therapeutics that enable rapid response to public health threats including emerging microbial threats, such as extensively drug-resistant tuberculosis, emerging viral strains such as Zika, and viral hemorrhagic fevers such as Ebola. The Budget continues investments in NIH in scientific research on these new threats, and

invests \$120 million in FDA to facilitate medical countermeasure development and availability to respond in the event of a microbial or other public health threat.

Strengthening the Indian Health Service

The Administration is committed to improving the health and well-being of American Indians and Alaska Natives. This population continues to experience significant health disparities, and the Budget includes key investments to ensure quality of care. The Budget invests \$6.2 billion in IHS, which includes \$125 million for electronic health record modernization, provides funding to support IHS Services, Ending the HIV Epidemic, and Maternal Health, and includes \$125 million for high-priority healthcare facilities construction projects. The Budget proposes a new, indefinite discretionary appropriation and reforms for IHS to address Indian Self-Determination and Education Assistance Act section 105(l) lease costs.

Reforming Oversight of Tobacco Products

The Budget proposes to move the Center for Tobacco Products out of FDA and create a new agency within HHS to focus on tobacco regulation. A new agency with a mission focused on tobacco and its impact on public health would have greater capacity to respond rapidly to the growing complexity of new tobacco products. Additionally, this reorganization will allow the FDA Commissioner to focus on its traditional mission of ensuring the safety of our nation's drug, food, and medical products supply.

Providing Shelter and Services for Unaccompanied Alien Children

The Administration for Children and Families (ACF) provides shelter, care, and support for unaccompanied alien children apprehended by the Department of Homeland Security or other Federal Government department or agency. The number of unaccompanied alien children requiring care is inherently unpredictable. In FY 2019, ACF cared for 69,488 children, the highest number in the program's history. To ensure adequate shelter capacity and care in FY 2021, the Budget requests a total of \$2 billion in discretionary funds to support capacity of 16,000 licensed permanent beds, depending on operational needs, and includes a mandatory contingency fund to provide up to \$2 billion in additional resources if needed.

PROMOTE INDEPENDENCE

Promoting Upward Mobility

In the human services work at HHS, the overarching goal is to promote personal responsibility, independence, and self-sufficiency—to help Americans lead flourishing, fulfilling, independent lives. HHS programs for low-income Americans achieve this goal by supporting work, marriage, and family life. HHS seeks to better align our social safety net programs with the booming economy, and focus on work as the means to lift families out of poverty.

Many Americans are joining the workforce as the Administration's policies continue to strengthen the economy and produce historically low unemployment rates. The Administration supports working families by investing in child care, an important work support that helps families achieve independence and self-sufficiency. The Administration is working to implement policies that increase access to high-quality, affordable child care.

The Budget proposes to improve the Temporary Assistance for Needy Families (TANF) program by restoring its focus on employment and work preparation, and by targeting funds to low-income families. The proposal fundamentally changes the way the program measures success by moving to measures that focus on employment outcomes, phasing out the ineffective work participation rate. In addition, the Budget establishes Opportunity and Economic Mobility Demonstrations that allow for the streamlining of funding from multiple safety net programs to deliver coordinated and effective services. The Budget also seeks to improve consistency between work requirements in TANF and Medicaid by requiring that able-bodied individuals participate in work activities at least 20 hours per week in order to receive welfare benefits.

Supporting Child Care

Child care is an investment in both present and future generations of the workforce. However, it is also one of the biggest expenses for families and can be a barrier to work. Funding plays a critical role in helping families achieve self-sufficiency by providing parents access to a range of child care options. In FY 2018, the most recent year for which preliminary data are available, over 1.3 million children from about 813,000 low-income families received a monthly child care subsidy from the Child Care and Development Fund. The Budget provides \$5.8 billion for the Child Care and Development Block Grant and \$4.2 billion in mandatory child care funding for a total investment of \$10.0 billion in child care. The mandatory funding includes a one-time \$1 billion fund for competitive grants to states to increase child care services for underserved populations and stimulate employer investment in child care. The Budget will serve 1.9 million children.

Promoting Adoption

Adoption gives children stability and love during their childhood, and also a safe and stable environment in which to grow into responsible adults who flourish. Approximately 20,000 youth exit or “age out” of foster care each year without the safety net of a forever family, and their outcomes are often concerning. A longitudinal study found that only 58 percent graduated from high school, and only half found employment by age 24. More than a third of youth in one study had experienced homelessness at least once by age 26. Children and young adults in foster care cannot be expected to achieve the independence they need to thrive and flourish on their own—but finding them a loving forever family could change all that.

According to ACF, the number of children adopted with help from public child welfare agencies rose from 59,000 in FY 2017 to more than 63,000 in FY 2018. To sustain this momentum, ACF has launched a Call to Action for states and other stakeholders, which aims to develop and sustain key partnerships across public and private groups, including faith-based groups, with the goal of reducing the number of children in foster care and increasing the number of children who find a forever family, through adoption or otherwise.

The Adoption Assistance and Guardianship Assistance programs will provide \$4.1 billion in FY 2021 in mandatory funding to provide monthly support payments to families adopting sibling

groups or other children with special needs. Under existing law, Adoption Assistance funding will keep pace with the number of qualifying children adopted each year.

HHS promotes adoption through administrative actions and funding incentives to promote adoption, and to identify and address barriers to adoption. Initiatives include family-finding programs, focusing on identifying the barriers that exist in the recruitment and development of foster and adoptive families, and the development and dissemination of court-related practice improvements addressing barriers to timely adoptions.

Supporting Families and Preventing the Need for Foster Care

Helping families receive the care and services they need before the involvement of a child welfare agency can help prevent a child from entering foster care. The Administration has focused on primary prevention, as well as adoption, and we are starting to see better results. HHS is implementing the Family First Prevention Services Act (Family First Act), which supports services to prevent child maltreatment and the need for foster care. This groundbreaking new legislation provides the opportunity for substantial improvements in outcomes for children and families. The Budget proposes to streamline the process for evaluating evidence-based prevention services programs under the Family First Act to give states and tribes access to more programs that help prevent the need for foster care and assist kinship caregivers.

The Budget invests \$510 million for discretionary child welfare activities in ACF, including services that allow children to remain safely with their families and education and training vouchers for youth aging out of foster care. In collaboration with CMS, the Budget proposes that Qualified Residential Treatment Programs (QRTPs) be exempted from the institution for mental diseases (IMD) payment exclusion allowing children in foster care to have Medicaid coverage in these placements even if a QRTP qualifies as an IMD.

The Budget provides \$197 million to ACF for child abuse prevention grants. These grants support increased use of evidence-based prevention programs, allowing states to explore new research opportunities and to adapt more rigorous evaluations of existing programs; demonstration projects to test the effectiveness of partnerships that strengthen family capacity and prevent child abuse through the co-location of services; and state plans for safe care of infants affected by substance use disorders.

The Budget also proposes to expand the Regional Partnership Grant program by \$40 million each year, which will increase funding for grants that help courts, child welfare agencies, and other government and community entities work together and improve practices to address the impact of substance abuse, including opioids, on child welfare. The Budget proposes an increase of \$30 million each year for the Court Improvement Program to help courts improve practices and comply with new mandates in the Family First Act.

Strengthening Efforts to Treat Serious Mental Illness and Serious Emotional Disturbances

In 2018, more than 11 million adults in the U.S. were living with a serious mental illness. More than 7 million children and youth experienced a serious emotional disturbance. They faced a greater risk of suicide and life expectancy 10 years shorter than the general population.

The Budget provides \$1.1 billion to SAMHSA for serious mental illness and serious emotional disturbances, which includes funding to support Assertive Community Treatment for Individuals with Serious Mental Illness, Community Mental Health Services Block Grant, and Children's Mental Health Services. These programs provide comprehensive and coordinated mental health services for some of the nation's most vulnerable populations and increases access to mental health services in schools. The Budget will also provide targeted flexibility for states to provide inpatient mental health services to Medicaid beneficiaries with serious mental illness.

The Budget also invests in programs that address the nation's alarming rates of suicide. Suicide is the 10th leading cause of death in the United States – responsible for more than 47,000 deaths in 2017 – and suicide rates have increased steadily for individuals of all ages. The Budget provides \$93 million for suicide prevention activities, including additional funding to expand Zero Suicide initiatives to focus on adult suicide prevention and allow communities and states to tailor strategies to prevent suicide in their local jurisdictions.

Supporting Independence for Older Adults and People with Disabilities

The Administration prioritizes community living for older adults and people with disabilities to ensure that they can maintain independence and live fully integrated in their communities. The Budget invests \$1.5 billion in the Administration for Community Living for critical direct services that enable seniors and people with disabilities to live independently, such as senior meals, in-home chore assistance, independent living skills training, employment training, and information and referral services. These programs empower older adults and people with disabilities to live independently and make critical choices about their own lives.

PROMOTE EFFECTIVE AND EFFICIENT MANAGEMENT AND STEWARDSHIP

HHS is responsible for more than one-quarter of total federal outlays. The Department administers more grant dollars than all other federal agencies combined. HHS is committed to responsible stewardship of taxpayer dollars, and the Budget continues to support key reforms that improve the efficiency of Departmental operations.

Advancing Fiscal Stewardship

The Administration 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.

As the Department overseeing Medicare and Medicaid, HHS is committed to exercising proper oversight of these programs to protect the millions of impacted beneficiaries and the taxpayers in general. In accordance with the direction in the Executive Order on *Improving and Protecting*

Medicare, HHS is investing in the newest technological advancements, such as Artificial Intelligence, to enhance our ability to detect and prevent fraud, waste, and abuse.

The Department is committed to reducing improper payments in Medicare, Medicaid, and Children's Health Insurance Program (CHIP). HHS continues to enhance existing program integrity tools to address improper payments and prevent fraud, including provider screening, prior authorization, and auditing providers and plans. New methods and technologies will allow HHS oversight to reduce improper payments and adapt to the changes in healthcare as we shift from a fee-for-service to a value-based healthcare payment system.

The Budget advances new legislative and administrative proposals to strengthen the Department's ability to address weaknesses in Medicaid beneficiary eligibility determination processes, while providing tools to facilitate the recovery of overpayments made by states. HHS also continues to support updates to Medicaid information systems that offer critical support to program integrity efforts, including the Transformed Medicaid Statistical Information System (T-MSIS) and a new Medicaid drug rebate system. In addition, HHS includes proposals that enhance oversight of Medicare Advantage and Part D plans, increase the period of enhanced oversight on new providers, and expand Medicare fee-for-service prior authorization.

Implementing ReImagine HHS

HHS supports the President's Management Agenda through *ReImagine HHS*, the Department's robust reform and transformation effort, organized around core goals to streamline processes, reduce burden, and realize cost savings. The effort takes an enterprise approach, affecting activities across the Department. For example, the Buy Smarter initiative plans to use new and emerging technologies to leverage the enormous purchasing power of HHS and streamline the end-to-end procurement process. The Maximize Talent initiative addresses modern-day human capital management and human resources operational challenges, resulting in key achievements: HHS's simplified recruitment process resulted in a significant increase in the number of new hires on-boarded since implementation, and HHS was rated the "Best Place to Work in the Federal Government" out of all executive departments in 2019. As part of the Bring Common Sense to Food Regulation initiative, FDA is working to increase collaboration between food regulatory programs to minimize dual jurisdiction and improve state product safety. As a result, 48 states and territories participate in the Produce Safety Implementation Cooperative Agreement Program, which increased state large farm inspections over 400 percent in FY 2019.

ReImagine HHS efforts are also making HHS more innovative and responsive. Under the Optimizing Regional Performance initiative, HHS developed a Regional Facilities Utilization Model with \$150 million in potential savings and a footprint reduction of more than 62 percent within ten years. For the first time since 1974, HHS completed a comprehensive assessment of regions to better align with Administration priorities and improve HHS's ability to serve Americans across the country. In addition, under the Optimize Coordination Across HHS initiative, HHS configured a new cloud environment for an administrative data hub to provide dashboarding capabilities for Operating Divisions, bringing together human resources, travel, and facilities data to inform better decision-making across the enterprise.

In FY 2021, all *ReImagine HHS* projects will reside in their permanent offices within HHS. This ensures that their work can sustainably continue going forward.

Grants Management

HHS continues to drive change for grants management government-wide. Leveraging the efforts and success of the HHS ReImagine Grants Management initiative. The Office of Management and Budget pre-designated HHS as the Grants Quality Services Management Office (QSMO) to create and manage a marketplace of solutions for grants management; govern its long-term sustainability; institute a customer engagement model; and drive the implementation of standards and solutions to modernize grants management processes and systems. Guided by a government-wide governance board, QSMOs are tasked with offering solutions that, over time, will improve quality of service and customer satisfaction; modernize and automate processes and supporting technology; standardize processes and data; and achieve efficiencies in government-wide operations and maintenance.

In FY 2018, the government awarded over \$750 billion in grants to approximately 40,000 recipients across more than 1,500 programs.

Full designation as the Grants QSMO is contingent upon approval of a 5-Year Implementation Plan and budget estimate in alignment with the published QSMO Long-term Designation Criteria. HHS is developing a vision and strategy to inform the Grants QSMO 5-Year Implementation Plan, with significant engagement with stakeholders to ensure the Grants QSMO can meet their diverse needs.

Regulatory Reduction

HHS is committed to streamlining the regulatory process and evaluating necessary steps to eliminate or change regulations that impose unnecessary burden. Burdensome regulations can drive up costs of healthcare, while poorly designed regulations can come between doctors and patients, reducing the quality of care and the essential trust to that relationship. From FY 2017 to FY 2019, HHS succeeded in cutting the economic burden of its regulations by \$25.7 billion through 46 deregulatory actions. HHS had the largest deregulatory impact of any Cabinet agency during this time period.

HHS is using the power of new cognitive technologies for greater operational effectiveness and research insights, including regulatory reduction. HHS used an Artificial Intelligence-driven regulation analysis tool and expert insight to analyze the Code of Federal Regulations, seeking potential opportunities to modernize regulations. HHS since launched a Department-wide Regulatory Clean-Up Initiative to implement changes based on these findings, by reviewing and – where a change is warranted – addressing incorrect citations and eliminating the submission of triplicate or quadruplicate of the same citation.

HHS is working to implement the provisions of the Executive Order on *Promoting the Rule of Law through Improved Agency Guidance Documents*. This Executive Order will accomplish important policy goals that will improve HHS guidance practices in the long term. Prior to the issuance of this Executive Order, several Federal agencies issued internal memoranda regarding the appropriate use of guidance. The Executive Order requires agencies to now go a step further

and codify certain good guidance practices and policies into Federal regulations. By August 27, 2020, each agency must finalize regulations to set forth processes and procedures for issuing guidance documents. In addition, by February 28, 2020, Federal agencies must establish a single, searchable database on its website that contains, or links to, all of the agency's guidance documents currently in effect. Any guidance document not included in the guidance website is deemed rescinded. HHS is committed to meeting the President's timelines.

Ms. DELAURO. Thank you very much, Mr. Secretary.

And we are going to step out of regular order for a moment. Chairwoman Roybal-Allard is chairing a hearing at 10:30 with the Department of Homeland Security, so I want to say thank you, you know, for—to my colleagues for your graciousness and allowing Congresswoman Roybal-Allard to ask her question before she has to excuse herself.

We recognize Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you, Madam Chair. And also thank you to the committee for the courtesy of being able to speak out of order.

Secretary Azar, since the initial passage in 2008 of my Newborn Screening Saves Lives Act, it has helped ensure high-quality diagnostics and lifesaving followup interventions for the over 12,000 newborn babies diagnosed each year with genetic and endocrine conditions.

As you know, the Newborn Screening Act codified the Advisory Committee on Heritable Disorders in Newborns and Children to help address the vast discrepancy between the number and quality of State screening tests. Because of this committee's work, today 49 States and the District of Columbia screened for at least 31 of the 35 currently recommended core conditions.

Last September, the reauthorization of the newborn screening law expired, and we have passed a new reauthorization bill in the House, and we continue to push our Senate colleagues to pass the bill out of their Chamber.

However, since October, your office has suspended the activities of the Advisory Committee, which is preventing it from completing its current work at commencing new business including a critical update to the recommended uniform screening panel nomination process. Meanwhile, you have the authority reinforced in the 2014 newborn screening reauthorization to deem the advisory council a secretarial Advisory Committee so it could continue its charter.

Given the essential role that the advisory council plays in our Nation's newborn screening system, why haven't you used this authority, and when will you extend the term of the committee until reauthorization occurs?

Secretary AZAR. Well, first, Congresswoman, I would like to thank you for your leadership with respect to maternal health and as co-chair of the congressional caucus on maternity care.

As you know, maternal health is a very serious public health challenge in the United States, and our budget is actually investing in—thanks to your leadership and both chairwomen of this committee—by increasing funding by \$74 million at CDC, HRSA, ARQH, and IHS to reduce maternal mortality and morbidity.

We are going to continue funding for maternal and child health block grants to States, which provide States with additional flexibility for programs such as heritable disorders. We also have \$126 million for Healthy Start for community-based strategies to reduce disparities in infant mortality and improve perinatal outcomes for women and children in high-risk communities.

With regard to the Advisory Committee on Heritable Disorders, due to that lapse in the authorization, that committee has halted activities. I am happy to look into the question of its work as we

work with Congress around reauthorization, of course, of the Neonatal Screening Act.

Ms. ROYBAL-ALLARD. Okay. Because you do have that authority to continue that committee.

And you mentioned another issue that I am concerned about, that in your 2021 budget that you propose to eliminate the HRSA, heritable disorder program, that provides grants to educate providers and parents to help States expand their newborn screening programs.

Without this funding, how will the States fulfill these newborn screening activities and improve followup care for infants diagnosed with heritable disorders, and who will operate, update, disseminate information from the Federal Clearinghouse of newborn screening information? Those are questions that I would like some answers to. But you did mention that you also rolled the newborn screening into the maternal health, child health block grant. Is that what you just stated?

Secretary AZAR. So, no, I was emphasizing that we have within the maternal mortality block grant that those provide addition that has flexibility to States for programs such as heritable disorders. So they could use that block grant funding, is my understanding, to continue while we are waiting for congressional reauthorization work on heritable disorders.

Ms. ROYBAL-ALLARD. Well, the concern is that, number one, you put less money into the block grant than was in the programs that you eliminated and then States are free to use their block grant money as they desire. So increasing funding for the MCH block grant, I think, is an important investment, but it does not guarantee the money will be spent on improving State newborn screening programs. So maybe we can work a little bit on that and talk a little bit more about the possibility of reinstating the committee, Advisory Committee.

Secretary AZAR. Happy to work with you on that.

Ms. ROYBAL-ALLARD. Thank you.

Secretary AZAR. Thank you.

Ms. ROYBAL-ALLARD. Thank you.

Ms. DELAURO. Thank you. We are going to return to regular order, and I have a question for you, Mr. Secretary. Just before you testified yesterday morning before Senate Appropriations, OMB finally submitted a supplemental funding request. And Chairwoman Lowey mentioned and that we both asked you to submit such a request 3 weeks ago, and while we are glad the administration has finally done so, what has been provided to date is unacceptable. It lacks the fundamental components of a supplemental request, including proposed bill language, supplemental documentation, and OMB did not transmit a budget table with programmatic details until last night.

To be clear, we want to be supportive. We realize this situation is evolving, and you are adjusting to shifting circumstances, but it is important for the committee to better understand the needs going forward.

One, can you tell us how much of the Infectious Diseases Rapid Response Reserve Fund has been used for this emergency response? Has—

Secretary AZAR. So as I think you—oh, sorry.

Ms. DELAURO. Has the \$105 million that was available from that fund been exhausted?

Secretary AZAR. We are at the point now where we have used or where we have either committed or obligated the moneys in that \$105 million rapid response fund, and that is why I sent you the notice last night about the reprogramming and transfer on the 136 so that future obligations we can continue our work pending—

Ms. DELAURO. So that the \$105 is gone?

Secretary AZAR. It is in budgets being committed or obligated, exactly. Right.

Ms. DELAURO. Yeah. Right. Well, it's not there, okay.

Secretary AZAR. Right.

Ms. DELAURO. And are you going to—how quickly are you expending the funds?

Secretary AZAR. The actual run rate of the money going out the door I don't know. I believe we were at about \$20 million the last update we had given to the subcommittee, but I would want to defer to staff if we could check with you on that.

Ms. DELAURO. Okay.

Secretary AZAR. I do want to make sure you are getting information on spend rate as quickly as OMB will, you know, authorize the release of that. But we are—basically we are out of the \$105, for which we are very grateful that you all funded. It has proven to be vitally, vitally important, so thank you.

Ms. DELAURO. Let me ask you to provide additional details of the supplemental request for the subcommittee. I have only seen the two-page letter from OMB and a one-page budget table. You know, I was around when the Obama administration submitted a supplemental request for Ebola. They sent a 28-page document outlining the intended purpose of each component of the request, and that was demanded by this committee. I was there. Every time they came with much more information.

So let me ask you these several questions. How do you intend to reimburse State and local agencies for their expenditures on the ground?

Secretary AZAR. So we have got—I appreciate your frustration with the two-page letter being the documentation. We have been working with your staff to provide detail—

Ms. DELAURO. By the way, this is the Obama submission.

Secretary AZAR. Yes. Right. So we have been working with your staff. We actually do—we do have plans that we are going to work with your teams to make sure we educate on and work together to flesh out. It is a very fast-moving process, as I am sure you understand.

So within the \$2.5 billion, at least \$2.5 billion request we would have the CDC have a major fund, which would be through the public health emergency fund, to allow them to work with State and local governments to reimburse for expenses around contact tracing, laboratory work, lab testing, et cetera.

Ms. DELAURO. So we are going to reimburse State and local agencies?

Secretary AZAR. Yes. So that would be—that is the goal to have a fund that would enable the feedback we have gotten from State

and locals, whether through grants or actual reimbursement, and we would work with the committee on the appropriate structure of how you think that should be done.

Ms. DELAURO. Okay. And I would just like to know what we think that is going to be, how much money is involved, et cetera, so that we can also respond.

Secretary AZAR. Absolutely. Yeah.

Ms. DELAURO. We are all getting those questions.

Secretary AZAR. Yes. So that is in the table. So if—there are five key areas that didn't—weren't quite transparent in the letter, if I could mention the key strategic announcements we want to make.

Ms. DELAURO. Quickly. My time is going to run out.

Secretary AZAR. Okay.

Ms. DELAURO. I will get the five areas.

How much of the funding is designated for international activities versus domestic preparedness?

Secretary AZAR. So I believe in the most recent document that I saw, the table that I believe you have access to, there is \$200 million in there of USAID funding that may be from existing sources. I don't know if that is new money or not. That may be existing moneys that would be dedicated on that.

We have focused our \$2.5 billion request at HHS frankly on U.S. preparedness and response. And I would say, compared to the Ebola response where getting that stopped in West Africa or now in East DRC is the critical element, here our activities are really mitigation—containment and mitigation preparation in the homeland because we are not going to help the Chinese stop this in China. China is going to do that or not be able to do that.

Ms. DELAURO. Does the supplemental request include funding to replenish the Infectious Diseases Rapid Response Reserve Fund? Yes or no.

Secretary AZAR. I don't believe we use the Rapid Response Fund, but what we would do is work with you on the 2021 appropriation to ensure that that is appropriately funded in light of this. The funding request, of course, was locked in December before any of this happened, so we want to be flexible on 2021 funding to respond to this.

Ms. DELAURO. Did OMB reject any of your requests for emergency supplemental funding to respond to the coronavirus?

Secretary AZAR. Well, I am not going to get into back and forth with the White House or OMB discussions, but I want to let you know, this \$2.5 billion request, it has my complete and full support. It attacks the five critical success factors that I made clear I needed to invest in, and it supports that. It is at levels I think are appropriate. And if not, if it doesn't fund it enough, we will come back to you and work with you. And, again, we are trying to be flexible. We said at least \$2.5. We want to work with you on both funding sources as well as top-line amounts.

Ms. DELAURO. Well, as the chair pointed out, we will put together a supplemental that will address this issue.

Congresswoman—Congressman Cole.

Mr. COLE. You gave me a promotion there for a minute. I am sorry? Oh, yeah. I know she has got to get to the next meeting.

Ms. DELAURO. Yes. I apologize.

Ms. GRANGER. No problem.

Ms. DELAUBRO. Congresswoman Granger.

Ms. GRANGER. Thank you for allowing me to go. I have to go to another one.

Mr. Secretary, I was alarmed to learn recently that almost 90 percent of active ingredients used for pharmaceutical manufacturing originate in China. What should we be doing in the United States to ensure the safety of the American drug supply?

Secretary AZAR. Well, Chairwoman, as you know, this is really—this has brought to light the issue of the complete internationalization of the supply chain not just for medical products but really across all of the economy. And so what we are doing now is the FDA is reaching out to all pharmaceutical manufacturers, device manufacturers, et cetera, to make sure we have got visibility.

The latest fruits of that work show that there are 20 pharmaceutical products we are aware of to date at FDA where either the entire product is made in China or there is a critical active ingredient that is solely sourced within China. So those would be obviously the most targeted to be concerned about.

To date we are not aware of any expected shortages, and we have aggressively proactively reached out to manufacturers for that information. I am told there are two manufacturers in Hubei province of pharmaceuticals, but fortunately the manufacturer has a large, large stockpile supply of advanced production there.

But we have to be very alert to this, and we have to be candid that there could be disruptions in supplies. We already experience that, of course, with medical shortages, generic shortages, due to sole-source producers, manufacturing defects, inspection problems. And we have got an aggressive agenda for shortages that we have worked with this committee and authorizing committees onto help alleviate shortages.

Ms. GRANGER. Good. Thank you. And would you keep us informed on those?

Secretary AZAR. Of course, yes.

Ms. GRANGER. Thank you, Madam Chair, for letting me do that.

Ms. DELAUBRO. Thank you.

I now would like to recognize the chair of the committee who has a hearing to get to as well, Congresswoman Lowey.

Mr. COLE. You are a very busy woman.

Mrs. LOWEY. We will all talk fast. Thank you.

First of all, I echo the concerns raised by Chair DeLauro on the coronavirus, and we really do need these answers right away, but I would like to turn to another matter on—which is impacting public health.

As you know, I have worked to restore funding for gun violence prevention since former Representative Dickey first attached his amendments to the spending bill more than 20 years ago. Some of us were there. The fiscal year 2020 spending bill enacted with bipartisan support in December included \$25 million for Federal gun violence prevention research split between the CDC and the NIH.

And when you and I have discussed this issue, including at the budget hearing 2 years ago, you expressed support for this research and responded that we are in the science-gathering business. Well,

clearly, that sentiment isn't shared by the White House as the President's budget would eliminate this groundbreaking funding.

Nearly 40,000 Americans lose their lives due to a firearm each year, hundreds of thousands more are injured. Why does the Trump administration not believe this is a public health priority worthy of funding?

Secretary AZAR. So thank you for having funded that in the 2020 appropriation in December, and we are actually executing on the funding both at NIH and at CDC. In fact, just on the 21st, the CDC put out a new research funding opportunity, research grants to prevent firearm related violence and injuries to solicit investigator initiated projects with a deadline of May 5 for submissions of those.

In terms of the budget submission and the continuation of that, as you know, with CDC's budget we prioritized infectious disease preparedness and global health security, and so that did mean cuts and prioritization away from chronic and preventive activities which included the firearm research there.

We, of course, continue at NIH to always be open for business as we have always been for firearm research within the peer review process of submissions, and so that would continue regardless of whether Congress accepts the budget submission or not.

Mrs. LOWEY. Well, with all due respect, the administration chose to make these cuts. This wasn't a tough choice; it was the wrong choice.

With limited time, I am going to go to another key issue. And I thank you, Madam Chair.

As I mentioned, at least 64 people died last year and nearly 3,000 were hospitalized with vaping-related respiratory illnesses. While many but not all of these cases were attributed to vitamin E acetate, the crisis raises serious question about how little is known about vaping, particularly as concern grows that there could be long-term health consequences such as heart disease, stroke, cancer, and more. This is particularly alarming as the youth vaping rates have skyrocketed.

So I was optimistic when President Trump said he would clear the market of flavored e-cigarettes. But after speaking to his political advisers, he turned his back on public health for political gain and instead proceeded with an announcement that has left thousands of kid-friendly flavors on the market and allowed disposable e-cigarettes to flourish. How many more people will have to be sickened or die for the administration to take this seriously and ban all flavors?

Secretary AZAR. Chairwoman, thank you for your passion around the e-cigarette and vaping issue and access for kids. I share that and want to keep working with you on this challenge.

When the President made the initial announcement with me on September 11, we included all flavors other than tobacco in that statement because at the time we had the National Youth Tobacco Survey data, which had mint and menthol together as single category of use.

We were actually at that time concerned about including menthol in the immediate removal from the market given the fact that menthol combustible is a discrete legal category used especially in the

African American community, and we want to make sure that off-ramp would not be immediately pulled away from folks.

After making our announcement we got the Monitoring the Future data out of NIH that broke apart for the first time and showed that menthol was really not being used by kids. It was much more like tobacco flavoring of the e-cigarettes, and it was the mint that was driving it. And that was what led to the modification of the flavoring question there as we move forward to the submission deadline.

We just—also, with regard to disposables, we don't have data on disposables. NJOY, the largest manufacturer, did pull their flavors off the market, is what they announced, the comparable kid-friendly flavors off of the market. But we are going to keep working and enforcing. If anybody is marketing to kids, we are going to enforce against them. We are going to watch the data in terms of enforcement priorities. And, of course, they all have to submit by May of 2020 per court order for the PMTA at FDA.

Mrs. LOWEY. Well, just a quick, final question. Frankly, we need more resources to combat this epidemic not less. So maybe you can think about why the administration recommended yet again to consolidate and then gut funding for the Office on Smoking and Health.

I guess I—oh, I guess I don't have any time.

Ms. DELAURO. No. You are out of time.

Mrs. LOWEY. Why don't you think about that and perhaps answer—just let me say, in conclusion, Madam Chair, this is an epidemic. You know, I speak to my grandkids, sixth grade, fifth grade, it is unbelievable what is going on out there. So we have to take it seriously, be tough and strong and respond to this epidemic that is growing. Thank you very much.

Ms. DELAURO. Thank you.

Mrs. LOWEY. Thank you, Madam Chair.

Ms. DELAURO. Ranking Member Cole, thank you, again, for your—

Mr. COLE. Absolutely. Thank you.

And, Madam Chairman of the full committee, you have all the time you want whenever you need it. I am sure our chairman will make sure—

Mrs. LOWEY. Oh, really?

Mr. COLE. Yes, you do. This is your committee.

Mrs. LOWEY. Thank you. But I am going to go over to Homeland Security.

Mr. COLE. Okay. Well, we will miss you because we know we are really your favorite, and we always have been.

Let me start—a couple things. I want to first associate myself very much with our chairman's request for the additional detail on the supplemental, and that is meant to try and help you—

Secretary AZAR. Of course.

Mr. COLE [continuing]. Quite frankly, because our job will be to sell this supplemental to our colleagues on both sides of the aisle. I know we will work together to do that. So the more you can arm us with information, the better off we will be.

I do have a couple of quick questions on the coronavirus. And I want to—again, my chairman made this point and I want to asso-

ciate myself with her on this too. I agree with her about Ebola. You know, I don't think you should sacrifice short term here what—this is bad dealing with coronavirus.

If we ever had an Ebola outbreak inside the United States, it would be devastating. So I just don't think we should be, you know, penny wise and pound foolish on that. I would hope working together we protect that funding going forward, and I just I say that just to advise you of that. And, again, I don't have any problem with people being prudent, trying to stretch the dollars as far as they can. That is a good thing. This is just one that I think we are going to have to do something different.

Now, I want to ask one question, and I know the answer to it but I want to get it clearly on the record. If you do not have enough money in the \$2.5 billion you asked for, you will come back and ask for it, additional funds. Is that correct?

Secretary AZAR. Absolutely.

Mr. COLE. I can tell you, I have talked to our leadership and they are fully supportive of that. They understand that this is difficult to estimate and that it could grow exponentially. And so, I mean, I have got the green light from our side of the aisle to say, look, if we have to go beyond this, please feel free to alert your colleagues on the other side that we are going to work with you on that.

Second question, and, again, a compliment, I want to thank you. We don't have the jurisdiction over funding on the Indian Healthcare Service, but you do, and you had a modest increase in that this year and a tight budget. I appreciate that. And thank you, and I will do my very best to give you more money than you asked for this that area.

But I do want to also alert you, the budget does propose for the elimination of the good health and wellness in Indian Country program at the CDC. That ain't going to happen. You know, that is a program that we work with tribal governments on. They are vastly underfunded in this particular area. And so, again, I sympathize with you dealing with OMB, but I just alert you that I certainly would be very opposed to that.

If you want to comment on some of the things you are doing in tribal health, I would be very interested in listening to what you have to say.

Secretary AZAR. Yeah, absolutely, Mr. Cole. Thank you very much. And I think you know our passion, my passion around tribal health. And we have—even in tight budget environments we have really tried to ensure appropriate investment in Indian Country.

While our budget does, as everyone has noted, propose an overall decrease of almost 10 percent in discretionary spending, IHS is funded in our budget request actually at \$6.2 billion, which is a 3 percent increase. So just by scale, I think that reflects the prioritization of Indian health that we are trying to make here.

Discretionary funding for IHS has actually gone up by 24 percent between fiscal year 2017 and 2020. We are working to improve quality, safety in our facilities. In fact, my deputy secretary is out there in South Dakota this week inspecting our facilities that we are trying to get brought up to certification.

We are working to—as part of this appropriation we want to really build up a whole quality, safety culture and mindset throughout IHS beyond just compliance with CMS certification requirements. So that is part of all that we are trying to do for Indian health, so thank you.

Mr. COLE. Well, again, I am very appreciative, and we are going to work with you where we can and then occasionally stop you where we must.

But let me move to another area. And you and I have talked about this recently, and I think it is important for the committee to know. We have had some very legitimate questions, in my view, about reimbursement particularly during coronavirus for State and local people.

But the reality is CDC provides, I think, 50 percent of all the funding for State and local health programs in the United States. I know in my own State it is 60 percent. So it is not as if you haven't put a lot of effort out there already, and, you know, this is something that maybe State and local governments need to be looking at, not that I am calling for any decrease in what we do, but maybe they need to be doing a little bit more themselves.

But I want to ask you how ready you think these State and local departments are to deal with this as we go forward and what additional steps you think we ought to take to strengthen those things without making them totally dependent on the Federal Government.

Secretary AZAR. Well, as you mentioned, thanks to this committee we, through the CDC fund, approximately 50 percent of the public health infrastructure at the State and local level in the United States. In addition there is—or connected to that is the Public Health Emergency Program, the PHEP, which funds over the last many years \$675 million a year to States to then give to locals to—precisely for this kind of situation, to be ready for public health emergencies.

I have been impressed by most States and local governments' degrees of cooperation and preparedness, but it has also highlighted to me, I believe there is a need for greater accountability and oversight with that money that is going out to ensure that it is, in fact, leading to readiness for a public health emergency.

Mr. COLE. Last quick question because I only have about 30 seconds, but I probably get more concerns about mental health in my district than almost anything else, and I think that is pretty common for all of us. Could you address quickly some of the things in your budget that would help us deal with the mental health problems that I know all of us face?

Secretary AZAR. Well, one of the most exciting things in our budget, from my perspective, is the proposal that would allow a State option on what is called the IMD exclusion, not just to have inpatient—expanded inpatient facility capacity for substance use disorder but also for serious mental illness, to really—we have seen where we have had IMD exclusions approved for—the waivers approved for States on substance use disorder and expansion in capacity, and by bringing this as a State option, which means it is not, I think, subject to the budget neutrality issues of a waiver,

that is a major investment that could allow that for serious mental illness. Just one example there.

Mr. COLE. Thank you very much.

Thank you, Madam Chairman.

Ms. DELAURO. Congressman Pocan.

Mr. POCAN. Thank you very much, Madam Chairman.

And thank you Mr. Secretary for being here.

First off, let me say your department is in the final stages of a regulation regarding the interoperability of healthcare data. More than 10,000 of my constituents work in the health IT industry.

I just wanted to let you know that the outcome of this rule is very important to my district. I appreciate you listening to the concerns of comments. I look forward to the improvements that will happen in the regulation, and I want to thank you for your leadership.

Secretary AZAR. I have worked directly with Epic leadership in hearing their concerns. I think often they—we put a proposal out, precisely because we want to get that feedback about operationalizing and everything. So I hope that we are trying to be reflective of—

Mr. POCAN. I look forward to—

Secretary AZAR [continuing]. As much as we can.

Mr. POCAN. So let me try to get the meat which may not be as pleasant. I would love to get to talks about the cuts to Medicare and Medicaid, the cuts to NIH, but I really want to talk about the coronavirus. And I need you to help provide some comfort to the American people that this administration and Federal officials actually have a grasp on this. So let me just go down a little bit of litany of what I found on the news just in the last few days. We had the Secretary of Homeland Security Chad Wolf yesterday say a vaccine was several months away, the President said we are very close to a vaccine, and yet I think you and the CDC and others have said it is more like 18 months.

We have heard from Commerce Secretary Wilbur Ross say that the coronavirus could be good for U.S. business because it hurts China. We have heard Larry Kudlow say it is contained. We have heard Rush Limbaugh, Medal of Freedom winner and White House surrogate, say it is no worse than the common cold. And, yet, we have also heard from CDC officials not a question of if this will happen anymore, but rather a question of exactly when. And Dr. Fauci, who many of us really respect, said it is inevitable this will come to the United States. So we have got those kind of comments.

Second, we know that this first started information coming around January 7, and the budget that was produced by the President on February 10 provided a number of cuts that would have actually worked to directly affect this from the almost \$700,000,000 cuts to CDC, \$167,000,000 from the Office of the Assistant Secretary for Preparedness and Response, \$18,000,000 from the House Preparedness Response Account, and \$200,000,000 cut to Project Bioshield.

We have seen recent reporting that 150 prescription drugs—and this is from the FDA—are at risk of shortage if this outbreak worsens, and yet the FDA Commissioner Stephen Hahn, is reportedly

not part of the task force as planning the U.S. response to the coronavirus virus.

In 2018, the CDC cut 80 percent of its efforts as part of the global health security initiative to prevent global disease outbreaks because it was running out of money, and it was reported that the Department could go from working in 49 countries to just 10 countries. Also, in 2018, the White House official that was responsible for leading the U.S. response of the deadly pandemic left the administration, and the global health security team he oversaw was disbanded.

And, finally, the tweet from this morning from the President talking about low ratings fake news, doing everything possible to make the coronavirus—spelled incorrectly, but I am a journalism major—look as bad as possible, including panicking markets if possible. Markets being the concern.

So help me, if this contained the common cold, inevitable, 2 months, 18 months, provide me some security that someone knows what is going on in this administration about the coronavirus virus.

Secretary AZAR. Well, thank you. Where shall I begin?

Mr. POCAN. It is a long list of—

Secretary AZAR. What we are trying to do, and we have tried to do this with Members of Congress, Senate, and the public and the media is really flood you with information about this to make sure that we are being transparent about what we are facing, what we know and what we do not know, as well as what our plans are.

So the risk right now is very low to Americans. We have—as Kudlow—as Larry Kudlow said, from a public health perspective, we technically are in a state of containment in the United States. We have had 14 domestically identified cases here from nonrepatriation. That has remained the case now for 15 days, but we have always been clear that, number one, that could change rapidly. And from the outset, I and the public health experts have said we fully expect we will seek more cases here in the United States. We have to be mentally prepared and, also, as a government prepared.

Mr. POCAN. If I can, just to reclaim my time. It still didn't provide me the comfort I was looking for. Because the variety of statements I said are from 2 months “it is nothing,” “it is a common cold” to “inevitable.” And I still do not think this administration seems to have grasp on it.

Let me ask you this, you are looking for the funds—I also agree with the bipartisan concern around stealing it from Ebola. I talked to a senior White House official last year—not White House, but administration official. One of his two main concerns he was dealing with was Ebola. So taking money from that would be ridiculous.

Let me ask you this. We have redirected \$3,800,000,000 from Defense for the wall. The wall is not going to stop any real or imaginary migration, and it is certainly not going to stop the coronavirus. Would you supportive of taking some of that \$3,800,000,000 or any money for the wall and transferring it to take care of the coronavirus.

Secretary AZAR. So the Ebola funding and all of the transfers proposed in the supplemental, I do want to be very clear: That is

simply a concept of how you could fund half of the supplemental. We are not wed to that. We wanted to give you ideas.

On the Ebola money, that in particular with Ebola, it is—thanks to the Ebola supplemental funding we had before, it is important to note, we have now an approved vaccine from Merck, and we now have two therapeutic candidates. I have been almost daily involved with the eastern DRC Ebola outbreak that, God willing, is coming close to being under control. It is certainly, on the epidemiological curve, is looking more like that if the security situation stays. But I want to thank this committee for the support on Ebola that we have had. And we have now major weapons to use against Ebola, which is really a revolution.

Mr. POCAN. And if I could may interject, just the specific last part of the question, would you be okay with taking funds that have been redirected for the wall and redirecting to stop coronavirus?

Secretary AZAR. I don't believe the administration would be supportive of that, but Congress would make the decisions about how to fund supplemental.

Mr. POCAN. Thank you very much, Mr. Secretary.

Ms. DELAUBO. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

I want to commend you for your initiative on advancing kidney health. Most people don't know that 750,000 Americans have irreversible kidney failure. And 90 percent of CKD patients are undiagnosed. So 9 in 10 people do not know that they are on this track. It represents—so, then, it is too late to slow the disease progression. So that is—Medicare spends more 120,000,000,000, 34 percent of total spending. And end-stage disease accounts for 7 percent of Medicare spending, despite representing 1 percent of Medicare patients. And this is only going to get worse.

So my hat is off. I have been super excited about the initiative that the White House, that you have launched to go after several of the problems within our current system to both educate and inform and help people more healthy, also to make sure that we are getting more solid organ procurements, that people are getting the transplants needed. And they are also going after—the big fear for most people that have transplants, which is when is the immunosuppressive coverage going to end, because I cannot afford that.

So I just want to say thank you. It is a breath of fresh air to have someone really taking on this issue. It represents a lot of hope for a number of us who have been laboring in this field.

I wanted to ask. There are two things—you know I have a lot of questions about the coronavirus, and I do appreciate it. I have seen multiple options for Members that come for briefings from your staff, from your team. So thank you for keeping us abreast. I think do think it is going to change and iterate, like you said.

I wanted to see if someone from your office would be willing to come in and just sit down with me about some real specific questions. How does it jump? What test kits are being made available locally? I saw something about commercial test kits becoming available. I think if it does iterate and becomes communicable—in each of our communities, we do not know how really our public health agencies and even our hospitals need to be able to test. That is

what we are going to need. I know they keep saying it is only 2 percent of people die with this as compared with SARS, but those 2 percent represent the elderly. I mean, almost every article I have read, it is someone 70 years or older, or it is someone with a chronic illness. And I think we should be defending those folks to the best of our ability. So I know we probably don't have the time to go into that now, but I would just love somebody to come in and spend a little bit of time with me on that.

Secretary AZAR. We would be happy to try to do that, or if we could address those—because those are questions everybody has. And so that might be one of our—

Ms. HERRERA BEUTLER. So if you want to take a quick swing at it.

Secretary AZAR. So in terms of—

Ms. HERRERA BEUTLER. So let me give you the three—

Secretary AZAR. Right.

Ms. HERRERA BEUTLER [continuing]. How does it spread?

Secretary AZAR. Right—

Ms. HERRERA BEUTLER. Is it on table tops? How long does it sit there? How does it jump? And the test kits and their availability?

Secretary AZAR. Right. So, in terms of transmissibility, obviously as a respiratory illness, it usually would transmit versus aerosolization. But there might be fomite—it is called fomite transmission when it would sit on a hard surface, for instance. Dr. Fauci has spoken publicly about this. But, of course, we don't have hard data with regard to the novel coronavirus. But usually one would expect fomite transmission in the several-hour range as opposed to multiple-day range. But, again—

Ms. HERRERA BEUTLER. You do not know.

Secretary AZAR. But, again, we do not have studies on this or the data on this that would be the usual with the coronavirus. But I rely on Dr. Fauci on that.

In terms of fatality rates, we are seeing various estimates. The WHO team that was just in China saw higher rates of fatality; I think over 2.5 percent in Wuhan. But outside of Hubei province, I believe they were seeing numbers closer to 0.7 percent. So there again is a range. And we are going to have—one of the numbers—the top projects for us is to get a set of public health statements of our beliefs and what is the fatality rate we believe would be applicable in a modern healthcare system like the United States with very aggressive active containment at the outset, as well as community mitigation efforts in the event of community spread here. So it might be quite different than that in terms of assumptions.

On testing, we currently have the CDC test, which they invented in 1 week. That is at CDC and is now validated at 11 other sites. We had an issue on the third stage of the—there is a third stage of the test. One of the 92 reagent aspects of it, if it is not done just right, was having issues on quality control on the control element, not leaving the false positives or negatives, just an inconclusive result on 1 of the 92. We are working on both fixing up, but also perhaps we have over-engineered that test in the first two stages of it. It may actually be enough to enable a faster test. So we are working on getting that as soon as possible to the remaining public health labs. The commercial sector is looking at, we hope, the bed-

side diagnostics, as you have said. And we have heard from dozens and dozens of them. And the FDA will obviously expedite work with them on that.

Ms. HERRERA BEUTLER [continuing]. Good. I know I cannot ask you more questions. Could someone—I would also like to talk about the pharmaceutical slowdowns. I realize the immunosuppressive—there are some other things that are happening both in India and China, kind of impacting India with regard to shortages that have started that we are seeing that is leading to some of the major pharmacies and retail pharmacies and mail order pharmacies—I do not want to use the—they are being judicious in how they are filling scripts. I only see that getting worse.

Secretary AZAR. I would say, just to clarify for the public, those would be our general shortage issues that are not connected to the novel coronavirus.

Ms. HERRERA BEUTLER. I would like—

Secretary AZAR. Because we have not seen any shortages connected to this.

Ms. HERRERA BEUTLER. I do not want incite any fear here, but I would like someone to come in here and talk with me about—I just want to know what the contingencies are and some forward planning.

Thank you so much, Madam Chair.

Ms. DELAURO. Thank you.

Congresswoman Frankel.

Ms. FRANKEL. Thank you, Madam Chair. I want to talk to you about something that I think is actually one of the greatest health issues here in this country. But I want to say for the record—and then I think my colleagues will follow this up—the public should know that Mr. Trump fired the government's entire pandemic response chain of command while in the White House.

But I am not going to get into that. I want to ask you a question, a couple of questions. Would you agree that doctors should not lie to their patients?

Secretary AZAR. Doctors should provide truthful information to their patients.

Ms. FRANKEL. All right. There is one. And doctors should give full information to their patients. All right.

Secretary AZAR. I know you said doctors should not lie to their patients, and I agree with that.

Ms. FRANKEL. Okay. They should give full information.

Secretary AZAR. If they are in a statutory system that precludes certain information or certain communications, then they have to comply with statutory requirements.

Ms. FRANKEL. Okay. Let's get that. So let's talk about the contradiction of really of those two statements. Because I am going to talk about Title IX. I am sure you anticipated that. And, listen, I just wanted to say thank you for being here. Okay.

Title X, that is right, I cannot even read my own paper. All right. So the Trump budget, Title X, you keep it stable funding, \$286,000,000. And I want to say something about Title X. It has in the past been a bipartisan and very incredibly effective program. It is meant to ensure people who are struggling to make ends meet, who do not have health insurance. They can still have access to

birth control, cancer screenings, STD testing and treatment, as well as annual exams.

Unfortunately, in March of 2019, HHS published a rule which prohibits providers from providing referrals for abortion, even upon a patient's request, and impose onerous physical and financial separation requirements, which under a rule, all abortion activities must be physically and financially separated.

So let me just say this: I call this the Trump abortion obsession. So, for example, even if a patient who came into a Title X provider found out they were pregnant and asked, "Do I have an alternative whether I keep this pregnancy or not," the provider is not allowed to tell them—not allowed to say. They are gagged, g-a-g-g-e-d. They are gagged. Because of this, Planned Parenthood announced it would leave the program. And, unfortunately, the courts have upheld the administration's rule. Planned Parenthood served 1,500,000 of the 4,000,000 of the Title X patients. And I have just to go—not going through all of the statistics, but half the patients who rely on Title X funding do not have the provider they had been turning to.

I want to ask you this, do you have a list—could you provide us with a list of the new providers that have come into the program?

Secretary AZAR. I believe we could, I think.

Ms. FRANKEL. Okay. I would like—do you happen to know how many new providers there are?

Secretary AZAR. The number of new—I am just looking to see if I happen to have that here. I do not believe I have just the exact number of new providers, but we could get that for you.

Ms. FRANKEL. Okay. Would it have surprised you that, as of 1 year after the rule was published, there had only been one new provider and/or maybe—and the provider did not provide contraceptive services.

Secretary AZAR. Well, actually, the provider has—I know the entity you are speaking of, but that provider has to, through their subgrantees have subgrantees that would provide the full range of contraceptive services required under Title X.

Ms. FRANKEL. And there are several States that have no Title X funding right now. Well, you know, I could go on and on about this. But let me ask you another question. Who should decide whether or not someone brings a child into this world? Who is in the best—should someone have to call the Governor or call you or call me?

Secretary AZAR. So, with regard to Title X, we are enforcing the Title X law, which by Congress prohibits referral for abortion as a method of family planning, and our final rule actually was upheld even by the—

Ms. FRANKEL. Well, abortion is a medical service that is legal. It is legal. Is that correct?

Secretary AZAR. The Congress decides where Federal money may be used in connection with abortion, and so the Federal, the statute in Title X prohibits referral to programs in which—

Ms. FRANKEL. I do understand that. And as a result, because what is called as a gag rule, which means providers cannot give their patients all the information they need to make important decisions, you have lost the biggest provider in the country, which is called Planned Parenthood? Are you aware that Planned Parent-

hood does a lot more than refer to abortions or provide abortions, STD exams, mammograms?

Secretary AZAR. So I am actually aware that between 2020 and—2010 and 2015, 141 Planned Parenthood clinics have closed; that, over the past 9 years, cancer screening and prevention services at Planned Parenthood decline by over 60 percent; contraceptive services declined by 30 percent; and there are important preventive activities, like HPV vaccinations and well women exams, that account for less than 10 percent of their activities as they focus on their abortion work.

Ms. FRANKEL. Hundreds and hundreds of thousands of patients are taken care of—were taken care of by Planned Parenthood. Mammograms, STDs, contraception. You need to check—all right. Sorry about that.

I would say you should go back to school.

Ms. DELAURO. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

Mr. Secretary, thank you for being with us here today and for the update on the coronavirus and the regular briefings that you and the administration, the team, have been doing. Also, I want to thank you for all that you and your team are doing kind of around the clock on this. So I appreciate that.

I wondered if we could talk a little bit about some of the initiatives you are doing in the rural health space. I know you have a 4-point strategy. A few specific areas I wanted to talk about. One is the opioid situation. You know and overdoses of opioids. That is a huge concern in my district. And I know Naloxone is used in kind of the front lines on this to help people. And I wondered what HHS is doing to help create an awareness with the general public, as well as work with pharmacists to make sure it is accessible and available, and then anything you can do to help us understand the insurance aspects as well to keep costs down for people.

Secretary AZAR. Sure. So, Congressman, with regard to rural health and the opioid crisis, I did want to mention that we have got consistent funding of \$23,000,000 for the First Responders Training Program, which actually trains first responders in opioid overdose in rural communities. We have the Project AWARE rural set-aside. We have the Rural Health Outreach Grants Program, which maintains \$80,000,000, consistent funding there to support grants for primary care and opioid use disorder treatment and prevention and behavioral services there.

In terms of Naloxone, with Naloxone, we have actually seen the genericization of that product. As a result, we have seen 405 percent increase in Naloxone prescribing. We have got, in 2019, FDA approved the first-ever generic Naloxone. We have granted priority review to every other Naloxone product that would be used for emergency treatment. And we also are encouraging over-the-counter by laying out what would be needed to do an OTC of Naloxone also. So we have seen pricing—I think, at this point, with CMS with part D, we have encouraged placement on the select care tier for Naloxone, which would be zero-dollar copay. I think we are seeing similar types of support in commercial insurance also.

Mr. MOOLENAAR. Thank you. And I also want to talk a little bit about telehealth, if we could. That is very important in these rural

communities. And I just wondered if you could discuss how your proposed changes to Medicare fee-for-service advanced payments will broaden access to Medicare at telehealth services.

Secretary AZAR. Absolutely. So we have got in the budget several proposals. One of those would be to modernize Medicare telehealth so that it would promote value-based payments. So we are moving barriers to telehealth in rural and underserved areas by expanding the availability and fee-for-service where we have advanced payment models. So those APMs, making sure telehealth is available in fee-for-service. So that is one.

The next is to enhance our services in federally qualified health centers and rural health clinics. So that would allow these centers to actually be distant site providers in rural America, which would make them eligible for payment under Medicare fee-for-service as part of that proposal.

We would also extend Medicare telehealth for his and Tribal facilities. As we know, his is of course one of the most important rural healthcare providers that we have in America.

Mr. MOOLENAAR. Wonderful. If I could take you to the CDC for a minute. I know the CDC surveillance data platform, can you talk or give us an update on the status of that and the plans going forward?

Secretary AZAR. So we have got one of the finest surveillance platforms in the world in terms of CDC support of this. In fact, one of the critical elements of the emergency supplemental is to enhance that surveillance system for novel coronavirus. What I want to get to is where we are getting data on suspected flu cases nationwide and getting those tested for novel coronavirus nationwide. We have expanded that immediately to six cities. So Seattle, San Francisco, Los Angeles, Honolulu, Chicago, and New York currently have this enhanced surveillance. We want an early detection system because this will be the backbone of our effective mitigation program.

We are also—something I am quite interested in, we are talking with Google and others about, how can we leverage novel IT social media interactions as part of a modern epidemiological surveillance system? They may know things faster than we can get public health reports in from local health agencies.

Mr. MOOLENAAR. Are we on track of these things? I know there are reports that are due to you and to Congress.

Secretary AZAR. I don't know about any particular reporting issues on that. But if we get the supplemental, obviously, we are going to use transfer money immediately to try to enhance that surveillance system and then working on the rest of these initiatives. If there are particular questions, we would be happy to get back to you on any timing or deadlines.

Mr. MOOLENAAR. Thank you very much.

Ms. DELAURO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Madam Chairwoman, Mr. Ranking Member.

And thank you, Mr. Secretary.

Real quick thing. I think we have a 6-degree-of-separation relationship. You clerked for Scalia. His aunt, who was very, very

proud of him, was my both French and Spanish teacher, and he comes from Trenton.

I want to ask you a couple of quick questions, and I have some questions regarding New Jersey specific. Number one is that you were quoted as saying we have a 30,000 stockpile of masks, and if there is a real pandemic, we need 300,000. And since we generally see products of that nature come out of China, where will we get ours and be prepared?

Secretary AZAR. Thank you, and, first, I would like to actually clarify something that I said yesterday in the Senate Appropriations Committee. I had been informed of some information that is a bit different than what I had at the time. To clarify first, we have more masks than the 30,000,000 that I related yesterday. But we have a different mix of those masks than what we have been informed of. So we have 30,000,000 surgical masks. Those would be the gauze-type tied-behind-the-ear-type mask. It is meant to really protect people from the healthcare worker spreading. We have 12,000,000 N95 NIOSH-certified masks in the stockpile. And then we have about 5,000,000 N95 masks that I believe may have expired. They are no longer NIOSH certified.

Mrs. WATSON COLEMAN. So where do we get the rest?

Secretary AZAR. And then we would need—so what we have talked about is we would need approximately 300,000,000 N95 masks from the emergency supplemental. We have already from the reprogramming—

Mrs. WATSON COLEMAN. But where will we get them?

Secretary AZAR. Well, so from the reprogramming, we are going to initiate immediately procurements to do domestic manufacturing around N95 as quickly as we can scale it up. And then, if we get the emergency supplemental money on the Strategic National Stockpile, that would add on to those contracts. It will be—I do want caution: It will take time because China, as you rightly mentioned, China does control a lot of the raw materials, as well as manufacturing.

Mrs. WATSON COLEMAN. Thank you. Thank you. I need to ask you some New Jersey specific questions because New Jersey has been designated a funnel airport, which means that individuals who are contagious or could possibly be contagious could possibly be contained or quarantined in New Jersey. So I am interested in sort of the costs associated with our responsibility to do that. And I know New Jersey is gearing up for that purpose. What do you think is an appropriate and fair model to reimburse the State for costs that might be incurred over incidences like that, including quarantine facilities, test kits, overtime, service, that kind of thing.

Secretary AZAR. So, first, with regard to the emergency supplemental, that is exactly why we are asking for a large amount of money to help State and local governments with larger scale containment activities. With regard to the particular issue of Newark Airport as one of the funneling airports, that means individuals who have been in China within the previous 14 days would be directed by DHS into Newark and others. We have worked very collaboratively with New York, which if we have any cases that required actual quarantine, New York has taken those on out of the Newark airport, New York. And then the others really are not—

should not be an impact on New Jersey because at this point, because we are screening them with CDC and DHS people for health screening. And then the rest of the people are going on. We have screened I believe total about 46,000 travelers and have yielded only, I believe, 17 nationwide who have actually needed to go into quarantine because they were in Hubei province.

Mrs. WATSON COLEMAN. Okay. Then let me clarify something for my own self. That they are being—that they are being brought in and looked at in Newark, there is no provision or no discussion about those individuals who need quarantining being like on the Joint McGuire Air Force Base, which is more southern New Jersey.

Secretary AZAR. I do not believe so, but I am happy and certainly can be corrected on that, and we would get you updated information. My understanding what we worked out was Newark would funnel—that any patients with Newark would go into New Jersey.

Mrs. WATSON COLEMAN. So New York I said—

Secretary AZAR. I want to make sure I am right about that.

Mrs. WATSON COLEMAN. Would you please because I understand that that is going to—allowing that is going to expire on March the 5th. But if there is going to be this need, we need to know what the emergency response is going to be to do that.

Secretary AZAR. Sure. I want to make sure I get you accurate information. If I could, we will call your office after the hearing to get you information.

Mrs. WATSON COLEMAN. I think that Ms. Frankel asked—made a comment about sort of the organization of the administration's response to pandemic diseases and things of that nature. And I was wondering why we do not have a, quote/unquote, czar and why this administration is not organized in a way that there is a person at the top who represents sort of the policies and has some authority? Because I know we had a pushback between the CDC and the State Department in terms of flying individuals who are contagious on an airline. So why don't we have that structure? What is a plan to have such a structure, and is there a plan to have such a czar?

Secretary AZAR. Under the national—if I might. Under the National Response Plan, Emergency Support Function 8 for public health emergencies, I am the lead—mine is the lead agency. I actually helped build these plans decades ago for pandemic preparedness after 911. So I serve as the lead on this while it is a public health emergency. I work on a daily basis with the chief of staff and the President. So if there is any deconflicting of agencies needed, that can happen there. So we effectively get that same function. And it is just the longstanding doctrine that this should be led by HHS with the public health emergency. There is not actually a change. The oddity was actually what President Obama did with the Ebola response. I do not know why they felt things were not working and needed to do that. This has been the smoothest inter-agency process I have experienced in my 20 years of dealing with public health emergencies.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you very much.

And thank you, Mr. Secretary. And I have to tell you, after hearing your testimony, you know, the inference that no one in the ad-

ministration knows about coronavirus is pretty stunning. Your knowledge is actually as up-to-date as you can get about it.

I will tell you the other fake news is the budget as referred to as cuts to Medicare and Medicaid. The first time I heard that, I went back and looked at that budget document. Medicare and Medicaid spending go up every single year in the President's budget, don't they? That is a rhetorical question. I know what the answer is. So only in Washington is an increase called a cut. I am not sure I understand it, but we will leave it at that. Let's talk about the emergency funds. I have not been aware of anything that could be done here in the United States that has not been done. Let me bring a couple of examples. For instance, we know that Moderna think just yesterday shipped their novel vaccine. 6 weeks after the idea of making a vaccine, it shipped for Phase 1 trial to NIH. Moderna, by the way, is an American company, right? It is. Right outside of Boston, isn't it?

Secretary AZAR. Right.

Mr. HARRIS. Absolutely. This is stunning. And this lays on the framework that the ranking member had mentioned over the years of us dealing and preparing for exactly this kind, this kind of potential crisis. I mean, that is stunning. But 6 weeks from conceptualization to shipping, a phase 1 vaccine is stunning. And I would urge that you and the Department to speed that through the Phase 3 trial hopefully to get it here before the next winter season.

Another American company, Gilead, Remdesivir, is developing a novel approach to an antiviral that could be effective in coronavirus. That is pretty good, I think. So we have incentivized—it is amazing that the two companies that have taken the lead in a pharmacological approach to dealing with this are American companies. Now, I will tell you what is disappointing is the President warned us China is a bad actor. Do we yet why the genotypes from China of the first cases of this virus?

Secretary AZAR. I do not believe we have the first generation isolates or genetic sequence.

Mr. HARRIS. That is a real problem, because we can talk about what this country can do, but when you are talking about DNA sequence or mRNA sequences of a vaccine, it depends on an accurate genotype that China is unwilling to share with the United States. Now I do not know why they are unwilling to share. You can use your imagination why they might be unwilling to share. But to hold the President of the United States responsible for the behavior of China in response to this is unconscionable. It is unconscionable. I pick the newspaper, and that is all I hear. You have heard some of it today in the subcommittee. No one is talking about China's role withholding the genetic sequencing of those initial isolates, exceedingly important to figure out how this disease is going to affect Americans ultimately. All right. But there are other things and I just want to congratulate you for your support of BARDA. As you know, Sanofi and J&J are making two other novel vaccines under the BARDA program. Again, we have thought about this in advance. We have done what we needed to do. And I believe that we are on the track to dealing with this. There are other issues that

are important to me, and I do not have the time to ask more in-depth questions.

Maternal mortality is very important. I was an obstetric anesthesiologist. I have seen patients get very, very ill. Fortunately, knock on wood, I have not seen a mother die. But it happens in the United States, it happens more often than it should, and I applaud you for doing things about it.

Antimicrobial resistance is incredibly important. And by the way as we begin strategies to fight coronavirus, we have to realize that the antivirals—I was unaware of this actually until very recently that viruses develop resistance to antivirals too. It is not just bacteria. So increasing or keeping the drug pipeline for antivirals open and working is very, very important.

One thing that I would ask you to look into—I have asked this for a year and a half—is that Medicare still does not pay for oxygen therapy for cluster headaches. And as I have told the CMS Administrator, I had cluster headaches; oxygen worked for me when I was younger. We should not deny it to Medicare patients. It is a serious disease. You should not deny it.

DIR fees, I am a little disappointed that the administration has not taken action on them. The rebating mechanisms and what happens helps I think drive up the cost of pharmaceuticals. I would ask you to take action on it. I think we have to come up—and this is one of the most frequent questions that I get asked in the town-hall meetings, is, what are we going to do about prescription drug prices? I would suggest, instead of separating into our opposing camps as we always do, let's get together and agree on some common things that we can do.

Finally, on Naloxone, incredibly important to make sure—as we know and is true in my district, the number of overdoses continues to rise or plateaus. The number of deaths, fortunately, has gone down mostly to the availability of Naloxone. So I want to thank the Department for what it has done with that.

With that, I yield back, Madam Chair.

Ms. DELAURO. Thank you.

Congresswoman BUSTOS.

Mrs. BUSTOS. Thank you, Mr. Secretary for being here. We appreciate it.

So I come from the State of Illinois where we have actually had some cases of coronavirus. And I actually want to shift my line of questioning not so much just around appropriations, even though we are here at our Labor-H Subcommittee of Appropriations, but more about preparing communities. About 85 percent of the towns I represent are 5,000 people or fewer; 60 percent are a thousand people or fewer. So a lot of small and rural areas. And with the expected increase in cases that we have learned about, what will you and your Department do to help prepare our local health providers to be ready for this?

Secretary AZAR. Yeah, and Congresswoman, first. Thank you for your leadership on rural health. I really appreciate you coming over and meeting with me.

Mrs. BUSTOS. I appreciated you having me. It was very nice of you. Thank you.

Secretary AZAR. In terms of rural communities and rural hospitals and providers in the coronavirus situation, first, we don't know how broad any spread would be. We prepare for community outbreaks. Those could be really localized, and then taking mitigation efforts. Dr. Anne Schuchat, who is the top career official at CDC, yesterday at our press conference, she tried to clarify one of the impressions—misimpressions that people have had from our current active containment efforts. Because, right now, we are bringing people back from China or from Japan, repatriating them. And they may be positive or in active containment. We are using high-end health facilities, like Ebola treatment centers, as really isolation units, even though they don't require that level of medical care; because we are in active containment, we don't have another place for them to be. So the impression I think is getting created that anybody who gets novel coronavirus not only goes to the hospital but also goes to very intensive type negative airflow facility, which our rural communities do not have. In fact, what she said is most people who would get novel coronavirus are going to stay at home. They are going to treat it the way they would treat a severe flu or a cold, managing symptoms. And we will publish clear information when you should seek medical attention. When you might, you go to the hospital for the rarer instances where that would be required. So part of it is really managing that patient flow so we do not collapse our rural hospitals unnecessarily. So it is really important that we all work together to educate the public and providers about that.

Mrs. BUSTOS. So really no different in rural America than urban America; it is just educating the public on how best to treat this, rather than head to the biggest hospital.

Secretary AZAR. It is not going to be race into the emergency room, right? But, also, the State and local support in the supp will, of course, be really important for our hospitals and local public health agencies.

Mrs. BUSTOS. Thank you. Let me shift to the discussion that we had when I was in your office back in November. That was about healthcare provider shortage. So I will give you an example in the congressional district that I serve. We have a county—it is called Henderson County—where the patient to physician ratio is 6,995 patients to 1 physician. That contrast, like if you look at Cook County, our largest county in Illinois where, you know, Chicago area, the ratio there is 1,200 to 1. So and then you have also have these example—we have a hospital that literally took 7 years to recruit a physician. So we talked a little bit about this before. So we work together—my colleagues and I, in last year's funding bill to direct the health resources services administration to provide a report to our committee within 120 days of how, how recruitment could be better handled to address these provider shortages. And so I did note that, in the President's budget, his proposal is to cut the Healthcare Workforce Program by \$824,000,000, or about 50 percent. So I was just wondering how your Department will square that massive cut with ending provider shortages or at least addressing provider shortages especially in rural America.

Secretary AZAR. Yes, so I understand your concern and your question. The program that we fund there is the National Health

Service Corp, which really lets us through tuition reimbursement get people who are nurses, doctors, dentists, through a reimbursement system to serve in rural communities and underserved areas. The other program, the one you mentioned that we proposed cutting, it doesn't have demonstrable results in terms of producing that kind of service in rural and underserved areas. It more goes to institutions as subsidies around teaching.

The other thing that we want to do is reform our graduate medical education program. That is why we advocate in combining the Medicare Medicaid in children's graduate medical education programs and getting rid of the caps that we had from the 1990s that freeze in place specialties so that we can enhance our primary care doctors that we produce and psychs other underserved specialty areas to get them into rural areas. That is part of the plan also.

Mrs. BUSTOS. I have several followup questions. I can get those to you later because I am out of time right now. But thank you being here, and thanks for your answers.

Ms. DELAUBRO. Congresswoman LEE.

Ms. LEE. Thank you very much.

Thank you, Madam Chair, and also ranking member.

And thank you, Mr. Secretary. A couple of questions. First of all, let me just follow up on the N95 masks. Last week, I came through the international terminal from the bay area in San Francisco, and I noticed quite a few people had masks on, but they were not N95. The reason I knew this is because of the fires in the bay area, and I have an aunt who is 99 years old and also some senior centers where they were wearing masks. But come to find out, they were useless in many respects. And that is how I learned about N95. And there was only one place where I could purchase them. I wanted to ask you how you are rolling out the public education just with regard to which masks are the appropriate ones to use and which ones are not. Because when I entered the terminal last week, no one had an N95 mask on. So how are we reaching out and letting the public know the difference between the masks and which ones to use?

Secretary AZAR. Thank you. I am so glad you asked about that. We just need to use avenues like this and when we have press conferences and all, because I do fear, especially given that this coming out of Asia where there is much more of a culture of mask wearing when one is sick or at risk of being sick, that people do have the sense of the mask as like the be-all end-all of either preparedness or response activity. It is an element in our armamentarium mostly for healthcare workers. And that is that N95 mask that is actually fitted; it has to be carefully fitted, and it can protect the worker.

The other mask, just you and me wearing these masks—what Dr. Fauci and what Dr. Schuchat have said is that actually sometimes be more harmful to you than not wearing a mask. Because if it is not fitted right, you are going to be fumbling with it, you are going to be touching your face, which is the number one way you are going to get disease is unclean hands touching your face. And so we are really—and every press conference I have been asked about masks, I have tried to settle these expectations that it is—that is not the be-all end-all. Basic public health hygiene,

washing hands at extended time with soap and water, not touching your face, coughing into your elbow. These are best things for flu season for common cold, for novel coronavirus that any of us can do.

Ms. LEE. So you are not suggesting that the public access the N95 mask.

Secretary AZAR. No, we do not recommend that. We do not recommend that, no.

Ms. LEE. Let me ask you now about some of these cuts in your budget. First of all, HIV and AIDS, while we know that we can achieve an AIDS-free generation by 2030, you have a funding cut of \$170,000,000 to PEPFAR, which, of course, reduces the transmission of HIV and AIDS throughout the world. Also, you have a cut in Medicaid, which is the largest source of coverage for people with HIV. So now it is estimated to cover 42 percent of people. So, while you are proposing an increase or new money for Ryan White and CDC, you are cutting 42 percent—you are cutting Medicaid which affects 42 percent of people.

Secondly, and I will do this very quickly, you propose to eliminate the teen pregnancy program. And I want to follow up with Congresswoman Frankel's comment about this obsession with abortion that this administration has, yet you have moved forward to eliminate programs that prevent abortion, such as the teen pregnancy prevention program. You just zeroed that out. You zero out the racial and ethnic approaches to community health, which is the only Federal program that funds community-based organizations to address racial health disparities. And you for the most part cut I think it is \$30,000,000 for the National Institute on Minority Health and Health Disparity. And so the impact of these cuts on minority communities, on young people, on people living with HIV and AIDS, they are horrendous. And I want to know how you justify cutting these programs which really do good and help people and provide for good quality public health strategies.

Secretary AZAR. So we clearly agree with you on the importance of solving minority health disparity, as well as supporting minority health. We may just approach it in different programs and different ways of doing it. We are providing \$5,700,000,000 for our health centers which serve 1 in 12 Americans. And 62 percent of patients in our health centers are actually racial and ethnic minorities. They are really one of the gems of our primary and preventive health system.

Our HIV program that you mentioned my—the one that I really am very passionate about to end the HIV epidemic—the investment of Ryan White HIV AIDS there is critical. And that serves—75 percent of Ryan White clients are actually racial and ethnic minorities.

Ms. LEE. But actually you are cutting Medicaid, which serves 42 percent of people.

Secretary AZAR. As Congressman Harris mentioned, we are actually not even proposing a cut to Medicaid. We would slow the rate of growth on Medicaid from 5.1 percent per year to 3 percent per year, increasing in every single year of the budget outlook in terms of Medicaid. So it actually grows Medicaid just by not quite as much, as its unsustainable pathway for States.

Ms. LEE. If we have a second go around, you can answer teen pregnancy prevention. That is totally crazy.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chair. Thank you, Secretary for being here.

So, when I was preparing for the hearing today, I really wanted to focus on the Low-Income Housing Energy Assistance Program, LIHEAP. There has been a lot of unpredictability because we simply cannot understand the formula that is being used. And this impacts over 7 million families who rely on LIHEAP for their cooling and heating in the season. So I was planning on asking you to follow up on the request of this committee that you provide an explanation of the formula. And I was given this particular—this is the formula for LIHEAP that I was given yesterday by some advocates. So I can understand why it is difficult for you to understand, but I am wondering if you can—I was planning on asking if you can tell us if you are going to have the formula explanation ready for us in time with the 120-day deadline that we gave you?

Secretary AZAR. We will work on getting that to you. I am not familiar with the request that you had for the LIHEAP formula in terms of information, but we will certainly work to get that to you.

Ms. CLARK. Well, it was in our fiscal year 2020 funding bill, and you have 67 days left to comply with it. So I would get cracking if I were you.

Secretary AZAR. I will put coronavirus on hold.

Ms. CLARK. But then maybe it does not really matter because you completed eliminated LIHEAP in this budget. Is that right?

Secretary AZAR. As we have before, the budget environment with budget caps we had a—

Ms. CLARK. That is right. You decided to eliminate the entire program.

Secretary AZAR. We did recommend that it is not as effective as a program, and it is duplicative of other State and local programs.

Ms. CLARK. You just zero out the budget item.

Secretary AZAR [continuing]. You make the choices on whether to accept that.

Ms. CLARK. But that is your recommendation.

Secretary AZAR. It is our recommendation, yes.

Ms. CLARK. Basically you said that is because you think that utilities now cover this because many more States have—that you cannot have your utilities cut off. Is that right?

Secretary AZAR. That is correct as well as GAO funding findings about the risk of fraud and abuse in the program. It is a tight budget environment, and making choices, it is a large discretionary program—

Ms. CLARK. Okay. So you decided that seniors, families with children, that is going to be where we are going to make our decisions in the tight budget environment. I do want to note that many of the rural electric co-ops, municipal utilities, and many of the larger utility companies, the rural and municipal have none of these protections in most States. And in many States, it is not based on income. It is based on whether and trying to figure out the Federal formula that nobody understands. But we will look forward to your report. But then it got a lot worse for LIHEAP because you not

only eliminated it, you decided to transfer \$37,000,000 to fighting the coronavirus. So that is another 750,000 families that you decided, okay, they can go cold, but we are going to put this money towards the coronavirus. And you also did that with \$535,000,000 in Ebola funding, which I know you talked about a little. Do you agree with those Ebola cuts?

Secretary AZAR. So, as I mentioned earlier on the emergency supplemental, we proposed funding half of it through various transfers and reallocations. Congress can of course decide other funding sources or no funding sources for the money. The Ebola money is, while it is useful to us, right now the most pressing need is the novel coronavirus and I—

Ms. CLARK. I agree with you.

Secretary AZAR. And we can restore in the coming years also. As we think about it.

Ms. CLARK. That is a pressing need, but I certainly think that you understand as Secretary that public health crises keep coming, and that is why you prepare. So I am mystified why the White House totally took apart the pandemic chain of command. And you have said today that you do not think you need it; this is one of the smoothest operations. But breaking news while we sit here and maybe the White House did not inform you, is that there is a press conference at 6 o'clock, and the White House is in fact now saying, we might need to appoint a czar to overlook this pandemic.

Secretary AZAR. No, not at all. The President and I spoke this morning as he returned from India, and he said: I want to keep being radically transparent. When you come over to brief me this evening, let's sit and invite the press in.

It is quite that simple.

Ms. CLARK. Quite that simple. Okay. So you have taken that apart. You have recommended \$700,000,000 in cuts to CDC. You have underfunded our emergency response. \$6,100,000,000 was what the President asked for in response to Ebola. This President is asking for \$1,250,000,000 to address this pandemic. But how if you consistently underfund the CDC, you have taken up the heart of chain of command, you are using other critical public health and security measures to fund this coronavirus even at those very low levels, are we possibly able to be transparent, as you just said and look at Americans and saying: Your country is doing everything we can, not only to prepare for this crisis, but for those that we know are coming in the future. I am sorry. My time has expired.

Ms. DELAURO. We are going to move to the second round and asking people to do 3 minutes so everybody has a chance to say or do what they need to do, and then we will wrap up. I will just mention, it just says here: White House is waiting whether to appoint a coronavirus czar to coordinate response to the spreading epidemic.

Secretary AZAR. I do not put much stock in anonymous sources in Politico.

Ms. DELAURO. Well, we will see what happens. But let me move to a different area. I am told that DHS can still be given significant incident reports which might include child's past accounts of trauma or witnessed activity. You know the vast majority of children that end up in ORR's care are there are a result of fleeing, un-

imaginable violence, gang activity, poverty, desperate situation. What is ORR's policy with regard to sharing information, sharing significant incidence reports collected by case managers or clinicians with ICE? It is my understanding that you have said, Secretary Azar, that you have talked about consent. How are children capable of giving consent to sharing notes from their confidential therapy sessions with ICE?

Secretary AZAR. So, as we have discussed, the transmission of the clinical notes should not have happened. That was under the Obama guidance in 2016 that led to misunderstanding where providers were putting their clinical notes either completely into the serious incident reports, or they were being transmitted by ORR correctly over to DHS. That should not have happened. When we learned of it in August of 2019, that practice has stopped. We corrected the understanding of providers. It is important, a serious incident report must be completed if a child evidences harm to self or harm to others. And that goes into the SIR which does get transmitted to DHS as important information about the child. But that should be minimal information, not include—we believe in respecting that psychiatrist or mental health professional relationship.

In terms of consent, our children who are not tender age of course, they are in our care, and they have to consent for medical treatment for any other things all the time. This is part of how ORR has to operate. Remember these are kids who do not have—who left their parents, whose parents abandoned them, whose parents sent them here. And they consent, that is what they do for whether they are getting vaccines or whether they are getting medical treatment.

Ms. DELAURO. But their ability to—

Secretary AZAR. We try to keep in touch with parents as best we can, as you know.

Ms. DELAURO. Again, that requires probably to have legal counsel in order to be able to provide the child with recommendations depending upon obviously the age. I do not know whether or not you require legal counsel if a child has asked to consent to sending their clinical notes or significant incident reports to DHS.

Secretary AZAR. Well, as you know, we do provide legal counsel. You fund it. So kids are offered, do have legal counsel. But we serve as the guardian for these individuals. They do not—

Ms. DELAURO. I understand that, but the guardianship has been—and there has been some changes made, but guardianship hasn't been a really, that substantial, as we have found out over the last 2 years about how we guard these children. Private rights, et cetera. It has not been the case. I would hope we would get to direct representation, legal representation of children. What guidance have you given case managers or clinicians to distinguish in a child's file or in the report that a child has witnessed gang activity or violence without forever associating that child as a gang member? There is an important distinction if that's what justifies sharing a child's information with law enforcement.

Secretary AZAR. We would be happy to work with you. The guidance that went out in August of 2019, I do not know about the divide between witnessing versus participation, and we would be happy to share that with you.

Ms. DELAURO. I would like to see that guidance and would like to sit down and figure out what your oversight is of DHS with regard to this transmittal of this information.

Congressman Harris.

Mr. HARRIS. Thank you very much.

And thanks again, Mr. Secretary, for staying over 2 hours to talk with us about the importance subjects. You know, with regards to the budget request, the emergency request, look, I applaud the Department for doing what every department should do when they come to Congress for an emergency request, which of course exceeds our budget caps—so this just directly contributes without the constraints of a budget cap to our debt and deficit—of actually only asking for only half of it coming from really new funding and the rest finding places where we perhaps over budgeted or we gained efficiencies and transferred it.

So, for instance, you know the \$535,000,000 from Ebola, well, the fact of the matter, as you mentioned, we do have a vaccine. We actually are participating with the international community in controlling Ebola. And it seems perfectly reasonable, instead of asking for new money above budget caps, I just read something that I think over in the Senate side, someone is requesting \$8,000,000,000 or something. I mean, you could not spend the money fast enough. I am going to ask you a question. Is there anything that could have been done up till now that has not been done that you haven't had money for?

Secretary AZAR. No, no. We have had that money. We have used the—thanks to this committee, the Infectious Disease Rapid Response Fund, we have been spending that. And then, with our transfer authority, we will continue to spend as a bridge to whenever we get the emergency supplemental. And we are using that money to seed contracts to be able to execute works on the expansions once we receive the supp.

Mr. HARRIS. Sure. In fact, we have a novel vaccine having been developed. We have a novel antiviral having been developed. You know, we used to say—I used to be in Maryland legislation, and we only met 3 months out of every year. We would say, well, we would meet every year. So if the problem is a—that you could bring it back, but Congress meets all year. Don't we? I am going to ask you, do you take an August recess and an October recess?

Secretary AZAR. No, we do not.

Mr. HARRIS. So we could. I mean, God forbid, this becomes more serious than it is—and it is anticipated it could be serious, more serious—we could actually come back any time and pass more emergency funding above our budget caps, couldn't we?

Secretary AZAR. We could. And in addition, it is important to remember, this request is only for 2020 funding, so through September of this year. And then we have said we would work with appropriators on modifying 2021 requests based on the progress of the disease over the next weeks and months.

Mr. HARRIS. Right. And the plan transfers that have occurred, as I read this chart, right, is \$135 million out of \$81 billion. So that is—

Secretary AZAR. I believe 0.2 percent.

Mr. HARRIS. I think it is a little less than 0.2 percent actually. You are being a little generous about that. I think it is actually less than that.

And, finally, just to clear up one question, because a question came about LIHEAP, but do I recall in the Obama budgets that LIHEAP was zeroed out?

Secretary AZAR. I do not remember if that is the case or not.
[Response from audience]

Mr. HARRIS. It was cut? Oh, so it was cut? It was cut in previous administration budgets, so you are just doing what previous—you are just following the lead of previous administrations. Well, on that I applaud you for following the lead; on other things, I don't.

Finally, look, on title 10 funding, the fact of the matter is that you and I both understand exactly what title 10 was intended for. It was never meant to promote or fund abortions. There are a vast number of Americans who believe the taxpayer dollars should not be used to promote or fund abortions.

And I congratulate the administration on finally restoring title 10 to its initial purpose and, again, allowing us to go home to many of my constituents who strongly believe—who oppose abortion and who believe the Federal Government has no role in promoting or funding abortions.

So I thank you, and I yield back.

Ms. DELAURO. Mr. Pocan.

Mr. POCAN. Thank you, Madam Chair and Ranking Member.

Okay. So I just want to make sure I understand on this czar part, okay. We just got an alert coming out. You said, "I don't put much stock in anonymous sources in Politico," but that is neither a yes or no. So you had a conversation this morning with the President. Have you ever discussed having a czar?

Secretary AZAR. Well, first, I am not going to discuss the content of my interactions and advise to the President, but the President is the one who said, consistent with the National Response Framework, as well as Emergency Support Function Eight, which I actually played a role in designing, that HHS is the lead agency on a public health emergency.

Mr. POCAN. So you don't anticipate a czar?

Secretary AZAR. I don't anticipate one. This is working extremely well. If it doesn't work or if there is a need for a change as there is, for instance, implication of other emergency support functions under the NRP, then that would be for the President to decide perhaps there is a multi-ESF leadership, which is part of the NRP is contained in there also.

Mr. POCAN. Okay. So you are saying from your conversations you don't expect a czar to be appointed today—

Secretary AZAR. I do not.

Mr. POCAN [continuing]. Or anytime in the near future. All right. That is good. Jared Kushner will have more free time then because I am sure, otherwise, he takes on a lot of those responsibilities. So that is good to know.

Let me go back to the question that Ms. Granger asked because I just over vacation read "China Rx," and pretty scary, you know, when you look at the amount of stuff that is being done. This is your wheelhouse, right, where you came from.

I am really concerned—and I saw the President had a directive for military personnel especially about buying American. Are you concerned that so many of our drugs or essential ingredients in drugs are made in places like China, and I think they said 90 percent of generics probably or 80 percent of production, but 90 percent of the essential ingredients are made in China, that at some point that could cause some problems, especially given some of the last—some of the recent various commerce activities we had had with China, how they could hold things up, or in this case what could happen in the Wuhan province where people may have to stop working for a while and you could have some problems? Are we able to do anything? Are we able to try to get production back in the United States?

Secretary AZAR. So I am concerned about that. Having our supply chain, especially on medical products, which can be strategic, so intertwined with China or any other—dependent on any other country is a challenge.

Here is the issue, and I know you have, as do I, a deep passion around getting drug prices down. If there is a reason they are being made in China or India, and that is low-cost manufacturing so—

Mr. POCAN. Yeah. Let me—if I can—

Secretary AZAR [continuing]. If we force them to make them here, we could see an increase in price.

Mr. POCAN. To that very point though, how much does it actually cost to produce a pill? So like the Hep C pill is \$1,000 a pill, right? What is the actual production cost on average for a pill?

Secretary AZAR. Well, it depends on the product, but the difference is a special and generic manufacturing between the U.S. and other countries—

Mr. POCAN. But what is the average cost of production for a pill?

Secretary AZAR. I couldn't tell you that. It depends on the product and how it is—

Mr. POCAN. 10 cents? \$1? \$100?

Secretary AZAR. It would depend on the product.

Mr. POCAN. Yeah.

Secretary AZAR. But manufacturing generics, just we see this, is materially different in lower cost countries than in the U.S. That is why we don't see generic production—

Mr. POCAN. So how about on generic drugs, because we know they are generic, the cost difference. I am just trying to decide why a company—like, are they saving a nickel or are they saving 50 cents by doing that and risking our flow potentially of those essential drugs?

Secretary AZAR. Well, I think it is important to remember the generic business is an extremely low-margin, high-volume business. And so even what you and I may think of as a penny difference could be bankruptcy versus success for a generic company on that, difference in manufacturing with competitors. So I absolutely understand it is a critical issue. I don't know the solution. I want to work with you on that because I don't want to do something that causes our generic prices to soar, of course.

Mr. POCAN. Thank you.

Ms. DELAUBRO. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you.

I want to shift gears a little bit to the announcement for the healthy adult opportunity proposal. And I noted that CMS specifically stated that children in very low-income households will, quote, not—will not be, quote, directly affected.

You know, one of the things that I have found that goes unnoticed is that kids are about 20 percent of the Medicaid population—or I should say it this way: They are about 40 percent of the population; they are about 20 or less percent of the actual dollars spent.

So any kind of shifts within Medicaid I believe need to be done with a specific eye towards safeguarding really the intended recipients of the program. It is a safety net program mostly for a certain population. I think children are kind of front and center in that.

I wanted to know how the Department is going to keep—so—and I know—the answer I have heard before is the States are going to do—the States can do that. I don't trust that my State is going to do that to the best—I should say it this way: I am a trust but verify with regard to how my State is going to make sure that the adults aren't just protected and we are going to push the kids to the edge, because I have children with disabilities who are on Medicaid who come to me and say they get put at the back of the wait lists with regard to Medicaid.

So how is the Department going to be able to step in? I know this is a little different from some of the Republican State's rights questions, you know, give it all to the States. Well, what if we haven't necessarily seen the best instances of children being protected at the State level? How is your department going to be able to do that in the midst of this new proposal?

Secretary AZAR. Well, I would just note first that the actual proposal or the actual opportunity is literally called the healthy adult opportunity. It is an optional demonstration program for States to restructure benefits for adult populations. It is important to remember this is not a mandatory change. This would only be if the State wanted to do it. It would require CMS approval. There is no entitlement on approval. It just states a pathway that we are open to look at these.

It doesn't allow stripping of benefits, limits on eligibility. They can't cap or limit adult enrollment even. So that is even with regard to adults. It requires coverage of essential health benefits. So, even with regard to adults whose name is in the title, all of those protections are in place. And so that is why for low-income individuals, for pregnant women, the elderly adults, people disabled, the traditional Medicaid populations aren't in any way impacted by that. This is that—the able-bodied adult expansion populations under the Affordable Care Act that would be at issue.

Ms. HERRERA BEUTLER. Perfect. That is what I wanted to know. And I am glad you mentioned the pregnant women receiving Medicare. That is the other piece there.

In my view, the goal should be to keep Medicaid as a safety net, a strong, robust safety net for those who it was intended to serve. And for those who are not—shouldn't be part—who weren't part of the original outlay, I think we need to get them into different programs and different options to get them care so that we are not breaking the safety net for, you know, a single mom with three

children, one of whom has multiple, you know, different abilities. So I appreciate that.

Continuing with the discussion on child health and disease, particularly with regard to research, they generally receive significantly less attention and funding compared to other age groups. In 2021—in the 2021 proposal, what is the administration doing to focus on child health and research and on childhood diseases?

Secretary AZAR. So, as you know, the President's pediatric care initiative, which you all funded through NIH, is really important because children and cancer really have been neglected for too long. Different disease profiles, so we have been building up the databases to share information so that we can actually help discover cures targeted for kids. So that has been part of the work of NIH. But really the budget continues that funding with \$50 million in 2021 on top of what you already funded.

Ms. HERRERA BEUTLER. Thank you.

Thanks, Madam Chair.

Ms. DELAURO. Congresswoman Lee. I am sorry, Frankel, Congresswoman Frankel.

Ms. FRANKEL. Okay. That is okay. My turn?

Ms. DELAURO. Your turn. Go for it.

Ms. FRANKEL. Thank you. All right. We are going to get back to our last subject. So, I guess, I want to correct what I think was some misinformation that you put out or maybe a spin. I am going tell you about Planned Parenthood, its last report: 2.4 million patients; 9.7 million services provided; over 4.7 million STI testing and treatment; 2.6 million birth control information services; they estimated that approximately 400,000 unintended pregnancies were averted; over 500,000 breast exams and Pap smears; and 1.2 million people reached through education and outlet.

So I would say, and I think most people in the public would say that Planned Parenthood has done a really good service, especially to poor women, women of color in this country. And your administration has basically, with what we call—with a very, very cruel gag rule, so putting the gag rule on steroids.

And what does that mean, gagging? It is like they put a piece of cloth across the doctor's mouth because I think we need to all understand that Federal money is never used for abortions, and Planned Parenthood has never used Federal money for abortions.

Oh, you are going to get the little red sticker from somebody there. But the fact of the matter is, now with the new gag rule on steroids, a provider who does not use Federal money for abortions cannot even tell somebody, when they go in office, if a patient says, "What are my options," they are now gagged, the provider is gagged.

And what Planned Parenthood has done, which I think is very courageous, but unfortunately I think it is going to maybe hurt a lot of women, is they have said: We are not going to be untruthful with our patients. We are an organization that, if a patient comes in for care, we are going to tell them the truth.

And I wanted to give you another example of your—the alternatives that are being provided in this country and now that Planned Parenthood has had to withdraw. In Louisiana, the State list of alternative providers include dentists and nursing homes;

and in Florida, it includes school nurses; in Ohio, it includes food banks.

So I would just—I am running out of time, but I am going to end it by saying this: The women and the girls in this country, we need to be in charge of our own bodies in order to have full, productive lives, not Donald Trump being in charge of our bodies.

And, with that, I yield back.

Ms. DELAURO. Congressman Cole.

Mr. COLE. Thank you very much, Madam Chairman.

Mr. Secretary, just a couple of quick questions. I know you are working hard on the President's request for targeted HIV testing and working toward the hopefully elimination in the next 10 years of this dreaded disease. But, unfortunately, the Interior Subcommittee did not provide additional resources to the Indian Health Service as part of this initiative.

You and I have had a little discussion about this. You know, what can be done as we move forward? And, again, let me just make clear, that is no criticism for our colleagues on the Interior Health because they have a very low budget. Actually, the chairman and I were talking about it, very difficult for them to provide the resources that they would like to do given the range of responsibilities they have. So I sympathize with them, but this is an important initiative. We have got to find a way to get it funded in Indian Country.

Secretary AZAR. It is quite important. We used money Congress had given us in 2019 to do four jump start projects. So we funded planning in all of the 57 jurisdictions so that, as soon as you funded the President's request, we would be able to get off to the races as we did with the funding from HRSA, this morning, the \$117 million that I announced on executing.

We had four jurisdictions, one of which was the Cherokee Nation that we advance funded so they could actually get moving right away on it in anticipation of funding for Tribal territory. We do have in this budget request a request of \$27 million for his that would support the critical needs of the disproportionately affected on the HIV spread in Indian Country.

That would be expanding HIV testing in Indian country; connecting American Indians and Alaska natives to care; getting previously undiagnosed HIV infections in treatment so that they can be—if they are undetectable, they can be un-transmissible; getting prep out among people who are at risk to ensure that they cannot transmit to others; and also supporting disease surveillance in Tribal epidemiology centers.

Mr. COLE. Well, again, we appreciate your efforts. I have very little time left, and this is a big question, but all of us know suicide rates have been rising literally in every State in the country. So I am interested in what you have in your budget that might help us to do more in that particular area.

Secretary AZAR. So we have been very active, especially in supporting on suicide with regard to our veterans. So we—with—the suicide hotline now has a very important function. The very first question you are asked if you call the suicide hotline is, are you a veteran? If you are a veteran, we now have an immediate hot

transfer over to a live person who will give immediate counseling tailored to veterans and the risk of suicide.

We have collaborated very closely between NIH and DOD and VA and have come up with artificial intelligence algorithms that help us actually predict, based on a veteran's history, certain categories, certain individuals who are at much higher risk of suicidality. Those individuals actually receive—I think it is monthly coaching and proactive intervention. So we really hope that this collaboration between us and DOD and VA can help with the just devastating issue of our veteran suicide issues.

We are also investing, of course, suicide prevention programs, 93 million community mental health services block grants with an increase of 35 million there. So and many other programs that are in the budget. Suicidality is a very important priority for us.

Ms. COLE. Thank you.

Thank you, Madam Chair.

Ms. DELAURO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chairman.

Mr. Secretary, I need you to check back with your Department because my understanding is that New Jersey was specifically told to get ready to be able to house or deal with those individuals that would come through the funnel airport, and that is why they were looking to use the Joint Air Force Base, and that is why it is important because the ability to use that is being eliminated as of next week.

Two other things really quickly. I am really pleased that you find maternal morbidity a really important issue. And I know we recognize that nearly half of pregnancies are unplanned. Women need to be able to have the kind of healthcare that they need when they find out that they are pregnant.

I have been working on Healthy Moms Act, which would open up a special enrollment period for women who are finding themselves pregnant, but I know you can do that by executive order by just—you know, by your authority, and I would like to work with you on that. Would you be willing to work with me?

Secretary AZAR. Yeah. I haven't been familiar with that as a special enrollment period option, but I am happy to look at that and work with you on that.

Mrs. WATSON COLEMAN. Oh, great. Okay.

Secretary AZAR. I did not know that that wasn't—that for new—so for new pregnant women, there is not currently a special enrollment period?

Mrs. WATSON COLEMAN. No. It is not—

Secretary AZAR. I didn't know that.

Mrs. WATSON COLEMAN. It is not eligible right now. Okay. We can talk about that.

Last thing is I did a lot of work with the special task force on mental health issues and Black youth suicide. As a result of that, we did—we had a report done by a series of professionals, working groups, identified a lot of issues that your department can address. So I am concerned about the \$200 million cut to the NIH.

I would like to, with unanimous consent, enter this report, which is called "Ring the Alarm: The Crisis of Black Youth Suicide in America" into the record. And I would very much like to have the

opportunity to work with you on making sure that some of these very important issues, particularly as access to culturally competent services, enough services, and research and things of that nature are addressed.

Secretary AZAR. Absolutely. That could be very valuable for us and our work on suicide. So, no, I look forward to that. Thank you.

Mrs. WATSON COLEMAN. Thank you. I yield back.

Ms. DELAURO. We will—unanimous consent to enter your document.

Mrs. WATSON COLEMAN. Thank you.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Thank you very much.

Okay. I want to go back to a couple of my remarks and questions earlier, Mr. Secretary. First of all, you know that PEPFAR has been a bipartisan initiative since we really began this when President Bush was President. And so, every year, we are trying to make sure that we are on target in terms of reaching the 2030 goals of really eliminating HIV and AIDS.

So this budget though calls for \$170 million cut in PEPFAR, which does not make any sense if, in fact, we are going to keep working together to try to get to our goals. So I am not sure what the rationale was for putting forth a cut. That is a significant cut to the PEPFAR program. We need to increase it.

Secondly, again, with regard to teen pregnancy prevention, for the life of me, I can't understand why you would eliminate this when we know for a fact that a wide range of evidence-based and innovative interventions to support the sexual health of young people is extremely important. It helps develop healthy—it really develops the education that is needed to help our young people prevent abortions, and so I can't understand why you would eliminate that program.

Also, it harms young people who are already marginalized, like LGBTQ youth and young people who have been victims of sexual violence. And so eliminating this program, what is the rationale, and what is the basis for that?

And then, finally, you mentioned community health centers, which are wonderful and provide health services where there are many gaps in both rural and urban communities, but they don't address the basic racial health disparities, and you know what they are.

And so the REACH program provides strategies to address the basic racial disparities in chronic health and the National Institute of Minority Health. It impacts millions of Americans by providing in the health delivery system specific perspectives and strategies to reduce health disparities as it relates to minority communities. So why would you cut that also? I mean, minority communities are really under attack through this budget.

Secretary AZAR. So, with regard to PEPFAR, I would have to defer to the Department of State on that. It is their program. I am not consulted on the funding levels for PEPFAR in terms of—but I would say PEPFAR is obviously an important program. I have gotten to see the fruits of the work of PEPFAR in building up public health capacity. PEPFAR plus the global health security agen-

da. As I traveled the DRC, Rwanda, Uganda on the Ebola crisis, I have gotten to see the fruits of that important work there.

The teen pregnancy prevention program, we just—we fundamentally disagree in terms of whether those are evidence-based interventions that actually from an evidence perspective deliver. The rate of teen pregnancy was declining long before the TPP was put in place. It serves less than 1 percent of the teen population.

And a longitudinal study of the program actually during the Obama administration looked at 37 of those programs, and it found that 73 percent of them either had no impact or actually a detrimental impact in terms of STDs and teen pregnancy, teen initiation of sex.

Ms. LEE. Well, I beg to differ with you, Mr. Secretary. Years of research have shown that the abstinence-only approach not only fails in getting young people to delay sex but also can harm young people.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chair.

I first want to correct myself. I told you that there were 67 days to get the congressionally mandated report. It is actually 53—

Secretary AZAR. Okay.

Ms. CLARK [continuing]. So an even bigger challenge than I first reported.

And I just want to add that President Obama never proposed eliminating LIHEAP, but he did propose dramatic cuts to it, to the tune of \$3 billion. And it was strong bipartisan opposition that rescued this program. I certainly hope we will see that again this year from your proposal to completely eliminate it.

But switching gears, Madam Chair, I would ask unanimous consent to enter this letter from the American Psychological Association chief into the record.

Ms. DELAURO. Without objection.

Ms. CLARK. This letter is addressed to you as of February 21 and is concerning the very dangerous and disturbing practice that we are seeing emerging at ORR, where, as you know, we are required—you are obligated to act in the best interest of immigrant children in their care.

But reports are that the notes from the psychotherapy sessions of children who have experienced trauma are being shared by ORR with ICE, and this information is being used against the children in deportation proceedings even though these conversations are supposed to be confidential. What are you doing to halt the sharing of this confidential information with ICE?

Secretary AZAR. So I am glad you raised that because I have been able to have a discussion with the chairwoman in private before the hearing about this issue. We agree that those notes and that interaction between the mental health provider and the child should be normally confidential. There are exceptions, as the APA would make clear also, where there is a risk of harm to the child or to others.

Ms. CLARK. But that is not—

Secretary AZAR. But there was guidance put out in 2016 in the Obama administration that was not clear, and it led to two mistakes happening: One was clinician notes were provided and that

was not correct to DHS; and sometimes clinicians just cut and pasted their notes into the serious incident report in the management system where they should have just noted there was a threat of harm to self or other, which they have to do by law, and they cut and pasted it, and that was provided.

When we learned about this in August of 2019 before any media reports, we stopped it. We issued corrective guidance and said that is not proper; minimal information should go in the serious incident report and go over, but it should not have happened.

Ms. CLARK. Okay.

Secretary AZAR. We agree with you.

Ms. CLARK. Speaking of children in custody, as I think about places that you can get money to address this coronavirus, and I still don't know why we are building a public health response once the pandemic threat is already here, but has the contract for Homestead where we were paying \$720,000 a day to not house children, has that actually ended as of November 30?

Secretary AZAR. I don't know—I don't think it has ended as of November 30 or what the current contours are. I can explain to you why we have that contract, which is, in response, in fact, to the chairwoman and this committee's concerns around the care for kids, we are increasing fixed capacity, but we do need influx capacity in the event that, if Mexico changes border policy and we see kids, the number one priority is not letting them be backed up at ICE or at the border and coming to us, so—

Ms. CLARK. So that \$80 million we have spent not to house children you feel that is better spent than putting that money into coronavirus. That is really an incredible set of priorities. Thank you.

Ms. DELAURO. Thank you.

Let me just recognize the ranking member for some closing remarks, and then I have two or three, and I am mindful of your hard stop.

Mr. COLE. Thank you very much, Madam Chairman. I will be brief. First, I want to thank you for the hearing, excellent hearing, a lot of good questions, a lot of excellent points made I think by every member on the committee. And I want to commit to you, again, I look forward to working with you on the supplemental. I thought the points you made were good points. We want additional detail, but we intend to work together on this and certainly work with you, Mr. Secretary.

And let me finish by thanking you again and your team. Look, this committee has worked hard for 5 years on a bipartisan basis to create the institutions that I think are serving us very well now, obviously, your entire department but specifically the NIH, the CDC, the strategic stockpile, the creation of the rapid response—Infectious Diseases Rapid Response Fund.

All those things I think have put us in a position to do well, and I think you have done a good job. I think you guys have been very transparent with us from day one. I think the congressional briefs have been excellent. Appearance of a number of members of your department before this committee and a special briefing session that my good friend, the chairman, convened for us, extremely helpful.

The contrast between what I saw yesterday in the Senate and what I saw here today on both sides of the aisle makes me very proud of our chamber and this subcommittee. I think we have a lot of people saying a lot of things that either haven't been participating in the process or have not been transparent about it.

And, again, I want to also thank you because you did commit here and I know it is sincere commitment that if we need to go beyond your initial recommendation to protect the American people, we are all prepared to do that. So I don't look at the—I want to be prudent in the use of funds. I know my colleagues up here do as well, but we are like you.

And I remember in one of our briefings—I think it was actually one that the chairman and I coordinated—you made the statement that, you know, you would rather be accused of doing too much in retrospect than accused of doing too little. And I think you have been true to that commitment every step of the way. I think the people that work with you have as well, and I am very confident you will continue to do that.

So thanks for your hard work on behalf of the American people. Thanks too for your honesty and transparency here. We will try to help you in a lot of the places you need help, and then we are going to help you in some places you probably officially don't need help but we officially think you do. And so I look forward to that working relationship and, again, just thank you for your service to the American people.

Thank you, Madam Chair.

Ms. DELAURO. Thank you. If I can just wrap up being mindful of your timeframe, I would just tell you that the issue of suicide makes me—and the commentary on that makes me view that you need to review whether or not you want to cut \$25 million from gun violence prevention research where the basic focus is on suicides. It is mostly suicides with veterans. And I don't care how good the hotline is; we need to find out what is going on in the minds of veterans and others in order to be able to plumb why they are taking their lives.

But the issue of—we are not going to talk influx facilities today, my colleague mentioned this, but we are, very flat out. And I will just tell you, it is my goal with an empty facility and millions of dollars being spent and the numbers declining as they are and we are nowhere near capacity at the State-licensed shelters, we are going to shut them down because we can deal with the issues in other ways.

I might also add the issue came up with regard to cuts, determining whether a Federal budget proposal counts as a budget cut is simple. If the proposal would reduce funding for a program's benefit or services or reduce the number of people who qualify for benefits relative to levels that would occur under current law, it is a cut. We are cutting \$920 billion over 10 years to Medicaid, \$756 billion over 10 years for Medicare.

I want to get—let me just do this, because you mentioned this, Mr. Secretary, and I thought it was very clear. You stated that infectious disease, global health, and preparedness were prioritized in the CDC budget request following essential programs we—were proposed for cuts, which makes the commentary, quite frankly, in-

consistent, cutting CDC \$693 million or 9 percent. We are cutting Infectious Diseases Rapid Response Fund by \$35 million, 41 percent, and you don't—not replenishing it in your supplemental.

The public health data initiative \$20 million, a 40 percent cut, specifically asked by the Director Redfield in order for us to modernize our efforts to transform public health data into analysis so that we can move more quickly; the public health workforce, which we talked about today, \$6 million or 12 percent; and the epidemiology and laboratory capacity program by \$40 million as a cut, 18 percent. This flies in the face of what you have talked about in terms of what your goals are.

Lastly, about information sharing with DHS. Is ORR sharing information about rejected sponsor applicants with ICE at DHS?

Secretary AZAR. So we have shared the names and addresses of 141 individuals who were denied sponsorship due to criminal histories or due to fraudulent representations to ORR that they have a bona fide relationship with a child. No parents were included in that group. And then whenever we have—

Ms. DELAURO. You are—

Secretary AZAR. I am sorry?

Ms. DELAURO. You are prohibited by law from detaining sponsors based on information that HHS collects on potential sponsors during the vetting process.

Secretary AZAR. Well, again, I don't detain sponsors. But also the Department of Homeland Security is complying with the legal restraints in the act, but this is not parents. This is individuals denied sponsorship due to criminal histories or due to fraudulent representations to ORR that they would—that they have a bona fide relationship with the child, no parents being included in that group is what I am informed.

Ms. DELAURO. Can you tell me also, is ORR sharing information with DHS on any adult who does not fall into the categories included in the DHS rider, the prohibition on use of funds to detain a sponsor unless they have a certain specific criminal criteria?

Secretary AZAR. I would want to get back to you on the details there. We certainly are complying with the rider, but if there is any beyond the rider, I don't have that detail.

Ms. DELAURO. And I would like the information.

Secretary AZAR. Yep.

Ms. DELAURO. What kind of firewall exists between ORR's information about potential sponsors and ICE given that information sharing for enforcement actions is prohibited?

Secretary AZAR. The use of it for enforcement maybe be prohibited, but there is no firewall that is required. And so information is shared, and it has been shared frankly for—I think for quite some time. For instance, we share information on sponsors within 24 hours of discharge, and that is part of also double—there are a couple things.

One, the sponsor actually has to certify to us and to DHS that if they move the child, that that will be reported. Remember, this is a child who is not legally in the country and subject to proceedings; and, second, that the sponsor isn't, for instance, illegally in the country and subject to a removal order and about to be deported. That wouldn't be a safe environment for us to then place

the child. So there is that last minute check and information sharing. I think that has gone on, my goodness, for at least over a decade, I believe.

Ms. DELAURO. Well, we need to get a very, very detailed view of the current information that is being shared and whether or not it is in contravention of the rider in the bill. And further to that is that we need—because ICE walks into State-licensed facilities and fingerprints. And you may or may not know about it. ICE is transmitting—ORR is transmitting clinical notes. There are all kinds of avenues here which are being breached in terms of the privacy and the care of these children and the intimidation of these children.

We need to get to a point where that is no longer the case and that ORR and DHS have only their concern about the welfare of these children. And, yes, I understand criminal activity. I understand human trafficking. But we have seen over the last year and a half or more that we are moving into what is really unbelievable mental health issues arising out of intimidation of children that are in our care. They are in your care, but they are in our care while they are here, and we are not going to continue to put up with that.

Thank you for being here this morning. Thank you for being up-front with us on issues. And as my colleague said, we want to be ahead of this crisis on the coronavirus. We do not want to be behind the curve. So thank you very much, Mr. Secretary.

[The following questions and answers were submitted for the record:]

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
2021 Hearing (2.26.20)*

Questions for the Record for Secretary Alex Azar

Submitted by Chairwoman Lowey

Preschool Development Grants

New York received a \$13,414,500 Preschool Development Grant Birth through Five (PDG B-5) renewal grant in FY19 to improve the coordination of existing funding streams and delivery models for providing high-quality early childhood education. In year one, 46 states received funding for initial planning grants and conducted comprehensive needs assessments for the first time. Due to funding constraints, only 20 of the 46 states that applied –including my home state of New York – were awarded Preschool Development B-5 renewal grant funding. Improving supports for our youngest learners, through close collaboration within communities, will ensure existing and future federal, state, and local resources are used effectively to promote quality early learning opportunities.

Question:

- Given state demand to further improve coordination of existing early childhood services and to serve more children effectively, why does the Department propose eliminating the program?

Response:

The Administration did not request funding for Preschool Development Grants in order to prioritize direct services like Head Start and Child Care.

Last year, the Administration awarded a PDG B-5 grant to 44 states, D.C. and the U.S. Virgin Islands so that they could each develop a comprehensive, statewide, birth through five needs assessment and strategic plan related to all things early childhood. Although 23 states have received continued funding in the form of 3-year renewal grants to implement their strategic plans, the Department prefers that states continue funding for implementation to ensure their commitment and sustainability.

The Department's (HHS) Administration for Children and Families (ACF), working in partnership with the Department of Education (ED), is engaging all states in a variety of efforts to facilitate cross-state connections and build capacity that will enable the progress

[Example from 2015]

made with PDG funding to continue. Specifically, HHS and ED are sharing new tools and resources with states and various early care and education programs, alerting states to various funding opportunities made available by other federal agencies, and inviting all states to participate in any annual meetings or other learning events (including webinars) that facilitate cross-state sharing and learning.

In addition, ACF created a template for and encourages states to annually share best or innovative practices, efforts to blend and braid funding, new and improved partnerships, new policies, procedures or legislation, progress on improving the access to and quality of early childhood care and education programs, infrastructure, policy, governance and/or funding established to sustain the activities, and improvements in meaningful parent engagement.

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
2021 Hearing (2.26.20)*

Questions for the Record for Secretary Alex Azar

Submitted by Chair DeLauro

Early Childhood Education

The FY 2021 budget proposal doesn't cut Head Start or CCDBG, but level funding doesn't mean that you will be able to provide same level of services that you were able to support in FY20.

Question: What would be the estimated reduction to the number of students served if Head Start were level funded in FY21?

Response:

The FY 2021 Budget estimates that Head Start will have a total of 857,627 slots for children. In FY 2020, ACF estimates that Head Start will have a total of 878,553 slots.

Question: What would be the estimated reduction to the number of students served by Child Care Development Block Grants if this program were level funded in FY21?

Response:

With FY 2021 CCDBG funding at the same level as the Enacted FY 2020 level and CCE funding at the Current Law level of \$2,917 million, the Office of Child Care (OCC) estimates that the number of children served will increase by 130,000, from 1.635 million to 1.765 million. This estimate assumes the following:

1. Spending rate for FY 2021 is 62 percent, an increase of 7 percent from FY 2020 spending rate of 55 percent.
2. Spending from Prior Years increases from \$2,831 million to \$3,499 million or 23.5 percent more in FY 2021 compared to FY 2020
3. Annual Subsidy rate increase of 3 percent.

OCC is projecting the caseload to increase even with flat funding because States still have remaining unused funds from prior years (FY 2018-FY 2019)—when CCDF funding increased significantly. It has taken time for States to ramp up their spending in response to the funding increase due to the need to enact State legislative and regulatory changes, IT system changes, and other implementation steps.

[Example from 2015]

Patient Matching

Research has shown that HHS can take steps today to improve patient matching—specifically through the use of common standards and data elements.

Question: What steps is Office of the National Coordinator for Health Information Technology (ONC) taking to require greater standardization of data for matching, including through use of the Postal Service standard?

Response:

ONC is taking numerous steps to increase the standardization of data, including:

- United States Core Data for Interoperability (USCDI):
 - The USCDI is a standardized set of health data classes and consistent data elements for nationwide, interoperable health information exchange that ONC develops and maintains for use as part of the ONC Health IT Certification Program.
 - Within the demographics section of the USCDI, a number of additional data elements to assist with patient matching are required, including an individual's address, previous address, phone number, phone number type (e.g., mobile), and email address. This expanded set of demographic data elements significantly assists patient matching.
 - Most recently, in the ONC Cures Act NPRM, ONC proposed to adopt the USCDI and required its use across a range of certification criteria adopted within the ONC Health IT Certification Program. This includes both document based exchange and exchange through standardized application programming interfaces (APIs). In addition, the USCDI is the data set referenced in the draft Trusted Exchange Framework and Common Agreement under the Cures Act, as well as the data set referenced by CMS programs. Through these additional policy levers, the USCDI and the specific data demographic elements it references can be used to assist with patient matching, across settings and service providers within the health care industry.
- Patient Centered Outcomes Research (PCOR) Projects:
 - In August 2019, through funding provided by the PCOR initiative to HHS, ONC led a team of experts to develop recommendations and a data quality framework to drive improvements in patient matching.
 - [Patient Matching, Aggregating, and Linking Final Report](#)
 - [Pilot of a Data Quality Framework to Support Patient Matching Report](#)
- U.S. Postal Service
 - Within ONC's recent Cures Act Final Rule we noted that we received numerous public comments on the proposed rule specifically requesting exploration and recommending the use of the U.S. Postal Service Postal Addressing Standards. As noted in the ONC Cures Act NPRM, while the U.S. Postal Service Postal

Addressing Standards include a single representation for certain data elements (such as rendering apartment as apt, building as bldg, floor as fl, etc.) they also allow variations for other data elements, such as “acceptable” and “preferred” spellings and abbreviations for street and city names. This may result in multiple “valid” addresses. To reconcile this variation, the U.S. Postal Service provides a file listing preferred city and state combinations as well as a file of street name and zip code combinations and the resulting aggregated address would then require manual reconciliation.

- Because of the variation, the required use of reference files to mitigate the variation, and the manual reconciliation necessary for implementation, the NPRM proposed to not adopt the U.S. Postal Service Postal Addressing Standards as a required standard for the address Data Elements within the USCDI. We encourage the use of standardized elements to accurately represent patient address including use of standardized references in the U.S Postal Service Postal Addressing Standards where applicable. In addition, we will continue to work with standards development organizations to evaluate potential solutions to improve patient matching, including considering the potential adaptability of the U.S. Postal Service formats for health IT use cases.
- See ONC 21st Century Cures Act NPRM for further information.

Electronic Health Records – Safety and System Usability

Many stakeholders—including clinicians—have encouraged HHS to prioritize patient safety as part of the electronic health records (EHR) Reporting Program given the correlation between safety and system usability, which refers to the design and implementation of the EHR.

Question: How are you prioritizing patient safety in the EHR Reporting Program—particularly in the aspects related to usability?

Response:

ONC has taken the following actions related to establishing the EHR Reporting Program, each of which contains aspects related to patient safety within the program:

- August 2018 - ONC issued a request for information (RFI) for public stakeholders to share their views on the components of the EHR Reporting Program and to provide feedback that will inform the development of EHR Reporting Program criteria and processes. <https://federalregister.gov/d/2018-18297>
- Beginning in 2019, ONC contracted with the Urban Institute to conduct a stakeholder engagement process to inform the development of draft criteria for the EHR Reporting Program. Stakeholders emphasized the need to promote safety and safe use of health IT, particularly to drive improvements in health IT system usability. Stakeholders also highlighted numerous challenges regarding objectively measuring usability in ways that allow for comparison across health IT products (e.g., due to the numerous locally-customized implementations).
- The Urban Institute provided ONC a report on priorities identified through the stakeholder engagement process. The report includes a section on usability, which

[Example from 2015]

identifies the following areas of stakeholder interest: Functionality; Performance; and Costs and Developer Practices.

- ONC and the Urban Institute are now considering these stakeholder priorities in the development of draft criteria for the EHR Reporting Program.

Community Services Block Grant

Community Action Agencies (CAAs) administer funds provided through numerous federal programs such as Head Start, child care, workforce development, and other initiatives to promote self-sufficiency or ensure a safety net for the truly needy.

Question: What attempts have been made to estimate the value of the infrastructure provided by CAAs in administering these programs?

Response:

Continuing a proposal from the FY 2020 President's Budget, the FY 2021 budget request does not include funding for the Community Service Block Grant (CSBG). In a constrained budget environment, difficult funding decisions must be made to ensure that federal funds are being spent as effectively as possible. The CSBG program does not use performance-based funding distribution formulas, and CSBG counts for only five percent of the total funding received by eligible local agencies.

Question: Before proposing to terminate CSBG, did the Administration consult with local elected officials, such as mayors and county commissioners, for their assessment of the value of Community Action in their local communities?

Response:

In preparing the budget request, this Administration prioritized ensuring limited federal funds go to programs that demonstrate results. CSBG continues to be distributed by a formula not tied directly to the local agency performance, and with limited resources available, the difficult decision was made to request the elimination of CSBG.

Question: What would be the potential burden on local governments if CSBG funding were eliminated?

Response:

We are aware that while the percentage can vary by agency, overall the Community Services Block Grant (CSBG) accounts for approximately five percent of total funding received by local agencies that receive these funds. In preparing the budget request, this Administration prioritized ensuring limited federal funds go to programs that demonstrate results. CSBG continues to be distributed by a formula not tied directly to the local agency performance, and with limited resources available, the difficult decision was made to request the elimination of CSBG.

Unaccompanied Children Program

Question: What is the average number of days that a child waits for a “long-term foster care bed” after they are determined to be eligible?

Response:

ORR policy currently requires that children who are expected to have a protracted stay of at least four months in custody be eligible for placement in long-term foster care (LTFC) (please see [section 1.4.3](#) of the ORR Policy Guide for further information on these requirements). However, ORR’s current database (the “UAC Portal” or “Portal”) does not capture the number of days that a child waits for placement in a long-term foster care bed. ORR is currently developing an updated case management database, which will incorporate a tracking function for long-term foster care referrals.

Question: What is ORR doing to increase the number of long-term foster care (LTFC) beds for children who are eligible, and how many LTFC beds does ORR estimate adding to its network by the end of FY20?

Response:

ORR will publish a Funding Opportunity Announcement (FOA) for LTFC beds later this spring. ORR anticipates awarding grants for LTFC programs based on this announcement this winter. ORR currently funds 645 LTFC beds (of which 627 have been delivered as of April 6, 2020). ORR will extend this grant through December 2020. Subject to applications for changes to bed capacity, ORR plans to award new grants to maintain total funded capacity.

Separate from the FOA for LTFC, ORR is exploring the creation of a hybrid form of care for Category 4 children. Category 4 children are considered those who are likely to remain in care for an extended period because they have no identifiable sponsor. (Please see [section 2.2.1](#) of ORR’s Policy Guide for more information). The proposed Category 4 setting will look similar to ORR’s current model of small transitional foster care programs, and will offer enhanced services in the areas of legal, educational, and behavioral health tailored specifically for the needs of Category 4 children and youths.

Unaccompanied Children and Influx Facilities

Question: What is ORR doing to ensure that children are discharged as fast as possible from permanent facilities, therefore helping to ensure that ORR will not need to use influx facilities?

Response:

ORR has taken a number of actions to improve the rate at which UAC are discharged from federal custody. For example, ORR has increased (and continues to increase) the number of UAC Program staff directly involved in the discharge process and implemented further programmatic and operational improvements to alleviate any bottlenecks and delays in discharges. As a result, ORR has seen a reduction in its length of care (LOC) for discharged UAC. The current average length of care is 38 days for those discharged as of April 5, 2020.

[Example from 2015]

Further, per ORR's Policy Guide section 7.2.2, ORR may activate and open an influx care facility when operational capacity is at or exceeds 85 percent. However, as of April 5, 2020, ORR had a 21 percent occupancy rate, well below the threshold to open an influx capacity. This low occupancy rate is due, in part, to efforts ORR has undertaken to build a network of licensed bed capacity to have 16,500 beds online by the end of the fiscal year, which is in line with the framework to minimize the use of unlicensed influx care facilities.

Question : When ORR opened the Carrizo Springs facility, it housed children for only 11 days. It is the Committee's understanding that ORR is in the second year of a three-year lease at Carrizo Springs, even though the budget justification does not include any information about the facility. What are the long-term plans for Carrizo Springs?

Response:

ORR is currently maintaining Carrizo Springs in "warm status," which means ORR does not place any children at the facility but the site is maintained with the minimum number of support staff to keep the facility safe and secure, in case ORR's permanent bed capacity reaches its maximum due to an increase in referrals. If activated, Carrizo Springs could provide up to 1,344 additional beds. Currently, ORR is investing in basic infrastructure improvements to widen the field of potential organizations that could provide services at the site and to lower the daily operating cost when the site is activated, if needed.

Question : Can Carrizo Springs be used for anything other than an unlicensed UAC shelter, and if so, what is HHS considering?

Response:

HHS is not considering the use of the Carrizo Springs Influx Care Facility for other purposes at this time.

Unaccompanied Children and Migrant Protection Protocols (MPP)

Question: What mechanism or process is ORR using to identify and track children affected by MPP?

Response:

ORR may discover that a UAC or the UAC's parents were previously processed under MPP during the intakes process, or while the child undergoes assessments upon entering ORR custody. In such cases, the ORR Case Management team, in coordination with the ORR Intakes team and ORR care providers, adds the UAC to a running list of all identified MPP cases. Every week, the ORR Case Management team sends its list to the DHS-ICE Juvenile and Family Residential Management Unit for further verification and additional information, to create a master tracking document. Information regarding MPP cases is also entered as a SIR in the UAC Portal.

Question: Does ORR notify the child's attorney of record and the child advocate when an "MPP-affected" child is identified?

Response:

Yes. Care providers are required to notify the attorney of record or the legal service provider shortly after the UAC arrives at the facility and informs them if the UAC has a removal order or requests a voluntary departure. The care provider works with the UAC's attorney of record or the ORR-funded legal service provider to have the UAC screened for potential legal relief, within five calendar days of the UAC's admission to the care provider facility. In most cases, if the UAC is eligible for legal relief, ORR will assign him or her a Child Advocate, who makes an independent recommendation regarding the child's best interests, as detailed in section 2.3.4 of the ORR Policy Guide.

Unaccompanied Children and Family Separation

Question: What improvements have been made to the UAC system to improve the tracking of children who have been separated from an adult?

Response:

ORR has several mechanisms for tracking UAC separated from an adult by DHS. ORR added a checkbox to its UAC database, which is marked for any child separated from a parent or legal guardian, and can be used as a means to quickly identify known separations for data reporting purposes. In addition, for children transferred to ORR custody subsequent to their separation from a parent or legal guardian, documentation of that separation is entered in ORR's UAC database upon ORR learning of the separation (e.g., through the creation of a Significant Incident Report). For any child, including UAC separated from an adult that is not the child's parent or legal guardian, the ORR care provider includes information of that separation in the UAC's case file as part of recording the child's experiences during their journey to the United States and placement in an ORR facility. On a weekly basis, ORR communicates with CBP and ICE staff to jointly reconcile a running list of children separated from their parents/legal guardians. Through these mechanisms, ORR continues to monitor children separated from their parent/legal guardian and document when separations from their parents or adult relations are brought to ORR's attention.

Question: When is a legal service provider and child advocate notified that a child is in ORR's care as a result of separation by DHS?

Response:

All UAC in ORR custody meet with legal service providers shortly after their placement in ORR custody. ORR notifies legal service providers of a UAC separated from their parent after initial assessments are conducted and when possible, prior to the child's legal screening provided by the legal service provider. Child advocates are notified upon their request or when appointed to a specific UAC in accordance with section 2.3.4 of the ORR Policy Guide.

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
2021 Hearing (2.26.20)*

Questions for the Record for Secretary Alex Azar

Submitted by Congresswoman Roybal-Allard

COVID-19 Surge Response

Over the decades, Congress has continued to provide funding to HHS for public health preparedness and response to protect our nation, save lives, and recover from emergencies. Similar to the military, public health preparedness is not a one-and-done exercise. With both the military and public health, an increase funding is also required when a surge in force is required.

The Infectious Disease Rapid Response Reserve Fund has been described as a “game changer” in that CDC has ready access to much needed funding to mount a prompt response to the unexpected threat of coronavirus. However, the rapid response fund was intended to be a bridge that would allow for the launch of a quick response while federal agencies assessed longer term resource needs and developed an emergency supplemental appropriations request. The amount of the fund is likely not sufficient for all aspects of the response, including supporting state and local health departments that are taking on significant aspects of the response, including implementing quarantine and isolation precautions which are among the most labor intensive of all public health interventions. I understand that HHS also has some transfer authority, though would be concerned about resources being diverted from other important public health priorities.

Question 1:

1. Do you agree that the Infectious Disease Rapid Response Reserve Fund is an important budget tool, and if so, please explain why your proposed FY 2021 budget cuts the Reserve Fund contribution from \$85 million in FY 2020 to \$50 million in the President’s Budget request, right at the beginning of a known infectious disease threat in China that we hope to prevent from spreading in the U.S.?

Response:

The Infectious Diseases Rapid Response Reserve Fund has been essential in CDC’s ability to respond quickly to public health emergencies, notably the COVID-19 pandemic. The Fund has been invaluable in CDC’s ability to respond swiftly and distribute funds to state and local health departments, the frontline of the nation’s response efforts, in a rapid manner. The robust investment in public health including \$600 million for the Reserve Fund through the

recent emergency supplemental funding bills will ensure CDC's continued capacity to respond to future public health emergencies and other significant threats to health.

2. Can you provide an overview of how HHS is capturing state and local public health expenditures to prepare for and respond to the coronavirus outbreak, and will these expenditures be fully reimbursed and replenished in a Supplemental Appropriations request?

Response:

The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 required states, localities, and territories to provide spend plans on the use of funds within 45 days of enactment. Reimbursement may be allowed for pre-award costs incurred on or after January 20, 2020, for certain public health expenses related to surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities associated with COVID-19. Currently, recipients of these funds are preparing and submitting budgets and budget narratives to CDC that will include expenditures for COVID-19 related activities up to the amount awarded. HHS develops weekly tracking reports and a dashboard of recipient expenditure/outlays and draw down percentages for the COVID-19 funds through using information available in the Payment Management System (PMS), the system recipients use to drawdown funds and report expenditures. Additionally, recipients report expenditures into PMS quarterly and submit a Final Financial Report 90 days after the end of the budget period.

3. With the transfer of millions of dollars from other programs to CDC and other responding agencies can you confirm that these expenses would be backfilled with supplemental funding?

Response:

Secretary Azar utilized the Secretary's transfer authority to direct resources urgently to the COVID-19 response. As directed in the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, funds that have been reprogrammed or transferred from an appropriation to support the response prior to passage of the Act, as described by the HHS Secretary on February 2, 2020, shall be reprogrammed or transferred back to that appropriation within 45 days of enactment. All funds have been transferred back to the original accounts.

4. How is the current COVID-19 response impacting other work at HHS, CDC and state and local health departments on other critical public health priorities, including influenza, measles and other vaccine preventable diseases; antibiotic resistance; and the opioid epidemic?

Response:

As of May 21, over 5,000 CDC personnel are currently engaged in the COVID-19 response. CDC and our Federal, state, and local partners are working diligently to maintain critical public health activities across the spectrum of health threats. Many departments are strained as staff are assigned to response work. Many public health services are conducted face to face, which have been paused as the nation practices social distancing. This response has demonstrated how investment in public health is critical.

5. The WHO declared the COVID-19 outbreak a Public Health Emergency of International Concern partly because of the threat the outbreak poses to countries with underdeveloped health care systems. What are US agencies doing to help resource-limited partner countries strengthen their readiness and response capacities?

Response:

CDC uses congressionally appropriated funds to enhance public health capacity abroad to improve global health security. Following significant investments in recent years, resources and efforts devoted specifically to global health security have an impact. Countries are actively applying the core public health capabilities they have built to detect cases of COVID-19 and to take actions to mitigate the spread of disease.

CDC works to bolster global health security and pandemic preparedness by focusing on enhancing the core foundations of strong public health systems – comprehensive disease surveillance and integrated laboratory systems, a strong public health workforce, and capable emergency management structures.

Programs within CDC's global health security portfolio include:

- **Field Epidemiology Training Program (FETP)** trains a global workforce of field epidemiologists, or “disease detectives”. The program increases countries' ability to detect and respond to threats, addresses the severe worldwide shortage of skilled epidemiologists, and builds critical relationships between CDC and other countries. Over 70 countries have participated in CDC-supported FETPs, training more than 10,000 graduates. As a result of CDC's investment over the past five years, the number of FETP graduates has doubled compared to the years prior to that period.
- **National Public Health Institutes (NPHI)** help many countries around the world carry out essential public health functions and ensure accountability for public health resources. Through the program, CDC helps countries become better equipped to collect and use public health data; plan, implement, and monitor public health programs; and, ultimately, save money and protect lives. CDC's support to more than 26 countries has ranged from technical assistance from abroad, to more intensive, hands-on, and on-the-ground technical assistance.

- **Public Health Emergency Management (PHEM) Fellowship** program trains international public health professionals affiliated with ministries of health, using a standardized emergency management framework and in-depth exposure to Public Health Emergency Operations Center. To date, the program has graduated 142 fellows from 37 countries (plus the African Union), many of whom assume key roles in public health leadership. These investments in workforce training help countries build capacity and aid in communication during steady state and in a response.

CDC's global preparedness activities—strengthening local partners and leveraging headquarters expertise—mirror CDC's approach in domestic disease outbreak response.

6. The WHO has estimated they need \$675 million for COVID-19 preparedness and response efforts through April. The bulk of this funding would go towards strengthening capacities in resource-limited countries to prevent, detect and respond to the outbreak. Has the U.S. made any contributions to meet the WHO's fundraising goal? If not, are there plans to contribute?

CDC Response:

CDC is leveraging current relationships between CDC headquarters, CDC country offices, and Ministries of Health, as well as existing global health security, influenza, polio, and HIV programs/platforms. The CDC has staff stationed in more than 50 countries around the globe, working every day with our in-country partners to address their public health priorities. As part of the COVID-19 response, CDC has been providing technical support to countries and remains receptive to requests for assistance.

CDC Data Modernization Initiative

CDC has an ongoing data modernization initiative that Congress has supported with an initial appropriation in FY 2020.

Question: Can you explain the importance of improving CDC and the Department's ability to collect and analyze data as it applies to an infectious disease outbreak such as the current coronavirus threat?

Response:

At the heart of any public health response, including the current COVID-19 outbreak response, is the critical need for information and data. Developing a more flexible, adaptive, and timely data system for diseases is important to monitor infectious diseases, and is an important part of public health data modernization. The most recent investment of \$500 million in the CARES Act is critical, and underscores the inherent value of data modernization and predictive data analytics. Investment in public health data infrastructure is essential to bring public health data systems into the 21st century and appropriately engage public health organizations, academic institutions,

and the private sector to accelerate our progress in making public health data available and actionable rapidly. States must move their data collection and surveillance capacities forward, and the federal government will continue to improve its internal capacity to collect data from state and local health departments as well as hospitals, labs and other patient points of care. CDC will also deploy analytical tools on health data that will enable us to better anticipate health threats. Data modernization will enable CDC to move from a reactive posture to a predictive one.

Senior Nutrition

You have previously spoken on the high costs associated with caring for older adults with malnutrition and the importance of screening, intervention, and continued support for this population. However, a recent GAO report classified federal research on older adult nutrition as “limited.”

Questions:

1. How can the Administration for Community Living’s senior nutrition programs be a bridge to medical care for seniors who have or at risk of developing malnutrition?

Response:

Malnutrition is a serious problem of older adults and its signs may go unrecognized by the older person, their family and caregivers, community programs, transition care teams, health care, and food assistance programs. The prevalence of malnutrition in community older adults is not well identified, with data indicating that 30 percent or more of community dwelling older adults may be malnourished.

The Older Americans Act (OAA) indicates that a purpose of the Senior Nutrition Programs is to reduce malnutrition. The Administration for Community Living (ACL) supports finding ways to meet this purpose and to build bridges with medical care through the integration of health and social service/human services.

The current participants of the Senior Nutrition Programs are at high risk; they have two- to three-times more food insecurity than the general older population and a higher rate of some chronic diseases as well. Both factors predispose them to high risk of malnutrition.

In the aftermath of the COVID-19 public health emergency, there may be an increased number of older adults with food insecurity, and likely an increased number with health issues exacerbated by social isolation and social distancing, and other health issues that may lead to increased malnutrition.

The aging services programs may be stressed to continue current services and prioritize services to those most in need since many older adults will have been added to their caseloads.

To address these challenges, ACL is engaged in:

1. Collaboration within the Department of Health and Human Services, including:
 - a. the Office of Health Promotion and Disease Prevention under the Assistant Secretary for Health to ensure a focus on older adults in the 2025-2030 Dietary Guidelines for Americans and in Healthy People 2030;
 - b. other HHS agencies such as the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Indian Health Service and the National Institute on Aging of the National Institutes of Health.
 2. Collaboration with its aging services partners such as the National Association of Nutrition and Aging Services Programs, Meals on Wheels America, National Association of Area Agencies on Aging, National Council on Aging, and ADvancing States.
 3. Collaboration with advocacy coalitions such as Defeat Malnutrition Today, the Academy of Nutrition and Dietetics, especially the Healthy Aging Practice Group.
 4. Utilizing current ACL resources, such as a listserv of State Unit on Aging nutritionists and administrators to learn of state initiatives, state reports focusing on malnutrition, and sharing resources and emphasizing the role of nutrition and its significance to overall good health as well as through its integration in State Plans into systems of home and community based services within broader long term services and supports systems.
 5. Utilizing the National Resource Center on Nutrition and Aging to compile and disseminate pertinent information; to act as a forum to share best practices; and to serve as a change agent for state and local practice.
 6. Utilizing the ACL Nutrition Innovation grants process to fund new approaches and ideas.
 7. Continuing the emphasis on serving nutritious, safe, quality meals to promote health and help manage the chronic conditions of high-risk populations currently served.
 8. Providing training to caregivers to understand the signs of malnutrition and available resources.
 9. Working with external partners to raise awareness of the need to enhance the integration of health and social services through innovations with our Aging and Disability Business Institute.
2. How will HHS achieve an increased focus on this topic despite the cuts to NIH and the National Institute on Aging proposed by the President's FY21 budget?

Response:

Recognizing the profound importance of diet and nutrition to the health of older adults, the National Institute on Aging (NIA) maintains an active and thriving portfolio of research in this area. For example, NIA researchers are investigating the role of undernutrition as one of a suite of factors potentially associated with disease susceptibility, disability, and frailty in older adults. Investigators are also testing the effectiveness of dietary supplementation with a wide variety of nutrients in different contexts. Examples include a natural supplement called nicotinamide riboside to lower elevated blood pressure and studies of the effects of protein supplementation on bone health, skeletal muscle health, and other outcomes. Other ongoing research includes

development of a possible intervention for binge eating among older women and a mobile health intervention to promote healthy eating among frail older adults.

NIA also incorporates questions about diet and nutrition into a number of cohort studies, including the Health and Retirement Study; the Healthy Aging in Neighborhoods of Diversity across the Lifespan (HANDLS); the Baltimore Longitudinal study of Aging; the Invecchiare in Chianti, aging in the Chianti area (InCHIANTI) study; and others. This enables researchers to identify and follow trends in diet and nutrition and to identify potential correlates to and long-term outcomes of dietary choice, food insecurity, and nutritional status. For example, HANDLS investigators assessed dietary quality over 13 years among African American and White participants, with both young and older adults represented. They found that over the study, dietary quality declined significantly for participants ages 60 and older, but not among younger participants. Risk for malnutrition was significantly associated with consuming a diet low in calories, lower protein as a percent of calories at baseline, as well as being food insecure, being a current smoker, and having income less than 125 percent of the Federal poverty level. The risk for malnutrition was not associated with a change in protein intake in years prior to age 60, age, sex, race, or having hypertension or diabetes.

A particularly active area of research is on the effects of diet and nutrition on cognition. Investigators have found that blood biomarkers of nutrient status can be used to link diet with brain health. For example, in the InCHIANTI study, individuals with higher blood levels of circulating fatty acids and vitamin E were less likely to have dementia and cognitive impairment. Studies have also shown that malnourished adults with dementia show a more rapid cognitive and functional decline than their better-nourished counterparts. Researchers are now studying the association between certain diets, including the Dietary Approaches to Stop Hypertension (DASH), Mediterranean, and Mediterranean-DASH Intervention for Neurodegenerative Delay (MIND) diets, and development and spread of brain pathology. These studies are beginning to suggest that better diet quality may be neuroprotective. NIA supports other studies on the effects of various vitamins and other supplements, including Vitamin D, Vitamin B12, and cocoa flavanols, on brain health and cognition.

NIA maintains a robust library of free materials to help older Americans make healthy food choices. Information is available online showing servings and portion sizes, weight maintenance, how to read food labels, food safety, and overcoming “roadblocks” to healthy eating. Information is also available in Spanish.

Lastly, with the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the U.S. Department of Agriculture (USDA), and other NIH Institutes and Offices, NIA participates in the DHHS Office of Disease Prevention and Health Promotion’s Older Individuals Collaborative on Nutrition. NIA also coordinates its own Nutrition Committee, with meetings that include representatives from across NIH as well as FDA, CDC, and USDA.

Liver Transplantation

The Department of Health and Human Services deserves credit for implementing reforms on how livers are allocated for transplant. The new “Acuity Model” is an evidence-based approach endorsed by medical professionals and other experts in the field after several years of intense debate. Unlike the previous liver allocation policy, it complies with the National Organ Transplant Act, which requires that patients’ medical need be prioritized over arbitrary geographic boundaries.

Question: How will you uphold this policy to ensure the ongoing prioritization of patient medical need when it comes to allocating livers and other organs for transplants?

Response:

The Organ Procurement and Transplantation Network (OPTN) implemented the new liver and intestinal organ distribution policy, referred to as the Acuity Circles policy, on February 4, 2020. The new policy replaces the use of decades-old geographic boundaries of 58 donation service areas and 11 transplant regions. It emphasizes the medical urgency of liver transplant candidates.

The OPTN is responsible for organ allocation policy and Health Resources and Services Administration (HRSA) is charged with oversight of the OPTN. HRSA and the OPTN are committed to the equitable allocation of livers and other organs for transplantation for patients across the country and will carefully monitor the outcomes of the Acuity Circles policy.

Early Hearing Detection and Intervention

The Center on Birth Defects and Developmental Disabilities has the mission is to advance the health and well-being of our nation’s most vulnerable populations. Among its many varied responsibilities, this Center is tasked with addressing some of the most significant child health issues facing American families, such as tracking the prevalence of conditions like autism spectrum disorder (ASD) and collecting and analyzing data for state-based Early Hearing Detection and Intervention programs.

Your budget proposes a \$48.5 million cut for the Center on Birth Defects and Developmental Disabilities, but does not specifically indicate exactly how much is budgeted for autism surveillance, and EHDI work to track the continuum of care for babies born with hearing loss. Failure to fund these initiatives at full authorized levels may leave thousands of children with undiagnosed hearing loss and a murky picture of the prevalence of ASD.

Question: Can you clarify exactly how much funding your budget is proposing to be allocated for the ASD and EHDI programs at CDC, and how these crucial programs will be impacted by proposed cuts to the Center on Birth Defects and Developmental Disabilities?

Response:

Similar to previous President's Budget requests, the FY 2021 President's Budget includes \$112 million to prevent birth defects and developmental disabilities, providing CDC the flexibility to efficiently manage resources while addressing the most pressing public health issues. CDC will continue to focus the birth defects and developmental disabilities portfolio on core public health activities that align with CDC's mission with evidence-based interventions to make a positive impact on Americans' health.

Preschool Development Grants

The Preschool Development Grant Birth through Five (PDG B-5) program, as authorized under the Every Student Succeeds Act (ESSA) with bipartisan support, aims to improve collaboration and coordination among early childhood programs at the state and local level, leading to maximized parent choice, improved transitions within early learning and care programs, and improved overall quality of programs. Improving supports for our youngest learners, through close collaboration within communities, will ensure existing and future federal, state, and local resources are used effectively to promote quality early learning opportunities. States have also shown an overwhelming interest in these grants, as demonstrated by the 47 states that applied in the first year and 46 that applied in the last round. Due to funding constraints, only 20 states, including my home state of California was awarded funding. Despite this, the Administration's FY2021 budget request proposes to eliminate PDG B-5 program at a time when the federal government should be looking to invest in programs that optimize existing early childhood education resources.

Questions:

1. Please discuss the innovative approaches' states are taking under the PDG B-5 program to increase flexibility in the use of federal funds to serve families, particularly in maximizing parent choice?

Response:

States recognize maximizing parent choice is one of the ultimate goals for the PDG B-5 program and are taking different, innovative approaches to working toward this goal. Below are examples of the different ways states are focusing on expanding parent knowledge, increasing parent involvement, and providing meaningful parent engagement opportunities that will lead to maximizing parent choice.

- Alaska has a parent marketing campaign to maximize parent knowledge and choice about quality early childhood education (ECE) programs in order for families to be better-informed consumers of child care.
- Arkansas has placed heavy emphasis in reaching parents via social media giving them information regarding child development, recognizing high quality early childhood education through resources, apps, infographics and sharing research/evidence based posts to guide parents through maximizing their early childhood care and education choices.
- Colorado's Home Visiting for Licensed Family Child Care Homes (LFCCH) and Friend, Family and Neighbor (FFN) Care Providers Pilot Program leverages existing MIECHV-funded home visitation models, Home Instruction for Parents of Preschool Youngsters

(HIPPY) and Parents as Teachers (PAT), and expands these models to LFCCH and FFN environments.

- Connecticut has implemented the use of app-based technology in 8 communities. Within early childhood settings, WIC offices, and community agencies, families and providers have used the Sparkler app as a way of focusing interactions on child development, delivering content to families to support it, and connecting caregivers and organizations to promote healthy development.
 - Indiana has begun several activities including implementation of texting applications that contain early childhood information to parents, providing families additional information to make choices about care and provider selection; updating websites to include information on provider selection and quality rating; and collaboration with Indiana State Department of Health to provide early childhood education and childcare information during pregnancy through prenatal education with the goal that new parents would begin infant care search earlier and be more informed.
 - Minnesota's family navigation and central intake model – Help Me Connect – assists families to get the culturally-responsive and geographically-relevant information and services they are seeking, and help those who work with families scaffold resources and services. The overall aim of Help Me Connect is to improve equitable access to services which address both developmental and behavioral health.
 - Maryland is implementing several projects that support parent choice: 1) WIDA Early Years, which support English language learners and their families; 2) Promoting and Supporting Inclusive Settings, which provides direct support to providers in evidence-based behavioral intervention models so that they may serve young children who exhibit challenging behavior; and 3) Our partnership with Maryland Public Television to develop and disseminate three PSA's emphasizing the importance of choosing high-quality child care.
 - Oregon's Early Learning Portal goals include meeting the accessibility needs of diverse families, including linguistically diverse families; supporting Hubs in their coordinated enrollment activities; unifying existing websites and search tools in one system; and responding to the needs of providers to utilize technology that supports their outreach and enrollment.
 - Rhode Island has awarded five contracts to increase parent knowledge, choice and engagement in the B-5 system. Contracts are focused on facilitating family knowledge of and engagement with the B-5 system and providing direct support to families through promising programming along with piloting facilitated parent involvement in governance.
2. Recognizing that PDG B-5 awards allow states, like California, to improve coordination of existing early childhood services and funding streams, how can the federal government leverage the efficiencies that states are finding through their planning and implementation of these grants to improve the use of federal funds and overall quality of early childhood education programs?

Response:

Although a major goal of the HHS/ED partnership is leveraging the efficiencies that states are finding to improve the use of Federal funds and overall quality of early childhood education programs, the 23 states with a PDG B-5 Renewal grants have only begun the 1st

year of these grants. As a result, we cannot yet fully answer this question. As we wait to learn more, here are two examples of movement in this area:

Colorado state law allows for an innovative funding strategy, contracted slots, to increase families access to quality providers. With contracted slots, child care subsidy payments are not tied to child care attendance and are made to providers on a monthly basis. Weekly payroll for attendance/billing through the state's Attendance Tracking System (ATS) is released every Thursday at midnight. The payment is for one week of care, two weeks prior to the payment date. Payments are made only for the care that has been authorized by the county department of human/social services.

In partnership with the Colorado Office of Early Childhood, Early Milestones Colorado conducted a study to assess the benefits and costs for families, providers, and county and state administrators of the contracted slots approach during a six-month pilot in three counties (Arapahoe, Denver, and Gunnison). See link (<https://earlymilestones.org/wp-content/uploads/2020/03/CCCAP-Contracted-Slots-Pilot-Final-Report.pdf>).

The pilot showed the potential that contracted slots hold for increased access to quality child care.

- Families that rely on child care subsidy to help with the cost of child care often can't find providers that offer high-quality, consistent care. Pilot results suggest more providers may participate in the child care subsidy program through contracted slots because it provides additional financial stability.
- Additionally, more consistent funding allows providers to invest in program improvements that benefit staff. Contracted slots also strengthened relationships between providers, families, and county administrators of child care subsidy programs.

Colorado is using PDG B-5 funds to implement necessary changes to state IT systems to allow for all counties to participate in contract for slots, issuing updated rules and policies in response to learnings from the pilot program, and providing additional technical assistance to counties participating in this model.

HHS and ED are encouraging states to learn from and replicate their efforts by helping states explore possibilities for improving coordination and integration of early childhood services. For example, as states coordinate their TA support across their various programs and services and provide more effective virtual learning opportunities, the Departments expect to see costs savings generated by no longer providing separate and duplicative training and TA supports to each individual program. ACF, with assistance from our TA provider will also be creating resources that can then be used across programs rather than having each program develop its own resources.

Early Head Start Child Care Partnerships

States across the nation are leading the way to ensure more children—especially those from low-income families—have access to high-quality early learning and care from birth through age five. Much of the progress at the state and local level has only been made possible through strong partnerships with the federal government aimed at expanding access and increasing quality. Early Head Start – Child Care Partnerships are a paramount example of these efforts as they bring together the best of Early Head Start and child care through layered funding to provide comprehensive and continuous services to low-income infants, toddlers, and their families.

Question: How could additional investments in Early Head Start-Child Care Partnerships assist providers in maximizing the use of federal dollars, while improving access to high-quality early learning for infants and toddlers?

Antibiotic Resistance/ Antibiotic R&D

A December op-ed co-authored by HHS Secretary Azar and CDC Director Redfield identified antibiotic resistance as “one of the greatest threats to public health today.” I agree with you, and I support the US government’s current investments in this area, but I am concerned that we are not doing enough, specifically with regard to antibiotic research and development. Two small biotech companies with new antibiotics on the market filed for bankruptcy in 2019, leaving private investors largely unwilling to invest in much needed antibiotic innovation.

Question: Does the administration have a plan to stabilize the antibiotics market and encourage antibiotic innovation?

Response:

The Early Head Start (EHS) Expansion and Early Head Start-Child Care (EHS-CC) Partnerships funding has allowed grantees to expand access for needed infant and toddler care in their community through traditional EHS programs or through partnerships with center-based and family child care providers who agree to meet the Head Start Program Performance Standards. Since 2014, about \$800 million has been appropriated and awarded through EHS Expansion and EHS-CC Partnership grants across three rounds of funding. In FY 2019, grantees were funded to serve 33,563 infants and toddlers in the EHS-CC Partnership model through this funding.

The EHS-CC Partnerships bring together EHS and child care through the layering of funding to provide comprehensive and continuous services to low-income infants, toddlers, and their families. Through EHS-CC Partnerships, new or existing grantees partner with local child care centers or family child care programs and are required to leverage current investments through the Child Care and Development Fund (CCDF) or other funding sources to improve the quality of infant-toddler child care. The EHS-CC Partnerships can enhance and support early learning settings to provide full-day, full-year comprehensive services that meet the needs of low-income working families; enhance access to high-quality, full-time child care; support the development of infants and toddlers through strong relationship-based experiences; and prepare them for the transition into preschool. Child care partners and their staff can also benefit from additional

support for professional development, family engagement services, and resources to help improve learning environments made available through the partnership funds. EHS-CC Partnerships build on the strengths of both child care and EHS programs. Integrating EHS comprehensive services and resources into the array of traditional child care and family child care settings creates new opportunities to improve outcomes for infants, toddlers, and their families.

Topic: Child Care and Development Block Grants

Working families need to know their young children are safe, healthy and learning, which quality childcare can provide. Yet affording quality childcare continues to be one of the largest financial burdens facing working families and it has proven to be cost prohibitive for many. Child Care and Development Block Grants (CCDBG), in partnership and coordination with other early learning funding at the federal, state and local level allows parents to work while their children attend childcare that promotes learning and healthy development. Establishing continuous access to affordable, reliable, and high-quality early learning and care opportunities promotes job stability for working families and overall economic security.

Question: Understanding that quality childcare is both a child development support and a workforce support, what do American families and the American economy stand to gain by increasing investments in Child Care and Development Block Grants?

Response:

Child care subsidy receipt is related to greater likelihood of employment (especially full time employment), earnings, and prolonged employment for families. Moreover, increases in reimbursement rates are linked to presence of more quality indicators in child care providers who accept CCDF subsidies. Such efforts enable a more skilled and experienced child care workforce that accepts CCDF subsidies. Investments in CCDBG support learning and development of young children—who are the workforce of tomorrow.

Antibiotic Resistance/Stewardship

In September 2019 CMS finalized a rule requiring hospitals to establish antibiotic stewardship programs that align with CDC recommendations. While the rule is a meaningful step in addressing the growing crisis of antimicrobial resistance, I am very concerned that the President's FY2021 budget proposes cuts or stagnant funding to CDC programs that complement the rule, including a cut to the CDC Antibiotic Resistance Solutions Initiative and flat funding for the CDC's National Healthcare Safety Network, which supports voluntary reporting of antibiotic use and resistance data by hospitals and other healthcare facilities. These data support the implementation and evaluation of stewardship programs. Additional funding is needed to achieve the stated goal in the National Action Plan for Combating Antibiotic Resistant Bacteria for 95% of hospitals to report these data by this year.

Question: How would these proposed funding levels impact the administration's efforts to combat antibiotic resistance, including implementing the September 2019 rule?

Response:

Under the Antibiotic Resistance Solutions Initiative (ARSI), CDC supports the efforts to detect, respond to, contain, and prevent AR infections in the U.S. and globally. Congress appropriated \$160 million in FY 2016 and has steadily increased that funding level to \$170 million in FY 2020. With funding provided by the Congress, CDC leverages its resources to ensure the greatest possible impact in the fight against antibiotic resistance and will work with our partners at the Centers for Medicare and Medicaid Services to support the successful implementation of antibiotic stewardship programs and practices in hospitals and other healthcare facilities nationwide.

An important tool to support these efforts is the National Healthcare Safety Network (NHSN) -- the nation's most comprehensive and widely used healthcare-associated infections (HAI) and antibiotic resistance (AR) surveillance and quality improvement system, and the tool which healthcare providers use to collect and report these data to improve their quality of care. Currently, about 23,000 U.S. healthcare facilities—including almost every hospital in the nation, more than 7,600 dialysis facilities, and more than 3,000 nursing homes—use NHSN to drive their HAI elimination strategies. CDC anticipates there will be an estimated increase of 5,000+ additional healthcare facilities using NHSN within the next year to 18 months.

The FY 2021 President's Budget request for NHSN is \$21 million, which will allow CDC to maintain current operations and continue to support ongoing NHSN reporting in current healthcare facilities to protect patients and improve healthcare across the continuum of care.

Evaluation and Management (E/M) Reimbursement Policies

The growing coronavirus outbreak is a stark reminder of the central role infectious diseases (ID) physicians play in responding to emerging infectious diseases and other public health emergencies. Despite the significant and vital contributions ID physicians make to patient care, research and public health, their work continues to be undervalued. While over 90% of the care provided by ID physicians is considered evaluation and management (E/M), current E/M codes do not reflect the increasing complexity of E/M work. This inappropriate reimbursement is driving fewer physicians to enter the field of infectious diseases at a time when these experts are urgently needed to respond to a host of threats including coronavirus.

CMS significantly improved valuation for outpatient E/M services in the CY 2020 Medicare Physician Fee Schedule (PFS), but I am concerned that these changes are not likely to fully appropriately value outpatient E/M services and do not address inpatient E/M services at all.

Question: Has CMS considered establishing a Technical Expert Panel (TEP) with input from external stakeholders that would contribute direction and guidance to refine E/M payment and policies, including outlining the specifications and objectives for conducting research regarding appropriate valuation of E/M codes?

Response:

The calendar year (CY) 2020 Physician Fee Schedule (PFS) final rule issued on November 1, 2019, adjusted the relative value units (RVUs) for office and outpatient evaluation and

management (E/M) visit codes effective beginning in CY 2021. The Department finalized the proposal to establish values based on recommendations by the American Medical Association Specialty Society Relative Value Scale Update Committee (RUC), which were based upon a survey of more than 50 specialty societies. We generally believe that the RUC-recommended values for these codes accurately reflect the resources involved in furnishing office and outpatient E/M visits and used them, with minor modifications, to establish values for these E/M visits.

CMS included a table that shows the estimated specialty level impacts of these changes, exclusive of any other changes finalized for CY 2020. Those specialties that see the greatest decreases are those that do not generally bill office/outpatient E/M visits. These estimates can provide insight into the magnitude of potential changes, but do not take into account other changes to payment rates finalized for CY 2020. Any potential coding changes and recommendations in overall valuation for new and existing codes between the CY 2020 and the CY 2021 final rules could impact the actual change in the overall valuation of office/outpatient visits relative to the rest of the PFS.

Opioid-Induced Respiratory Depression

Opioid-induced respiratory depression can lead to overdose and death – in individuals taking opioids both in and out of the hospital. In inpatient settings, system-wide changes may be the most important target for Adverse Drug Event (ADE) prevention because many opioid ADEs occur from medication and prescribing errors and inadequate monitoring of patient outcomes.

After implementing continuous monitoring with measure-through motion and low perfusion pulse oximetry and a remote monitoring and clinician notification system, researchers at Dartmouth-Hitchcock Medical Center were able to eliminate preventable deaths and brain damage due to opioid overdose in post-surgical units as well as reduce rapid rescue events by 60%, ICU transfers by 50%, and cost by an estimated \$1.48 million annually. The potential a

Despite this research, CMS has no formal recommendation that hospitals continuously monitor patients taking opioids on the general floor of the hospital.

Questions:

1. Has AHRQ looked at the benefits of continuous monitoring for all patients taking opioids in the hospital?

Response:

AHRQ has not conducted a systematic evidence review of the benefits of continuous monitoring for all patients taking opioids in the hospital.

2. Does CMS track hospital policies regarding continuous monitoring of Medicare patients taking opioids?

3. What would it take for CMS to institute a standard of care requiring continuous monitoring for all Medicare patients taking opioids in the hospital?

Response to 2 and 3:

CMS expects all hospitals participating in Medicare to meet CMS Hospital Conditions of Participation at all times, including numerous requirements regarding the preparation and administration of drugs. Under the survey guidance used to enforce the CMS Hospital Conditions of Participation, patients must be carefully monitored to determine whether the medication results in the therapeutically intended benefit, and to allow for early identification of adverse effects and timely initiation of appropriate corrective action.

In 2014, CMS issued a Survey and Certification Memorandum to update guidance for hospital medication administration requirements. This guidance included updates to reflect the need for patient risk assessment and appropriate monitoring during and after medication administration, particularly for post-operative patients receiving IV opioid medications.

The guidance states that hospitals are expected to address monitoring for over-sedation and respiratory depression related to IV opioids for post-operative patients. Hospitals must have policies and procedures related to the use of high-alert medications, including IV opioids for post-operative patients. These policies and procedures must address, at a minimum, the process for patient risk assessment, including who conducts the assessments, and, based on the results of the assessment, monitoring frequency and duration, what is to be monitored, and monitoring methods. The memorandum further states that the effects of IV opioids in post-operative patients must be monitored vigilantly, and at a minimum, monitoring must include: vital signs (blood pressure, temperature, pulse, respiratory rate); pain level; respiratory status; and sedation levels.

This memorandum also includes a discussion of recommendations of patient safety organizations for best practices related to the use of IV opioid medications, including sedation assessment, frequency of monitoring and use of technology-supported monitoring, such as continuous pulse oximetry and/or capnography linked to clinical staff notification devices. These recommendations were highlighted in the guidance in what is called “blue boxes”. Although adoption of these “blue box” best practices is not required, hospitals are strongly encouraged to review these practices and consider whether to adopt them.

It is expected that hospitals will develop policies and procedures that meet the requirements outlined in this memorandum on hospital medication administration requirements, and that align with current standards of practice.

With respect to tracking hospital policies regarding continuous monitoring of patients on opioids, hospitals are surveyed on a regular basis to verify they are meeting the Conditions of Participation, and compliance surveys may be conducted at any time. Our survey guidelines include a requirement for surveyors to observe the preparation of drugs and their administration to patients in order to verify that procedures are being followed, such as making sure patients who are at higher risk and/or receiving high-alert medications are monitored for adverse effects. When surveyors identify noncompliance with federal Conditions of Participation and standards, they document this for the facility. To continue to participate in Medicare, the hospital is

required to address identified issues and develop a corrective action plan. Failure to come into compliance will result in a hospital's termination from the Medicare program.

Breastfeeding Services and Supplies

As a co-chair of the bipartisan Congressional Caucus on Maternity Care, I have strong interest in providing a health care system through which all moms can access important lactation counseling, education, and breastfeeding equipment and supplies. Actuarial analysis indicates providing these services as an insurance standard in the US will have minimal, if any, impact on insurance premiums.^[1] The Health Resources and Services Administration FY21 Budget Justification indicates that, during FY2021, HHS will conduct a review of evidence for breastfeeding services and supplies under the Women's Preventive Services Initiative (WPSI).

Questions:

1. What is the status of the agency's timeline for this review?

Response:

In FY 2021, the Women's Preventive Services Initiative (WPSI) will undergo an open competition with an anticipated award date of March 1, 2021. An evidence review of breastfeeding services and supplies will be conducted after the new award of this project.

2. Will you ensure that the review is responsive to a request in House Report 116-62^[2] that HRSA "incorporate into the clinical and implementation considerations section of the guideline: evidence of the critical timeframe for breastfeeding initiation following delivery; and recommendations for assessing risk factors, initiating milk production and ensuring that women are able to build supply and sustain breastfeeding in the early postpartum period (as well as during the antenatal, perinatal, and the postpartum period) in both pre-term and term infants?"

Response:

Currently, Women's Preventive Services Guidelines recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure successful initiation and maintenance of breastfeeding. HRSA continues to support the current recommendation, and will review the updated evidence and recommendations for breastfeeding services and supplies and consider other suggestions from public comment, during the next project period.

Quality breastfeeding services and supplies can be very confusing for new moms and reports indicate that access varies greatly depending on the policy of individual insurance companies.

Questions:

^[1] <https://apha.confex.com/apha/2019/meetingapp.cgi/Paper/439443>

^[2] <https://www.congress.gov/116/crpt/hrpt62/CRPT-116hrpt62.pdf>

1. Is HHS tracking how health insurers are implementing comprehensive lactation services?

2. What standards are they using to set reimbursement rates for breastfeeding supplies?

Response to 1 and 2:

With respect to private insurance, “Women’s Preventive Services: Required Health Plan Coverage Guidelines” (HRSA Guidelines) were adopted and released on August 1, 2012, based on recommendations developed by the Institute of Medicine (IOM) at the request of HHS and have been updated in the years since then. These recommended women’s preventive services are required to be covered without cost-sharing, for plan years (or, in the individual market, policy years) beginning on or after August 1, 2012. Under the topic of “Breastfeeding Counseling” the United States Preventive Services Task Force (USPSTF) recommends interventions during pregnancy and after birth to promote and support breastfeeding. The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling, and equipment rental. Accordingly, the items and services described in the HRSA Guidelines are required to be covered in accordance with the requirements of the final regulations at 78 FR 39870 (that is, without cost-sharing, subject to reasonable medical management, which may include purchase instead of rental of equipment).

Coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. Nonetheless, consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.

Medicaid is another source of coverage for breastfeeding supplies for many low-income women. Some of the Medicaid authorities states can use to permit payment for lactation services include:

- Inpatient hospital services, per section 1905(a)(1) of the Social Security Act (the Act);
- Outpatient hospital services, per section 1905(a)(2)(A) of the Act and 42 C.F.R. § 440.10;
- Early and periodic screening, diagnostic, and treatment services for individuals who are eligible under the plan and are under the age of 21, per section 1905(a)(4)(B) of the Act;
- Physicians’ services furnished by a physician under the physician’s supervision, whether furnished in the office, the patient’s home, a hospital, or a nursing facility, or elsewhere, per section 1905(a)(5)(A) of the Act;
- Services furnished by a nurse-midwife, which the nurse-midwife is legally authorized to perform under State law, per section 1905(a)(17) of the Act;
- Freestanding birth center services, per section 1905(a)(28) of the Act; and
- Services furnished by nurse practitioners per 42 C.F.R. § 440.166 and other licensed practitioners per 42 C.F.R. § 440.60.

3. What best practices currently exist to provide coverage to help women breastfeed?

Response:

The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure the successful initiation and maintenance of breastfeeding. This HRSA-supported Women's Preventive Services Guidelines' recommendation is covered by most insurance plans without cost-sharing to the consumer.

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
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Questions for the Record for Secretary Alex Azar

Submitted by Congresswoman Lois Frankel

Title X

I was extremely troubled to see this Administration, despite massive outcry from the medical community and American people over the past two years, recently enforced the final rule on the Title X program that, among other things, makes it illegal for health care providers in the Title X program to refer patients for an abortion. This rule effectively gags providers and prevents patients from having information about all their options, and implements cost prohibitive and unnecessary “physical separation” requirements on health centers. This rule flies in the face of congressional intent and is instead a targeted attack on providers like Planned Parenthood. As a result, hundreds of health centers have now been forced out of Title X leaving many patients without access to trusted providers in their communities. The most significant burden of this policy is being felt by communities that already face major barriers to affordable care -- including communities of color, young people, immigrants, and rural communities.

Title X is the only federal grant program dedicated to providing family planning and basic preventive care to uninsured, underinsured, and people with low incomes, with services that include birth control, STI/HIV services, well-woman visits, and lifesaving cancer screenings. Before this gag rule, Title X providers served more than four million women, men, and young people every year.

Question: Throughout the process the administration has claimed that the Title X final rule would increase access to care, but now it is in effect, as medical groups and public health experts predicted - the opposite is happening. It is estimated that the program now serves just half of the patients annually as it did before the rule was implemented. Several states are now without any Title X providers, hundreds of health centers have been forced out of the program, and among those remaining health centers are providers that don't even offer birth control pills. The administration has clearly decimated this program and the impact is disproportionately experienced in communities that already face severe barriers to care -- people of color, young people, low-income people, and rural communities. Given all of this, how is HHS accounting for the devastating impact that this rule is having on these specific communities and people who rely on Title X services?

Response:

At the time of drafting this response, preliminary 2019 Family Planning Annual Report data reports the total number of Title X clients served in 2019 was 3,102,969 compared to 3,939,749 clients served in 2018 (a decrease of 20 percent). In addition, 84 percent of those served were from families with income of <200% of the federal poverty index.

Between July and September 2019, 19 Title X grantees voluntarily relinquished their Title X grant awards back to HHS, rather than comply with statutory and regulatory requirements and indicated they would not fulfill their commitment to serving their patients through the Title X program. In order to address these gaps in service, HHS awarded \$33.7 million in supplemental grant funds to qualified organizations that are compliant with applicable laws, regulations and administrative requirements. The number of clients projected to be served through the supplemental awards will come close to—if not exceed—prior Title X coverage, once these sites are fully operational. HHS will continue to seek qualified entities to provide these critical services.

Under Title X, Title X projects have to “offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents).” The Title X Rule recognizes this requirement. In the Title X Rule, the definition of “family planning” expressly includes contraceptive methods. Furthermore, the Rule requires each project to “provide a broad range of acceptable and effective family planning methods” which, again, expressly includes contraceptives. Similar to the 2000 Title X Rule, the Title X Rule provides that projects “are not required to provide every acceptable and effective family planning method or service” and permits a participating entity to offer only a single method or a limited number of methods of family planning as long as the entire project offers a broad range of such family planning methods and services. Accordingly, there are no funded Title X projects that do not offer access to birth control pills as part of the broad range of effective and acceptable family planning methods and services.

HHS Office for Civil Rights, Division for “Conscience and Religious Freedom”

In January of 2018, the Department of Health and Human Services Office for Civil Rights announced the establishment of a new division solely focused on protecting health care providers and institutions that use personal beliefs to discriminate against and refuse to treat patients. In its notice of proposed rulemaking and in later court proceedings the Department basically admitted that the division has not received a large number of complaints. Yet, the Division continues to be funded and prioritized over other divisions within the Office for Civil Rights. The Department stated that prior to the creation of this division in early 2018, “there was approximately one complaint per year” that would presumably fall under the purview of this division. Yet, the Department sought not only to allocate millions of dollars each year to this division, but asked for a vast increase for both FY 19 and FY 2020. Since that time, attorneys for HHS admitted in open court that 94% of the 343 complaints HHS claimed to have received had *nothing* to do with the federal refusal laws. In fact, the federal judge in a pending case has concluded that your

Department's assertion that there was a vast uptick in the number of complaints was "flatly untrue."

Question: What is the justification for maintaining the funding for this division in the FY 2021 budget? Please list the justifications for this funding level.

Response:

OCR's Conscience and Religious Freedom Division (CRFD) conducts OCR's nationwide outreach, and policymaking activities under HHS's conscience and religious freedom authorities. While these functions are similar to the Health Information Privacy and Civil Rights Divisions, CRFD differs in that it is also the principal investigator and enforcer of the laws assigned to it. Thus while the resources associated with complaint intake, triage, investigation, and enforcement associated with OCR's other divisions are funded out of OCR's Operations and Resources budget, all of the costs associated with complaint intake, triage, investigation and enforcement are funded within the CRFD total. A small portion of CRFD's complaint docket are highly complex and sensitive cases of national significance implicating sophisticated covered entities or dealing with previously unenforced areas of law, and thus often warrant a disproportionate amount of staff resources, relative to lower-impact cases.

The FY 2021 Budget increased the Program Level for each of OCR's components, relative to the FY 2020 Enacted Level. This included a relatively modest increase of \$227,000 for CRFD. The increase reflects the addition of 3 FTEs and associated overhead costs. This FTE level is necessary to keep pace with conscience and religious freedom complaints and maintain operations of other activities of the Division.

As you note, the court in *State of New York, et al. v Azar* (S.D.N.Y.) found that a certain proportion of complaints submitted to the CRFD do not implicate the statutes implemented by the Conscience Rule, a matter that the United States' called "erroneous" in its opening brief appealing the court's decision to the Second Circuit Court of Appeals. However, the rise in complaints was only one of many reasons for the rule. The rule helps inform the health care providers of their rights and provides a clearer enforcement process for handling and resolving complaints. Indeed, the Department of Justice counsel for the United States in the *City and County of San Francisco v. Azar* case, which regards the 2019 Conscience Rule in litigation before another Federal district court, stated that "HHS did not rely on these complaints for the substance of what was contained in them. It simply noted that it received 343 complaints from people who were saying that their conscience rights were violated." Whether or not a complaint is ultimately meritorious, CRFD must devote resources to evaluate the increased number of complaints received, as CRFD did with the 343 complaints referenced in your question, and if appropriate, further investigate their claims.

Faith Based Regulations

On January 16, the Trump administration announced nine proposed rules that would significantly change the existing regulations that govern the partnerships between the government and faith-based social service. One of those Departments was HHS. The proposed rules would strip religious freedom protections for people who use social services. For example, the proposed rule would eliminate the requirement that faith-based providers have to give people notice of their rights and the requirement that providers have to take “reasonable steps” to refer beneficiaries to an alternative provider if they are uncomfortable with the religious character of an organization. These existing protections were put in place at the suggestion of a diverse, Presidential Advisory Council, whose members were “individuals with serious differences on some church-state issues.” Yet, they all found “common ground.”

Question: Can you tell me the religious freedom rights that a person who uses a Department-funded social service program has?

Response:

As an executive branch agency that formulates and implements policies with implications for the religious liberty of persons and organizations in America, HHS honors Federal law's robust protections for religious freedom. An amalgam of Executive Orders, Federal statutes authorizing certain block grant and other social services programs, and certain HHS regulations protect the religious freedom rights of beneficiaries in HHS social services programs. The U.S. Attorney General's Memorandum, Federal Law Protections for Religious Liberty, guides the Department's application of these provisions. “Although the application of the relevant protections may differ in different contexts, individuals and organizations do not give up their religious-liberty protections by providing or receiving social services, . . . by receiving government grants or contracts; or by otherwise interacting with federal, state, or local governments.” 82 FR 49668 at 49669 (Oct. 26, 2017). As the Attorney General's Memorandum describes, the right to be free from religious discrimination protects not only religious beliefs and identify but also religious observance and practice. As the Attorney General's memo outlines, beneficiaries of social service programs do not give up their rights under the U.S. Constitution by virtue of receiving benefits or services. The First Amendment's Free Exercise and Establishment Clauses, and the Religious Freedom Restoration Act, apply to protect the religious freedom of individuals participating in HHS grant programs.

Certain program statutes prohibit recipients of HHS funding from discriminating on the basis of religion, which are nondiscrimination provisions under the jurisdiction of the Department's Civil Rights Office. E.g., 42 U.S.C. §§ 290c-33 (projects in assistance to transition from homelessness), 300x-57 (community mental health services and substance abuse prevention and treatment), 10406 (family violence prevention services act programs). Other statutory provisions are under the purview of various HHS operating divisions and prohibit faith-based organizations from discriminating on the basis of religion and from being discriminated against on the basis of their religious character to allow religious organizations to serve as grantees without impairing the religious character of the organizations or the religious freedom of the individuals. E.g., 42

U.S.C. §§ 300x-65(b), (f) (mental health and substance abuse), 604a(c), (g) (temporary assistance for needy families).

Certain HHS regulations mirror the principle of the statutory provisions and prohibit faith-based organizations that are grantees of HHS-funded social services programs from discriminating against individual beneficiaries on the basis of religion. E.g., 42 C.F.R. §§ 54a.7 (certain discretionary grants), 54.7 (certain block and other grants); 45 C.F.R. §§ 87.3(d) (certain HHS social services programs), 260.34(f) (TANF), 1050.3(e) (community services block grant).

The proposed rule announced in January 2020, Ensuring Equal Treatment of Faith-Based Organizations, 85 FR 2974, would amend the existing regulations at 45 C.F.R. pt. 87 and pt. 1050 to foreclose unequal treatment of religious organizations by ensuring that they are not required to provide assurances or notices that are not required of secular organizations. You referenced the current regulation's requirement to provide notice of the ability to receive services from a secular provider and to provide a referral upon request. As noted in the preamble to the January 2020 proposed rule, the Department believes that such requests for referral are very rare, even with the provision of such notice. This is consistent with the Department's experience with certain SAMHSA grants which require recipients and subrecipients to report all such referral requests; as of the date of the proposed rule, SAMHSA had not received reports of any such requests.

Question: Imagine that an LGBTQ teen is seeking help at a drug recovery program, but soon realizes that the religious provider condemns them for being gay. They would rather not seek help at all than go to that provider, but they don't know that they have any other options, let alone know how to go about finding them. Under the current rules, the provider would have told them their rights on their first visit, including that they have the right to request an alternative provider. Your proposed rules would strip this notice requirement and strip the alternative provider requirements. This teen, therefore, will likely end up without the help they need. What is the justification for this? What protections do you intend to put in place to ensure individuals receive notice of their rights?

Response:

HHS is in the Administrative Procedure Act rulemaking process. HHS will consider any and all comments received during that process and will respond appropriately in the final rulemaking.

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
 2021 Hearing (2.26.20)*

Questions for the Record for Secretary Alex Azar
Submitted by Congresswoman Watson Coleman

State-Federal Cost-Sharing for COVID-19 Response

New Jersey is one of the 11 states that has been designated by the federal government as a “funnel site.” This means that it is likely to take on a substantial burden on behalf of other states that don’t have the same designation.

If an out-of-state resident is subject to quarantine in NJ, it is currently our burden to house them and provide all necessary services.

Question:

What is the cost-sharing model that states should expect? How much should states expect to shoulder for quarantine costs? What about testing and other medical expenses for staff and equipment?

Please provide proposed percentage cost-sharing for the categories below:

	Category	Federal %	New Jersey %
Travelers: cost of housing; security & all wrap around services	quarantined travelers from out of State		
	NJ quarantined travelers		
Staff time	Normal working hours and additional staff required to keep up with routine responsibilities		
	Overtime for staff in New Jersey		
	Hotline staffing after hours		
Supplies	Additional supplies, including PPE		
	Travelers care kits		

National Bio- and Agro-Defense Facility (NBAF)

While our nation's public health system is principally administered at the state and local level, the Public Health Service Act charges the Secretary of Health and Human Services with responsibility for leading all Federal public health and medical response to public health emergencies and incidents covered by the National Response Plan developed pursuant to the Homeland Security Act of 2002. The Assistant Secretary for Preparedness and Response (ASPR) serves as the Secretary's principal advisor on public health and medical emergency preparedness and response.

The Biomedical Advanced Research and Development Authority (BARDA) currently supports advanced development of vaccines, diagnostics, drugs, and therapeutics to minimize serious threats of infectious diseases, including supporting advanced development efforts of private industry. The Project BioShield Special Reserve Fund ensures that the nation is adequately prepared against chemical, biological, radiological, and nuclear attacks, including by providing a market guarantee through government financing where little or no commercial market presently exists for particular medical countermeasures.

Response:

The quarantine sites are no longer operational. When they were operational, all expenses were funded with Federal dollars. National Disaster Medical System personnel, Public Health Service Commission Corps Officers, and other federal personnel were deployed at Federal expense to support the quarantine sites (including all wrap-around services and specific medical needs (e.g. prescription refills)). The only exception for care was if a quarantined individual was transported for care for a need unrelated to COVID-19, the individual's private insurance would cover the health costs.

Please provide proposed percentage cost-sharing for the categories below:

	Category	Federal %	New Jersey %
Travelers: cost of housing; security & all wrap around services	quarantined travelers from out of State	100%	0%
	NJ quarantined travelers	100%	0%
Staff time	Normal working hours and additional staff required to keep up with routine responsibilities	100%	0%
	Overtime for staff in New Jersey	NA	NA
	Hotline staffing after hours	NA	NA
Supplies	Additional supplies, including PPE	100%	0%
	Travelers care kits	NA	NA

Topic: National Bio- and Agro-Defense Facility (NBAF)

While our nation's public health system is principally administered at the state and local level, the Public Health Service Act charges the Secretary of Health and Human Services with responsibility for leading all Federal public health and medical response to public health emergencies and incidents covered by the National Response Plan developed pursuant to the Homeland Security Act of 2002. The Assistant Secretary for Preparedness and Response (ASPR) serves as the Secretary's principal advisor on public health and medical emergency preparedness and response. The Biomedical Advanced Research and Development Authority (BARDA) currently supports advanced development of vaccines, diagnostics, drugs, and therapeutics to minimize serious threats of infectious diseases, including supporting advanced development efforts of private industry. The Project BioShield Special Reserve Fund ensures that the nation is adequately prepared against chemical, biological, radiological, and nuclear attacks, including by providing a market guarantee through government financing where little or no commercial market presently exists for particular medical countermeasures.

Question:

1. The National Bio- and Agro-Defense Facility (NBAF), which is scheduled to come on line in FY22 will be a state-of-the-art biocontainment facility for the study of foreign, emerging, and zoonotic animal diseases that pose a threat to U.S. animal agriculture and to public health.

What plans does HHS have to leverage NBAF capabilities to strengthen the Public Health Emergency Medical Countermeasure Enterprise, particularly related to zoonotic or other animal diseases?

Response:

NBAF will be owned and operated by the U.S. Department of Agriculture (USDA). In collaboration with USDA, NBAF high-containment facilities may be leveraged to safely handle animal work involving HHS priority pathogens that do not currently have medical countermeasure treatments especially if control in the animal reservoir is protective for humans. HHS will continue to work with USDA as an interagency partner in the Public Health Emergency Medical Countermeasure Enterprise and other One Health initiatives related to zoonotic or other animal diseases.

2. With what frequency do you anticipate research activities funded by the Biomedical Advanced Research and Development Authority (BARDA) being conducted (wholly or partially) at or in coordination with NBAF?

Response:

HHS will continue to participate in annual stakeholder meetings for NBAF and work with USDA through coordination with BARDA industry partners to identify opportunities to generate animal data that is supportive of medical countermeasure development. This can include leveraging the use of the NBAF Biologics Development Module.

3. How does HHS and the Assistant Secretary for Preparedness and Response (ASPR) plan to ensure that NBAF annual and long-term research programs are adequately addressing preparedness,

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response, and recovery knowledge and operational gaps related to current and emerging infectious zoonotic diseases or other animal diseases that could substantially impact public health?

Response:

The National Biodefense Strategy (NBS) encompasses five goals for strengthening the biodefense enterprise including: enabling risk awareness to inform decision-making across the biodefense enterprise; ensuring biodefense enterprise capabilities to prevent bioincidents; ensuring biodefense enterprise preparedness to reduce the impacts of bioincidents; rapidly responding to limit the impacts of bioincidents; and facilitating recovery to restore the community, the economy, and the environment after a bioincident. The prospect of the natural, accidental, or deliberate release of biological agents presents a significant challenge to national security and our global health security.

HHS will continue to be responsible for overseeing and coordinating the execution of the strategy and its implementation plan. As a requirement under the NBS, USDA will continue to submit data on annual and long-term research studies to include NBAF. The information will inform the overarching goals of the NBS and will identify improvements as well as potential gaps in efforts.

Establishing an SEP for Pregnancy

Currently, the Secretary of Health and Human Services has the power to establish an SEP for pregnant individuals.

Question:

What is the Department doing to ensure that pregnant women have access to health care? What steps would need to be taken for the Secretary to establish an SEP for pregnancy?

Response:

The Administration is committed to providing pregnant women access to the health care they need. The ACA requires that most individual and group health plans cover certain preventive services without cost sharing, including well-woman visits during which women can obtain recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. HHS has promulgated rules and implemented plan review and audit processes to ensure that Marketplace plans offered through Federally-Facilitated Exchanges are in compliance with these requirements.

The ACA defines the special enrollment periods that must be provided by Exchanges. ACA section 1311(c)(6)(C) establishes that Exchanges must provide the special enrollment periods specified in section 9801 of the Internal Revenue Code (referring to special enrollment periods enacted under the Health Insurance Portability and Accountability Act of 1996) and other special enrollment periods under circumstances similar to those in part D of title XVIII of the Social Security Act (Medicare Prescription Drug Program). Pregnancy is not specified as a qualifying event in the Internal Revenue Code, nor is it similar to those special enrollment periods available under Medicare Part D.

Exchanges do however have some flexibility under HHS regulations to grant special enrollment periods under exceptional circumstances that impeded an individual's ability to enroll in health coverage. However, HHS does not consider pregnancy or any other specific health condition to be an exceptional circumstance in Exchanges that rely on the Federal eligibility and enrollment platform that, by itself, would have impeded an individual's ability to enroll in coverage during the annual open enrollment period. This policy mitigates risk of adverse selection that is created when persons abstain from enrolling in health coverage until they require medical care. However, Exchanges do grant special enrollment periods for certain changes in household size, including any individual in a household who has had a baby, adopted a child, or placed a child for foster care. Under this special enrollment period, mothers would be eligible to enroll in Exchange coverage after childbirth.

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Funding to Address Minority Health and Health Disparities

The work of the National Institute on Minority Health and Health Disparities and the Office of Minority Health impacts millions of Americans burdened by disparities in health status and health care delivery, including racial and ethnic minority groups, rural populations, populations with low socioeconomic status, and other population groups.

While the Office of Minority Health is flat-funded, NIMHD has a \$30 million cut in the FY21 President's Budget.

Moreover, the Racial and Ethnic Approaches to Community Health (REACH) program which has historically provided direct support to various communities of color with the highest rates of mortality *was eliminated in the budget*.

Question:

How does your budget ensure continued support for the unique needs of communities of color?

Response:

The Office of Minority Health, located within the HHS Office of the Assistant Secretary for Health, will continue to implement their programs, given a flat FY 2021 budget.

NIH Response:

Thank you for your continued support and steadfast commitment to the importance of minority health and health disparities research. The National Institute on Minority Health and Health Disparities (NIMHD) is very appreciative of Congress' support of that goal. The issue of health disparities remains a key priority and investment for the NIH. NIMHD leads the agency's health disparities research efforts, and coordinates with the other Institutes and Centers on minority health and health disparities research activities. Health disparities are the result of multiple interconnected behavioral, social, biological, clinical, economic, and environmental factors and their interaction with the health care system. These disparities affect many Americans across a wide range of health conditions that varies by population group but includes higher infant and maternal mortality, higher HIV infection rates, and higher prevalence of obesity, diabetes, hypertension, cardiovascular disease, cancer, stroke, chronic liver disease, and dementia. Health disparities are multifactorial and addressing health disparities requires input from a variety of disciplines at many levels.

NIH is committed to seeking solutions to the health issues that disproportionately affect racial and ethnic minorities, rural residents, and other medically underserved populations. Through our various Institutes and Centers, NIH works to enhance understanding the causes of health disparities. In 2015, NIH released the NIH-Wide Strategic Plan, FY 2016-2020: Turning Discovery into Health, which outlined a vision for biomedical research that capitalized on new opportunities for scientific exploration and addressed new challenges for human health. Based upon this plan, NIH's health promotion and disease prevention efforts "place particular emphasis on research in several key areas: studying healthy individuals across the lifespan; applying technological advances in early detection, diagnosis, and prevention; and utilizing evidence-

based interventions to reduce health disparities.” Evidence-based interventions to reduce health disparities address the importance of understanding the social and demographic determinants of health, manifestations and management of diseases, and the disability resulting from chronic diseases; disproportionate disease risk; and opportunities for progress in prevention. Understanding mechanisms that lead to disparities in health outcomes by race/ethnicity and socioeconomic status requires multi-disciplinary collaboration with researchers and community stakeholders.

At NIH, the goal is to seek solutions to health disparities through collaboration and the integration of different disciplines. Charged with leading scientific research to improve minority health and reduce health disparities, NIMHD has developed the 2020-2024 NIH Minority Health and Health Disparities Strategic Plan. During NIMHD’s planning and engagement process, they obtained input from a variety of groups, including experts in research, medicine, public health, and public policy from across NIH Institutes and Centers and externally through working groups, workshops, and town hall meetings at multiple sites. The strategic plan will set the direction and goals for minority health and health disparities research for the coming years.

CDC Response:

CDC continues to support communities of color and communities with high rates of mortality through chronic disease prevention programs like the National Diabetes Prevention Program, which provides funding for 10 national organizations to implement diabetes prevention programs in regions with fewer resources to address health disparities. Data from the U.S. Census Bureau indicate that 78 percent of these counties have a higher than average poverty rate. CDC’s cancer prevention programs work to reduce health disparities by making screening and testing services accessible. For example, 65 percent of women served through the [National Breast and Cervical Cancer Early Detection Program](#) are racial and ethnic minorities. In the [Colorectal Cancer Control Program](#), 68 percent of clinics are Federally Qualified Health Centers and 30 percent are located in nonmetropolitan areas. The [National Comprehensive Cancer Control Program](#) requires each grantee to serve an underserved (priority population) and the [National Program of Cancer Registries](#) collects data that can be used to highlight cancer burden and outcomes in an area to determine disparities.

Funding to Address Mental Health

While the Administration seems to be making mental health and suicide a top priority, you make a \$200 million cut to the National Institute of Mental Health. Not investing in gains is dangerous when this is such a wide-ranging issue. Further, while suicide in general is on the rise, there has been a particular rise among youth, including a disparate impact on youth of color.

Question:

How does this budget make investments to address youth suicide and mental health disparities among youth of color?

NIH Response:

Suicide prevention research is a top priority for the National Institute of Mental Health (NIMH). NIMH has steadily increased its support for suicide research across the spectrum, from basic to applied research; in fiscal year (FY) 2019, NIMH invested approximately \$89 million in suicide research, up from \$41 million in FY 2016. To address rising rates of youth suicide, NIMH funds a broad portfolio on suicide risk and prevention, including research to address known disparities in mental health care among youth of color.

American Indian/Alaska Natives (AI/AN) have the highest rates of suicide of any racial/ethnic group in the U.S. Suicide rates in this population have been increasing since 2003, especially among youth: from 2003 to 2014, more than one third of AI/AN suicides occurred among youth aged 10-24 years. NIMH and the National Institute of Minority Health and Health Disparities (NIMHD) continue to support three collaborative research hubs, which aim to develop and increase the reach of effective, culturally relevant preventive interventions that will reduce the burden of suicide and promote resilience among AI/AN youth. NIMH is also supporting a number of intervention studies that are developing, adapting, and testing the effectiveness of health promotion and disease prevention interventions among AI/AN communities.

Suicide also has a disparate impact on black youth in the U.S. Suicide rates among black youth more than doubled between 1999 and 2017, and black youth under 13 years are now approximately twice as likely to die by suicide as their white counterparts. NIMH is funding a number of studies aimed at optimizing suicide risk detection and interventions among black youth throughout the country. For example, NIMH-funded researchers at DePaul University in Chicago are testing the effectiveness of a culturally-adapted, school-based suicide prevention intervention for low-resourced, urban, black 9th grade students. These researchers hope to learn how interpersonal and socio-ecological factors (i.e., community violence exposure, limited neighborhood resources, and family dynamics) influence active suicidal ideation. Additionally, an NIMH-funded study in New York City public schools will examine the effectiveness of a 1-2 session intervention designed to improve engagement, perceived relevance, and treatment satisfaction among depressed, black adolescents. In Baltimore, NIMH-funded researchers are planning to adapt Youth Aware of Mental Health, a school-based universal mental health promotion program, to a racially diverse middle school population; the program was previously shown to be effective in a predominantly white high school population. NIMH is also supporting researchers in Ohio who are examining specific vulnerability factors associated with the familial

risk of suicidal behavior in a group of pre-pubescent children at high risk for a first suicide attempt due to parental history of suicidal behavior. Another NIMH-supported study will bring together data from past suicide prevention trials to assess the impact of childhood universal prevention programs on mental health outcomes and suicidal behaviors in early adulthood; the cohorts of these past prevention trials were predominantly black youth. NIMH is also actively working to respond to a recent report by the Congressional Black Caucus (CBC) on the alarming rise in suicide and suicide-related behaviors among black youth. On April 21, 2020, the NIMH Office for Disparities Research and Workforce Diversity (ODWD) and the Office of Behavioral Health Equity at the Substance Abuse and Mental Health Services Administration (SAMHSA) will co-host a virtual panel to discuss the CBC's report and formulate strategies to engage and care for these vulnerable youth.

NIMH continues to use its Administrative Supplements program to support projects that aim to reduce mental health disparities by studying how disparities arise and optimizing delivery of mental health interventions to diverse groups. For example, NIMH-funded researchers are examining the effectiveness of Electronic Bridge to Mental Health (eBridge), an intervention that identifies university students at elevated risk for suicide and facilitates their linkage to mental health services. This study received an Administrative Supplement to further examine campus mental health services among sexual, gender, and racial/ethnic minority groups. The study also received a Diversity Supplement to support further analysis and publication on the barriers to mental health service utilization for African American college students.

In addition to focusing on suicide prevention, NIMH supports research aimed at understanding and reducing mental health disparities more broadly. In March 2020, NIMH issued a request for applications to encourage research into evidence-based, effective mental health interventions and how best to implement them in primary care settings, with an emphasis on reaching vulnerable youth. NIMH is also requesting applications for effectiveness studies that will examine strategies for implementation and sustainable delivery of evidence-based mental health practices to underserved populations in under-resourced settings in the United States. These studies will employ innovative approaches to remediate barriers to provision, receipt, and/or benefit from evidence-based practices, and to identify factors integral to achieving equity in mental health outcomes for underserved populations.

SAMHSA Response:

SAMHSA makes a number of budget investments to address youth suicide and mental health disparities through the provision of funding to communities through grant programs, technical assistance, and capacity building activities. In addition, SAMHSA's Office of Behavioral Health Equity (OBHE) coordinates the National Network to Eliminate Disparities in Behavioral Health (NNED), a network of 1,200 community-based organizations serving racial and ethnic minority communities across the country.

SAMHSA Grant Activities and Expectations:

The Suicide Prevention Branch in SAMHSA's Center of for Mental Health Services (CMHS) provides youth suicide prevention grants to states and tribal organizations to reduce suicides. There are currently 59 active grantees, receiving over \$43 million in Federal funds in FY 2020. Within the Suicide Prevention Branch, there is also a subject matter expert on Black youth

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suicide who is working to engage stakeholders on the topic. Screening youth in health systems is a key indicator for grantees funded through the Garrett Lee Smith State/Tribal Youth Suicide Prevention Program. In FY 2019, Federal funding provided over 192,000 screening for youth suicide risk. SAMHSA's grant programs, including the suicide prevention program, require a "disparity impact statement (DIS)" from all successfully awarded grantees. The DIS serves to increase the inclusion of racial and ethnic minority populations in SAMHSA's suicide prevention grants.

Training and Capacity Building:

Other investments that SAMHSA makes to address youth suicide and mental health disparities among youth of color include the following:

- SAMHSA-funded National Network to Eliminate Disparities (NNED) provides training on culturally-based, evidence-supported interventions targeting the prevention of suicide and other self-harmful behaviors among ethnic minority youth. In April 2020, the NNED in collaboration with NIMH held a virtual roundtable on Black/African American Youth Suicide, featuring Dr. Michael Lindsey, Chair of the Congressional Black Caucus Task Force on African American Youth Suicide. Dr. Lindsey also hosted a webinar called: "Dying to Ask for Help: Suicide Trends and Treatment Disparities among U.S. Adolescents" through our Region 3 Mental Health Technology Transfer Center.
- SAMHSA realizes that increasing the number of providers of color is important to the health outcomes of youth of color. To help address this concern, the Minority Fellowship Program (MFP) is a grant initiative that awards funding to organizations to support the development of behavioral health practitioners. The MFP aims to increase the presence, knowledge, and skill base of practitioners available to serve racial and ethnic minority populations. By increasing the number of culturally competent professionals in the workforce, the program seeks to reduce health disparities and improve behavioral healthcare outcomes for underserved, minority communities.
- In 2018, the OBHE at SAMHSA conducted a webinar of the rising rates of Black youth suicide (<https://www.youtube.com/watch?v=ZeAg&pnz98&t=9s>).
- SAMHSA's OBHE collaborated with the Asian Pacific American Officers Committee of the National Public Health Commission Corps to develop the "Healthy Mind Initiative", an education and public awareness initiative to increase understanding of suicide and mental health issues for Asian American families. In-language trainings are provided in Asian American community and school settings.
- The Suicide Prevention Resource Center (SPRC) is currently working to update the fact sheets included in the SPRC Resource Library on suicide specific data points of various racial ethnic groups.

One of the key initiatives to help transform communities is Faith.Hope.Life. This campaign, developed by the National Action Alliance for Suicide Prevention's Faith Communities Task Force, is an opportunity for every faith community in the United States, regardless of creed, to support suicide prevention. The Faith.Hope.Life campaign is currently developing resources for youth ministries to support and be prepared for youth who experience suicidal ideation and to recognize the specific risk factors for Black children.

CDC Response:

With a dedicated funding line for suicide in FY 2020, CDC is expanding its ability to provide data for states and communities to understand who dies by suicide, why, and how to prevent it. Towards that goal, CDC published a new notice of funding opportunity forecast on grants.gov that will fund states and emphasize vulnerable populations, including youth and/or minority populations. Applications for this funding opportunity are due June 29, 2020 and CDC will determine which vulnerable populations will be the focus of this funding.

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ORR and ICE Information Sharing

The Flores settlement obligates you and ORR to act in the best interest of immigrant children in your care. I was pleased to hear that ORR has stopped sharing psychotherapy notes of children in its care with ICE and DHS.

Question:

I know you have mentioned that therapists did this only due to guidance from the Obama administration.

Can you explain further which policy or guidance this was?

Further, what will happen to the children whose sensitive information was shared? Has ORR contacted DHS on their behalf?

Response:

ORR receives roughly 300 requests for individual UAC case files per month. Case files may contain clinical notes and other documents that reference clinical notes (e.g., Significant Incident Reports, or SIRs). Typically, requests come from UAC's attorneys or ORR-funded legal service providers.

ORR generally does not share clinical information without the UAC's consent, except as required by state "mandatory reporting" laws (e.g., in cases where concerns are raised regarding child abuse and maltreatment, or where a minor is in imminent danger to self or others). ORR does transmit certain SIRs to DHS following ORR policy (please see [section 5.8.5](#) of the ORR Policy Guide).

Between September 2016 and August 2019, ORR received 262 requests for case files from DHS entities (USCIS, ICE, and CBP). Over the same period, over 150,000 UAC were referred to ORR care and custody. Decisions to release the case files were made on a case-by-case basis, and in some cases clinical notes were inadvertently disclosed to DHS. ORR provided clinical notes in 46 cases to ICE, in eight cases to CBP, and in 192 cases to USCIS.

ORR has since acknowledged this error and issued internal guidance to clarify information sharing practices. In August 2019, ORR issued guidance stating that, in response to case file requests from DHS, ORR will provide only documents related to the child's name and identifying information, placement/transfer, release/discharge, immigration/legal, educational records, and contact/communications records. Further, HHS contacted USCIS, the DHS agency that received the bulk of the case files, to inform them of ORR's error and to request that USCIS destroy the clinical records.

ORR is evaluating ways to improve communication with children to inform them regarding when disclosures may be required under mandatory reporting laws, as well as ways to improve training and guidance to ORR care providers concerning SIRs (i.e., that when sharing SIRs, they should only include information that is necessary for reporting purposes if the SIR includes

information from a clinical session). It is also updating its online Policy Guide so as to make it consistent with the previously issued internal guidance.

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Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
2021 Hearing (2.26.20)*

Questions for the Record for Secretary Alex Azar

Submitted by Congressman Cole

Alzheimer's Disease

Congress unanimously passed the National Alzheimer's Project Act at the end of the 111th Congress, which requires the creation of an annually updated national strategic plan to address the rapidly escalating Alzheimer's crisis. Since NAPA was enacted, the amount of Alzheimer's research funding at the National Institutes of Health has increased more than six-fold.

Question: What scientific advancements has this sustained, increased investment enabled at NIH?

Response:

The Nation's Alzheimer's disease and related dementias (AD/ADR) research program has never been more robust—or more promising. AD/ADR research over the last several years has brought tangible progress, revealing more clearly the mechanisms and mysteries of dementia. We have been able to develop and test novel and potentially more effective therapies at the earliest possible time, and greatly intensified the search for new and better ways to provide medical care and long-term support and services for people living with these diseases, their families, and caregivers. There has been significant progress on several fronts including:

A deeper understanding of AD genetics. Ten years ago, we knew of just 10 genes associated with AD and 20 years ago, we knew of only four. Today, we know of more than 50 genetic areas that scientists are exploring further. These discoveries — which keep coming — provide researchers with multiple new pathways toward uncovering potential preventions, treatments and cures for this devastating disease. A recent example of our new understanding of AD genetics is a unique case of disease resistance.¹ A woman who carried a gene mutation known to cause early-onset AD did not develop signs of the disease until her 70s, nearly three decades after her expected age of onset. Researchers suspect that she may have been protected because, in addition to the gene mutation causing early-onset AD in her family, she also had two copies of a

¹ <https://www.nia.nih.gov/news/unique-case-disease-resistance-reveals-possible-alzheimers-treatment>

[Example from 2015]

different rare gene variant. Further research may reveal this gene variant as a new direction toward developing a treatment that could prevent AD.

Large-scale data access and sharing enabling crowdsourcing of science. Dramatic advancements in technology have led to our ability to generate large-scale data and provide broad, open access and sharing of this information. NIA's Accelerating Medicines Partnership – Alzheimer's Disease (AMP-AD) program, conducted in collaboration with academia and industry, is a resource that features such data and capabilities that are then leveraged through the strength and creativity of multiple investigative groups. This is enabling new opportunities to discover targets beyond amyloids and tau. To date, AMP-AD researchers have identified 500 novel candidate targets (over 50 of which were independently identified by more than one AMP-AD team), sharing data widely so that the scientific community can begin target validation and preclinical testing of promising approaches. One notable result is that scientists have been able to analyze large data sets from thousands of post-mortem brain samples of people with and without AD, leading to the discovery of new evidence that viral species, particularly herpesviruses, may have a role in AD biology.

Biomarker tests leading to less invasive diagnosis. Before biomarker tests were developed in the early 2000s, the only sure way to know whether a person had AD was via autopsy. Because of advances in research, we now have brain imaging tests and lab tests of spinal fluid that researchers can use to help make a diagnosis. These advances in biomarker tests have enabled scientists to make the critical discovery that AD begins years before early symptoms, like mild cognitive impairment. Recently, NIA-supported research teams have made additional progress in developing easier, faster, cheaper, less invasive biomarker tests using blood samples. In 2020, a project to further explore amyloid in the blood as a biomarker for AD was launched. Specifically, this project² will compare different blood test platforms to determine which ones are best at predicting the presence of beta amyloid in the brain. After further development, these blood biomarkers may help researchers and doctors screen people for early AD even before cognitive changes occur, and to track the effectiveness of interventions designed to treat or prevent AD.

Accelerating drug design to human testing. NIA supports several initiatives to facilitate the advancement of new drugs, from the identification of targets and biomarkers, to compound development and testing in both animals and humans. NIA has created several layers of infrastructure, to close the many gaps in the often complex and difficult process of bringing a new compound to testing, particularly when the initial compound is identified by academic investigators with limited drug development experience. At the target identification stage, NIA's AMP-AD program is using advanced computational approaches to enable new opportunities to discover targets beyond amyloid and tau. AMP-AD also serves as a foundation for the newly launched Alzheimer's Centers for the Discovery of New Medicines. These centers will provide additional infrastructure for developing high-quality research tools and technologies needed to validate and advance the next generation of drug targets for AD. Further along the drug development pipeline, NIA supports a program to make animal models more predictive in initial phases of testing and has generated 29 new mouse models of late-onset AD. NIA also supports a

² <https://fnih.org/plasma-abeta>

vibrant drug discovery and development program, which features more than 30 novel AD/ADRD drugs against various targets in different stages of development. With respect to evaluation in humans, NIH currently supports approximately 230 clinical trials on a wide range of interventions aimed at AD and cognitive decline. The range of targets explored in these clinical trials is broader than ever before. While amyloid continues to be a focus of clinical investigation, of the 46 pharmacological trials supported by NIA, 30 are assessing targets other than amyloid. In addition, more than 100 current trials involve tests of nonpharmacological interventions, while almost 70 are aimed at care and caregiving for people with dementia.

Greater understanding of blood pressure control and dementia prevention. In 2015, NIA commissioned a systematic review of the scientific evidence on interventions that prevent AD. While the science was not sufficient to warrant a broad public health campaign, three areas of research emerged as being supported by encouraging albeit inconclusive evidence: cognitive training, blood pressure management for people with hypertension, and increased physical activity. NIA has continued to support investigations in all of these areas. Importantly, in 2019, newer NIH-funded research demonstrated that intensive lowering of blood pressure significantly reduced mild cognitive impairment (MCI), a well-established risk factor and often a precursor to dementia. This was the first randomized clinical trial demonstrating that an intervention significantly reduced the occurrence of MCI, and a subsequent observational study examining blood pressure control and cognitive decline has provided additional evidence consistent with these findings.

Intensifying research on care and services. Fueled by the first National Research Summit on Dementia Care, Services, and Supports for Persons with Dementia and Their Caregivers in 2017, NIH is expanding its crucial research program on care and services. The summit process resulted in 58 identified gaps, and NIH in response quickly took steps to solicit related applications. New funding opportunity announcements (FOAs) called for expansion of NIA's Edward R. Roybal Centers for Translational Research in the Behavioral and Social Sciences of Aging to focus on interventions for dementia care and support, projects that examine how community-based services can be used more effectively by people with dementia and their caregivers, and establishment of a new AD/ADRD Health Care Systems Research "Collaboratory"³ to organize studies within and among health care systems.

Medicaid Fiscal Accountability Regulation

The Medicaid Fiscal Accountability Regulation, published on November 18, 2019, proposes to promote transparency in states' Medicaid programs through new reporting requirements on provider payments and other measures to limit financing arrangements believed to be impermissible. While some of these proposed reforms have been advocated by the Government Accountability Office and Medicaid and CHIP Payment Advisory Commission, there remains concern among stakeholders regarding the impact of this proposed rule on provider payments and access to services. The proposed rule itself describes the fiscal impact of its policies as "unknown" and contains limited analysis of its impact.

³ <https://impactcollaboratory.org/>

[Example from 2015]

Question: What steps, if any, do HHS and CMS intend to take before promulgation of a final rule to determine its effects on states' Medicaid funding and financing mechanisms, beneficiaries' enrollment and access to services, and changes to beneficiaries' coverage?

Response:

The Medicaid Fiscal Accountability Regulation (MFAR) proposed rule (CMS-2393-P) is intended to ensure accountability of state financing, transparency of payments, and the fiscal integrity of the Medicaid program through reporting requirements and numerous clarifications to Medicaid financing and oversight rules. Specifically, the proposed rule seeks to clarify existing financial policies, many of which have been previously described in sub-regulatory guidance issued by CMS and through our work with states. As you know, the proposed rule was published in the November 18, 2019, issue of the Federal Register, with a 60-day comment period that was to close on January 17, 2020. Because CMS believes it is important to ensure a process for public notice and comment that provides for a meaningful level of public input, and in response to stakeholder requests we decided to extend the comment period by an additional fifteen days, to close on February 1, 2020. During this time, CMS has also conducted numerous calls with states and other stakeholders to receive substantive feedback to help us understand the potential impact of the proposed rule. We are carefully considering all relevant comments that were received during the public comment period, including comments regarding the impact the proposed rule will have on payments to providers and access to care for beneficiaries.

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
*Department of Health and Human Services Budget Request for FY
2021 Hearing (2.26.20)*

Questions for the Record for Secretary Alex Azar

Submitted by Congressman Moolenaar

Topic: Medicare Part B

Medicare Part B is the medical insurance portion of Medicare which covers both medically necessary and preventative services. This includes services and items such as doctor office visits, ambulance services, flu shots, physical therapy, chemotherapy, and durable medical equipment.

Question: The Medicare Part B standard monthly premium rose 6.7% this year after the prior increased 1.1%. What is driving this increase in cost and what is your department doing to ensure these premium increases are minimized? What office determines the percentage increase? Finally, is there any office responsible for reviewing this decision?

Response:

Medicare Part B pays for physician, outpatient hospital, End-Stage Renal Disease, laboratory, durable medical equipment, home healthcare unrelated to a hospital stay, and other medical services. Part B coverage is voluntary and 91 percent of all Medicare beneficiaries have Part B coverage through either fee-for-service Medicare or a Medicare Advantage plan. Beneficiary premiums finance approximately 25 percent of Part B costs with the remaining 75 percent covered by general revenues from the United States Treasury.

Each year the Medicare premiums, deductibles, and copayment rates are adjusted according to the Social Security Act. The standard monthly Part B premium is \$144.60 in CY 2020, an increase of \$9.10 from \$135.50 in CY 2019. A statutory “hold harmless” provision applies each year to 70 percent of enrollees, limiting the annual rise in Part B premiums to no more than the Social Security cost of living increase. For these enrollees, any increase in Part B premiums must be lower than the increase in their Social Security benefits. In 2020, Social Security benefits include a 1.6 percent cost-of-living adjustment, equivalent to the average beneficiary receiving \$24 more each month or about \$1,503. Thus, enrollees who fall under the hold harmless provision will see an increase in Part B premiums of no more than that amount. Some beneficiaries also pay a higher Part B premium based on income: those with annual incomes above \$87,000 (single), or \$174,000 (married) will pay from \$202.40 to \$491.60 per month in CY 2020. The Part B annual deductible in CY 2020 is \$198 for all beneficiaries, an increase of \$13 from \$185 in CY 2019.

The increase in the Part B premiums and deductible is largely due to rising spending on physician-administered drugs. These higher costs have a ripple effect and result in higher Part B premiums and deductible. The actuarial assumptions and bases used to determine the monthly actuarial rates and the monthly premium rates for Part B are established by the Centers for Medicare & Medicaid Services Office of the Actuary.

The President's FY 2021 Budget continues to implement the President's Executive Order on *Protecting and Improving Medicare for Our Nation's Seniors*, building on those aspects of the program that work well, while also introducing market-based approaches to Medicare reimbursement. The Administration seeks to protect and reform Medicare with proposals that strengthen fiscal sustainability and deliver value to patients. For example, the FY 2021 Budget included a package of three proposals that promote site neutral payments. These proposals would reduce Medicare Part B expenditures by over \$180 billion over 10 years and help to minimize Part B premium increases.

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Questions for the Record for Secretary Alex Azar

Submitted by Congresswoman Herrera Beutler

Indian Health Service

Question: Mr. Secretary, I wanted to ask a question regarding the refusal of Indian Health Service officials to release the full report that identifies the officials responsible for the unbelievable failure in handling a government pediatrician that abused Native American children for decades. Currently, the IHS is claiming that a medical record confidentiality law prevents them from disclosing the full report, despite a previous order from a judge to share records related to investigations and audits. I would like to know what you are doing to ensure that this information is released, hold the officials that caused this accountable, and ensure that this does not happen again

Response:

HHS is committed to ensuring a culture of quality, leadership, and accountability. The Indian Health Service (IHS) prioritizes a workforce that is dedicated, caring, competent, and trustworthy. Protecting our patients is a key element of delivering quality care.

Last year, the IHS awarded a contract to Integritas Creative Solutions, LLC® (ICS) to examine whether the laws, policies, and procedures that were in place to protect patients, particularly minors, from sexual abuse were followed. The review looked back over 30 years. ICS was asked to recommend improvements that the IHS can implement to better protect patients.

Many have asked why the Indian Health Service is not releasing the entire document to the public. In accordance with federal law, the ICS Report is a confidential and privileged medical quality assurance record prohibited from being disclosed under section 805 of the Indian Health Care Improvement Act (25 U.S.C. 1675). The fundamental purpose of the protections is for agency staff to adequately evaluate actions and decisions made in IHS in an open and confidential environment that will lead to improvements in quality of patient care. If detailed findings and reports by staff who are involved in a medical quality assurance review believe that their participation and information shared will be made public, this will serve to dampen -- not encourage -- more critical reporting. IHS' approach to making improvements in this area include both angles: mandatory staff reporting, and protection of staff who make those disclosures.

This is fundamentally important to the culture change we are making at the IHS. We can -- and always should -- do more to ensure a culture at IHS focused on quality – a culture that expects accountability from every IHS employee. Ensuring that the Indian Health Service promotes a culture free of sexual abuse, harassment and discrimination is a top priority. Consistent with federal laws, IHS is also committed to protecting employees from retaliatory behavior when reporting abuse, harassment, and acts of discrimination.

THURSDAY, FEBRUARY 27, 2020.

**DEPARTMENT OF EDUCATION BUDGET REQUEST FOR
FISCAL YEAR 2021**

WITNESS

HON. BETSY DEVOS, SECRETARY, DEPARTMENT OF EDUCATION

INTRODUCTION OF WITNESS

Ms. DELAURO. The subcommittee will come to order.

Good morning, Secretary DeVos. Good to see you this morning, and welcome to the subcommittee.

CHAIRMAN'S OPENING STATEMENT

This is our second budget hearing of the year, and it is your fourth hearing with us. And today, as you know, we are going to examine the President's Department of Education budget request for fiscal year 2021.

As I was reviewing the budget materials, Madam Secretary, this much was clear to me, that you are seeking to privatize public education. I believe—and I have had this conversation before with you. I believe that is the wrong direction for our students and for our country.

IMPORTANCE OF PUBLIC EDUCATION

Instead, we need to be moving toward expanding public policies like early childhood education that we know help students succeed. We see this in other countries around the globe. They are not shrinking public support but, in fact, are expanding it. I will get more into the consequences of the cuts that you are proposing, but I want to start by examining your privatization philosophy, the false premise on which it is built, and the research that it ignores.

Contrary to your claims, the Nation's public education system, which 90 percent of our children attend, has witnessed significant progress for all groups of students over the last 30 years. Average mathematics scores on the National Assessment of Educational Progress, NAEP, have improved for fourth graders by 13 percent, eighth graders by 7 percent. While overall, reading improvements have been more modest—Black fourth graders' scores improved by 6 percent and eighth graders' by 3 percent; Hispanic fourth graders' scores improved by 6 percent and eighth graders' by 5 percent—these are significantly higher than 40 years ago for all racial and ethnic groups.

And I reflect on that and ask myself the question, where would we be without Federal investment? There is no question that there is more to do to address the disparities in achievement. We know we face significant challenges in assisting the kids that come into

our system in education districts where they experience poverty and exposure to violence, often resulting in trauma. But the solution is not less resources, nor is it more privatization.

Let me, if I can, just quote for you from a report by Dr. Pamela Cantor, who is a psychiatrist, and she co-founded an educational organization called Turnaround for Children, which translates the science of learning and development into problem-solving in our schools. She led a team commissioned in New York City by the Board of Education to assess the impact of the terrorist attacks on the city's public school children. What did she find? Surprisingly, while 68 percent of the children they observed had experienced trauma sufficient to impair their functioning in school, it is from their ongoing experience of growing up in poverty, not from what they witnessed that terrifying September day.

In fact, the Administration's own data has shown how privatization has let students down. The Trump administration evaluated the D.C. Opportunity Scholarship Program and found that vouchers had a statistically significant negative impact on the mathematics achievement of impacted students. In other words, more vouchers, lower math achievement.

That is not a lone data point either. Previous multisector studies using NAEP data have found that no student achievement scores for children in private schools were higher than those of children in public schools by any statistically significant degree. And I think they found this to be the case, I believe, in Indiana and in Louisiana, and there are other examples, which I can make available to you and to your staff.

So your push to privatize public education is based, in my view, on a false premise that is not supported by data. But its consequences would be to undermine the education of our students in nearly every State, particularly for vulnerable students in high-need regions, including the rural parts of our country.

CUTS IN PRESIDENT'S EDUCATION BUDGET

You would end career and college readiness for 560,000 low-income middle school students across 45 States by eliminating the highly competitive grant program known as GEAR UP, a minus \$365 million.

You would endanger academic tutoring, personal counseling, and other programs for 800,000 students in sixth grade by slashing TRIO programs by \$140 million. TRIO serves low-income, first-generation students and students with disabilities, helping them to graduate from college.

You would endanger education access for children experiencing homelessness by eliminating the Education for Homeless Children and Youth Program, minus \$102 million. This funding is desperately needed. In the 2016–2017 school year, more than 1.3 million enrolled children had experienced homelessness at some point in the past 3 years, an increase of 7 percent from 2014–2015.

You would endanger youth literacy, as well as potentially increase class size and undermine efforts to support diverse teachers by eliminating the main program, Supporting Effective Instruction State Grants, which we increased for the first time in many years. And you have taken \$2.1 billion away from this program.

You would potentially put higher education out of the financial grasp of students by flat-funding the Pell Grant. Forty percent of undergraduate students, 7 million students, rely on Pell Grants to afford higher education. But while Pell covered 79 percent of the average costs of tuition, fees, room and board at a 4-year public institution in 1975, it covers only 29 percent today. Our students cannot afford for us to stand pat for this.

And finally, your budget would risk exacerbating the financial challenges of under resourced rural districts by converting rural formula grants into a block grant. These districts already struggle with lower student populations, higher transportation cost, and your move to undermine their funding in this way is unacceptable.

With all of this, and I just say this to you, Madam Secretary with all sincerity, this is not going to happen. It is not going to happen.

OTHER REQUESTS IN THE BUDGET

I am supportive of the recognition of the IDEA State grants, \$100 million proposed increase; career and technical education, \$680 million proposed increase for the CTE State grants. I am disappointed that adult education State grants are left with level funding, which I plan to ask you about later.

You have also once again requested an increase for student loan servicing. We included new reforms, as you know, in the fiscal year 2020 bill to help us conduct more oversight and ensure that borrowers are getting the help they need. Many of these ideas stem from an oversight hearing that this subcommittee held last year. And to be direct, I will need to see how the Department implements the new requirements as I review your request for next year.

With regard to charter schools, there is a place for them. They have a role in our education system. However, we have moved in the direction of creating a parallel education system. Concerns remain around issues of accountability and transparency, which, to this point, they have not been forthcoming. As I have said time and time again, I believe charter schools ought to be held to the same rigor, and where they fail, we need to know about it.

And to close, Madam Secretary, you are clearly, again in my view, seeking to privatize public education. I hope that I have been clear that we are not going to do that. Because doing so ignores the research indicating the gains we have made, ignores the many areas private education shortchanges students, ignores the very reason the Federal Government has needed to be involved in education, as so powerfully indicated with Brown v. the Board of Education, and ignores the spirit and the values of this country.

No, instead, we need the expanding public policies that boost education attainment, not restricting or reducing them. So I look forward to our discussion today, and now it is my pleasure to turn to my colleague, the ranking member of the subcommittee, Congressman Tom Cole from Oklahoma.

RANKING MEMBER'S OPENING STATEMENT

Mr. COLE. Thank you very much, Madam Chairman.

I want to tell you this is my favorite time of year because I get to spend so much time with you in this committee hearing. We are

going to have dinner tonight, and it is always a delight. It honestly is a vigorous exchange of ideas and more cooperation than we tend to get credit for.

And Madam Secretary, it is a particular pleasure for me to have you here today. I have known you for a long time, long before either of us were in our respective capacities. And I will leave it to you to describe your public philosophy, but there are two things that I know about you—your public education philosophy.

But one is that you have always been for individualizing education. You have always been for what is the right job, role, or place for this particular student to be, and I see a lot of that in your proposals. And two, you have never been afraid to put a bold idea on the table and advance it, and I see a lot of that in this budget as well. There is a lot of boldness here. Some of which I agree with, some of which, quite frankly, I don't. But that doesn't bother me. I like the idea that you are willing to break the mold and think about this because we have got a lot of challenges.

And also, you know, you are our chief officer overseeing probably the most diverse educational system in the world. And I just think about my own district. I have got five colleges and universities, everything from great comprehensive State institutions to elite liberal arts institutions, to regional facilities, to private Christian colleges.

I have got, like everybody else, most of the young people that I am privileged to represent and their families go to public schools, but I have got charter schools. I have got private religious schools. I have got home schools. And they all do a good job. They all wrestle with the same problems.

And I have got one of the most robust career/tech systems anywhere in the country throughout Oklahoma, and certainly in my district. And I was particularly pleased with a number of proposals that you made in that regard. So I think we will have a great discussion today.

I am looking forward to your testimony. As a former educator, I understand how important it is for our entire population to have access to quality education. Without question, education is one of our most important building blocks for success, and access to quality learning directly impacts lifelong development and unlocks each individual's potential.

PROPOSALS IN THE PRESIDENT'S EDUCATION BUDGET

I was pleased to see that your budget request continues to prioritize resources to certain populations of children who need additional support, including children with special needs and disabilities, and Indian education and school districts whose revenues are impacted by a Federal presence within their boundaries.

As you know, I am a strong supporter of career and technical education, and I am proud that my home State of Oklahoma is leading the way in innovative models for delivering cutting-edge skills that can lead to good-paying, rewarding careers for students who do not wish to pursue a 4-year liberal arts degree. And I thank you for your support of these programs, and I am looking forward to asking you more questions about the substantial increases in

your budget, that your budget proposes for these programs this year.

I also want to recognize your proposal to expand Pell Grants to students enrolled in short-term programs that offer a credential in a high-demand field. These opportunities offer high-payment employment in a variety of fields needed throughout my district, as well as many others.

Interesting to me how many times we have had, when we do Member testimony, Members come here and specifically push the need for career and technical education, both in terms of job opportunities and talking to their employers in terms of needed skills. So I think you have really focused on a key area here.

I have spoken, again, to small business owners, other Members of Congress who believe it is time to make Pell Grants available to individuals for enrollment in certificate-based programs, and I applaud you for putting that on the table for us to consider.

CONCERNS OVER PROPOSED CUTS

Madam Secretary, your budget once again proposes to eliminate, consolidate, or change over two dozen programs. Some of these proposals may make sense in the context of a reauthorization or consolidation. I believe others are shortsighted.

I actually agree with my friend the chairman, I am particularly concerned about the proposal to move the successful TRIO program from a competitive grant model to the formula grant to our States. That is no surprise to you. That has been a position I have held throughout my career.

I am also concerned about the proposal to consolidate several Minority Serving Institutions' funding into a single stream. As you know, these institutions serve distinct populations with different needs, and I am not certain that such a change makes sense. Moreover, I feel that these often-disadvantaged minority populations may be overlooked or marginalized if they are not singled out for special attention. So I am interested in hearing your perspective on that.

I also would like to acknowledge your proposal to address limitations in the student aid program. Establishing Federal Student Aid as a separate organization is an issue I think is worth thinking about. I am not sure we are the right people to consider it here. It really is much more of an authorizing function than we are probably equipped to handle on this committee.

But I do support your efforts to streamline and create a more user-focused system for student borrowers. The Next Generation project promises to modernize and improve the student loan infrastructure, benefitting over 40 million customers.

Finally, while I tend to support block grants to States and freeing school districts from the bureaucracy involved with administering dozens of small, separate Federal programs, I do have some concerns that consolidating some programs, such as the Charter School Program, could have a negative consequence for the very students we hope to benefit by these proposals. And I will have a few questions about that.

Again, there is a risk here that some States are welcoming the charter schools. Others, quite frankly, are not. And so I worry a lit-

tle bit about the public sector taking money that we want to try and seed these innovative things.

And I know you probably know more about this than anybody on this panel. You have got a lot of experience here. So I am interested in your perspective on that.

EDUCATION BUDGET IN BROADER CONTEXT

I know you faced a very difficult challenge in making all the pieces fit into a tight budget. I made this point with Secretary Azar yesterday. This isn't necessarily your budget. This is the OMB's budget that you are tasked to defend. And that is what you are supposed to do. You work for the President of the United States. That is the budget process here.

But obviously, you had to wrestle with a much smaller budget than you might have otherwise chosen. I am not going to ask you about that. I would expect you to be, of course, supportive of the President's position on this and overall budget priorities. But I think that does put you, just as it did Secretary Azar, in a difficult position. Sometimes you may well have been forced to make cuts that you did not advocate.

SPECIAL OLYMPICS

We had a rather famous incident of that last year on Special Olympics, as I recall. So I know you sometimes privately make an argument that we might agree with up here, but publicly, you have got to go, you know, make the case. So, again, I respect that. That is one of the obligations you undertake when you accept a position, as you have, at—by the way—great personal sacrifice. It is not exactly a job you need, and I admire you, quite frankly, for your commitment to public service.

I know that under the leadership of our chairman, the gentlelady from Connecticut, a strong quality education for students across the country will remain a fundamental priority in the creation of this year's Labor-HHS bill, just as it was last year. Frankly, just as it was when I was privileged to be chairman.

And my friend has always been a good partner in that endeavor, whichever role she has—chairman, chair of the committee, or ranking member. So I look forward to working with my friend once again to craft a budget that balances our many priorities and invests in our country's people and its future.

I look forward to your testimony today, Madam Chairman, and I yield back the balance of my time. Or Madam Secretary, and I yield back to you, the chairman.

Ms. DELAURO. I thank my friend the ranking member and, again, look forward to working with you on this, and we will put it together, as we have in the past.

And now I would like to turn to the distinguished chair of the full committee for any comments that she may have, Congresswoman Nita Lowey.

FULL COMMITTEE CHAIRMAN'S OPENING STATEMENT

Mrs. LOWEY. Good morning, and thank you, Madam Secretary, for appearing before the committee. I look forward to the exchange of ideas.

And I want to thank Chairwoman DeLauro and Ranking Member Cole for holding this hearing. This is the fourth budget request Congress has received for the Department of Education under your leadership that has been filled with program cuts and outright eliminations. Without fail, your vision hurts our students and their families.

PROPOSED CUTS AND ELIMINATIONS

Like every previous year, we are going to reject this proposal. You would like us to believe this proposal empowers States and districts with flexibility, but the numbers don't lie. You propose eliminating 41 programs, cutting education funding overall by \$6.2 billion.

The Department of Education's mission is to promote student achievement in preparation for global competitiveness by fostering educational excellence and ensuring equal access. Secretary DeVos, your budget is clearly on a different mission, one that shirks accountability to our students and taxpayers.

It would take more than my allotted time to read the complete list of eliminations and funding cuts. So I will only highlight a few, all of which demonstrate a lack of commitment to educational equity across elementary, secondary, and postsecondary education.

Where we should be protecting and building on a \$16.3 billion investment in Title I schools, your budget proposal has eliminated this crucial support for students in high-poverty schools.

You propose eliminating Full-Service Community Schools in my district. The Thomas Edison Elementary School in Port Chester was among the first in the country to implement the Full-Service Community School model, and their success has shown that integrating academics, social services, community engagement improves student learning, strengthens families, and empowers communities.

I must admit I was an author at that time. I have visited this school, and it is so exciting to see these youngsters get all that they need within the school itself because many of these parents are working two jobs. And to have it all there, to have the parents come in and be a part of it, is very, very exciting. So I must admit it was disappointing to me to see this program eliminated.

Now we will put it back, but it is still disappointing because I know of your interest in educating all the kids.

The budget request eliminates the English Language Acquisition Grant Program, which is vital for combating inequality by improving outcomes for English language learners. Working families count on after school programs so that they can go to work knowing their child is safe and learning, but your budget request eliminates this funding.

More than half of Americans live in a childcare desert, and that includes the one in five college students who are parents. On-campus childcare programs, like the Virginia Marx Children's Center

at Westchester Community College, help student parents successfully pursue degrees. But you would cut funding for the Child Care Access Means Parents in Schools, the CCAMPIS program, by nearly 72 percent.

I am trying not to elaborate in getting to the point, but 72 percent is a lot of parents and children who won't be able to access this opportunity.

It would be absurd to champion this budget request for its so-called fiscal responsibility. More than \$2 billion in student financial aid and grants to institutions would be cut and instead squandered on a border wall.

By eliminating programs and reducing funds, this budget request would exacerbate the opportunity gap. Our students deserve better, and I sincerely hope your response to our questions will address these concerns.

And I thank you again for appearing before us.

Ms. DELAUBRO. Thank you.

INTRODUCTION OF SECRETARY DEVOS

Madam Secretary, we will now turn to you for your testimony, and your full testimony, as you know, will be made into the record. And I would ask that you take 5 minutes to summarize so that we can get to everyone's questions, and after that, we will proceed to 5-minute rounds for questions. And in that effort, I would recognize members in order of seniority and appearance at the time that we put the gavel down.

And so, Madam Secretary, please begin when you are ready.

OPENING STATEMENT

Secretary DEVOS. Thank you. Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the opportunity to testify on the President's fiscal year 2021 Budget.

While we are discussing a budget, it is important to remember that Federal Government spending does not determine everything that is important to us, nor is it the only solution when we encounter challenges and opportunities. Instead, we the people overcome challenges and seize opportunities.

That is why this Department's budget is focused on returning power to the people, to those closest to students and to students themselves. Our budget begins by recognizing that education is a local issue.

Congress recognized that truth when it created the U.S. Department of Education 40 years ago. It promised the move would, and I quote, "not increase the authority of the Federal Government over education, nor diminish the responsibility for education, which is reserved to the States."

This administration proposes Congress align the budget with that 40-year-old promise. Our budget would take a big step toward right-sizing the Federal role in education so that families, teachers, and State and local leaders are free to do what is right for students.

The budget would expand education freedom for students so that they can prepare for successful careers. And it would refocus our

approach to higher education so that students are at the center of everything we do.

First, let us consider recent history. Over 40 years, Federal taxpayers have spent more than \$1 trillion trying to fix K–12 education. Each year, Congress grew the budget from nearly \$7 billion in 1980 to more than \$41 billion in 2020 for K–12 education alone.

But what have we bought with all that spending? Just open up the latest “Nation’s Report Card” to see the sad results. No real improvement in student achievement in decades. So instead of holding fast to what we know does not work, let me suggest we find the courage to do something bold and begin a new era of student growth and achievement.

The Every Student Succeeds Act gives us good insights into where we should go. ESSA became law because many of you on both sides of the aisle realized Federal overreach in education had failed. So you moved to restore the proper roles in education. The bipartisan K–12 law affords States and communities more flexibility to address local challenges.

This administration proposes Congress complement its work on ESSA and make the budget match the law. States must work with local communities and families to develop comprehensive plans that best meet the needs of their students, and so States should be able to target their Federal taxpayer dollars accordingly. To that end, we propose putting an end to education earmarks by consolidating nearly all Federal K–12 programs into one single block grant.

ESED BLOCK GRANT

Overall, Americans spend about \$860 billion on K–12 education every year. Last year, Congress appropriated about \$24 billion of that through the programs in our proposed block grant, or roughly 2.5 percent of total education spending. And yet, each year, teachers and school leaders spend more than 2 million hours complying with Federal reporting and recordkeeping requirements for that small slice of the pie—2 million hours, more than 83,000 days, more than 225 years. That is time that could have been focused on helping students learn and grow.

Teachers, administrators, and State leaders need to be free to focus on people, not paperwork. Results, not regulations. Different States will invest their share of the block grant differently, and that is okay. In fact, that is what we hope they do.

EDUCATION FREEDOM SCHOLARSHIPS

They can better figure out what their students need because they know their students. Every student is unique, and each one of them learns differently. Every child needs the freedom to learn in places and in ways that work for them. That is why the President’s 2021 Budget also renews its call for a historic investment in America’s students, Education Freedom Scholarships.

Our proposal is a dollar-for-dollar Federal income tax credit for voluntary contributions to State-based, nonprofit organizations that provide scholarships directly to students. I like to picture kids with backpacks representing funding for their education following them wherever they go to learn.

The budget also requests a \$100 million increase in supporting children with disabilities, amounting to a total of \$14 billion for IDEA programs.

There is also a request for a dramatic expansion of career and technical education programs. At an overall increase of nearly \$900 million, it is the largest investment in CTE ever. It includes a total of \$2 billion for Perkins State grants, which is an increase of nearly \$800 million.

Additionally, we are requesting \$150 million, an increase of more than \$135 million, to fund STEM activities led by HBCUs and other Minority Serving Institutions located in Opportunity Zones. This administration wants every student in America to have more education options that focus on preparing them for successful careers.

FEDERAL STUDENT AID

That goes hand in hand with our ground-breaking initiatives at Federal Student Aid. Consider that FSA is essentially a \$1.5 trillion bank that has dramatically outgrown its governance structure. We propose evaluating a new governance structure and whether FSA should be a standalone entity.

In the meantime, we are continuing to build on our important reforms that establish one platform, one operating system, one website. And importantly, on providing customers—students and their families—with a seamless student loan experience.

PRIORITIZING STUDENTS

In the end, our budget is about one thing—putting students and their needs above all else. It is a budget that recognizes that no student and no State, no teacher and no town are the same. States need to be free to address the particular problems and possibilities of their people, and students of all ages need the freedom to find their fit.

This budget proposes that Congress give it to them.

Thank you for the opportunity to testify. I am happy to respond to your questions.

[The information follows:]

DEPARTMENT OF EDUCATION

**Statement by Betsy DeVos
Secretary of Education
on the
U.S. Department of Education Fiscal Year 2021 Budget Request**

Good morning Chairwoman DeLauro and Ranking Member Cole.

I'm pleased to be here today to present the President's fiscal year 2021 Budget Request for the Department of Education. I'm excited about our 2021 Budget proposal because it puts a clear focus on helping students achieve better outcomes by ending the Washington-knows-best controls of the past and restoring authority to States and local communities. At the same time, our request would invest in supporting continued economic growth and significantly improving services to recipients of postsecondary student financial aid.

President Trump and I are asking Congress to take several bold steps in our request. As the President urged in his recent State of the Union, we ask you to help approximately one million students find the right education fit for them by creating a Federal income tax credit for voluntary contributions to state-based, non-profit organizations that, in turn, provide scholarships directly to students. To help students enter high-demand careers, we ask you to make a historic investment in Career and Technical Education State Grants so that every student has access to a high-quality CTE program. To better serve students with disabilities, we ask you to increase funding for State Grants under the Individuals with Disabilities Education Act. And to unleash innovation by giving local educators more control of their Federal K-12 funds, we ask you to consolidate most programs into a block grant for elementary and secondary education.

But before I get into those and other proposals, I want to remind the Committee that none of us should be comfortable with the dismal results in the latest "Nation's Report Card." We

have not seen meaningful progress in a decade, and worse yet, the most vulnerable and disadvantaged are actually performing worse. The failures of our education system are dooming too many students as they pursue further education, meaningful work, and successful lives.

Our education system is demonstrably not preparing all students for today's workforce, much less tomorrow's. There are nearly 7 million jobs left unfilled today because employers are unable to find the workers with the needed skills and education.

This skills gap is the inevitable result of America's antiquated approach to education. Can we really be surprised that employers have trouble finding workers with the needed education and skills when the Nation's Report Card tells us that more than 25 percent of our 8th graders cannot read a basic, grade-level passage? "The system" is failing far too many children, and they need something far better.

The Members of this Subcommittee should recognize that the answer is not merely supplying more Federal taxpayer dollars. You have nearly doubled spending on K-12 education since 2000, from \$23 billion in 2000 to just over \$41 billion in 2020. You've increased funding six-fold over 40 years. The Federal taxpayer has been asked to invest \$1 trillion over the past half-century, and the achievement gap has failed to budge. I could go on, but suffice it to say, there is no evidence at all that the Federal Government can simply spend its way to better educational outcomes.

We must try a new approach, and I have a two-part prescription for change.

First, we need to expand education freedom for all students. Every family in America should be able to choose the education setting that they believe is best for each child. Assigning students to schools based on district boundaries may be convenient for public school systems, but it clearly doesn't work for our children, our economy, or our Nation.

Second, the Trump Administration wants to empower state and local leaders and educators by dramatically reducing the Federal Government's prescriptive, compliance-driven role in K-12 education. Fifty-five years of steadily increasing Federal involvement in K-12 since enactment of the Elementary and Secondary Education Act (ESEA) has not improved outcomes or reduced the achievement gaps for our disadvantaged students. Federal rules and regulations often make it harder for local officials to target taxpayer resources optimally.

You will see both of those solutions — education freedom and local control — throughout the President's FY 2021 request.

Overall, the President's fiscal year 2021 Budget Request includes \$66.56 billion in new discretionary budget authority for the Department of Education, an 8.4 percent reduction below the fiscal year 2020 appropriation. This is consistent with the Administration's belief that we cannot continue to increase Federal spending for K-12 education and simultaneously expect to shift power and control back to local educators. Federal money inevitably comes with Federal rules, regulations, and burdens that constrain local educators and students. If you doubt this, remember that only about 3 percent of total K-12 spending is tied to the Elementary and Secondary Education Act. Any superintendent will tell you that ESEA represents far more than 3 percent of the administrative burdens placed on them.

EDUCATION FREEDOM SCHOLARSHIPS

The most transformative proposal in the Administration's fiscal year 2021 Budget is our Education Freedom Scholarship tax-credit proposal, which would encourage voluntary contributions to state-based elementary and secondary education scholarship programs. States could create scholarship programs that give families more education options, including public,

private, home schooling, or all of the above. My goal is to help States create more options for families, and the Federal Government should be agnostic about which types of options are offered. Because the scholarships would be funded by private donations, Education Freedom Scholarships would not divert a single dollar away from public school students or public school teachers, nor would they create any Federal entanglements for students or schools.

ELEMENTARY AND SECONDARY EDUCATION FOR THE DISADVANTAGED BLOCK GRANT

Our 2021 Budget also would build on the 2015 Every Student Succeeds Act (ESSA), which reauthorized the ESEA and sought to restore State and local control over education by significantly reducing the mandates from Washington that accompany Federal education funds. As ESSA expires in 2020, we ask Congress to take the next logical step and block-grant Federal funds to States and local districts, so that people closest to students can determine how best to use those funds to improve student outcomes.

Our proposed Elementary and Secondary Education for the Disadvantaged Block Grant would consolidate 29 Federal elementary and secondary education programs into a single \$19.4 billion formula grant program. Funds would be allocated to the district level through the same need-based formulas used by the Title I program, and grantees would have discretion to use those funds for any authorized purpose of the consolidated programs. We believe this would unleash new innovation at the state and local level, and continue to expand proven reforms, including public charter schools, magnet schools, and student-weighted funding.

Under the new block grant, States and school districts would continue to meet key ESEA accountability and reporting requirements aimed at protecting students, supporting meaningful school improvement efforts, and giving parents information they need to support a high-quality

education for their children. In addition to eliminating Federal overreach and empowering State and local educators, the consolidation of 29 formula and competitive grant programs into a single formula grant would allow the Department, State educational agencies, and local districts to reduce staffing and administrative costs over time by streamlining program administration.

CAREER AND TECHNICAL EDUCATION

President Trump has compiled an extraordinary record in spurring strong economic growth, creating new jobs, and increasing wage growth. The 2021 Budget would double down on this commitment to ensuring that every American can pursue success by increasing our investment in Career and Technical Education (CTE) by nearly \$900 million. In particular, a \$680 million or 53 percent increase in CTE State Grant funding supports the Administration's goal of ensuring that every high school student in America has access to CTE programs that provide multiple high-quality pathways to high-paying, in-demand jobs. The Request also renews the President's proposal to double fees under the H-1B visa program and redirect a portion of the proceeds—totaling an estimated \$117 million—to the CTE State Grants program. Finally, we are seeking \$90 million for CTE National Programs, an increase of \$83 million, to spur the development and implementation of high-quality CTE programs in STEM fields and careers, including computer science.

SPECIAL EDUCATION PROGRAMS

We also are proposing to increase support for programs that serve more than 7 million children with disabilities in our Nation's schools. The Request would provide \$12.9 billion for Grants to States under the Individuals with Disabilities Education Act (IDEA), an increase of

\$100 million over the 2020 enacted level, while maintaining level funding for all other IDEA programs. Our Budget proposal urges Congress to provide more resources for States and school districts to ensure every student with a disability receives a high-quality education.

HIGHER EDUCATION PROGRAMS

Our Request for higher education programs also reflects our continued effort to consolidate duplicative programs and funding streams, reduce administrative burden for applicants and grantees, and streamline the Federal bureaucracy. The Request renews and expands our proposal for a Consolidated Minority-Serving Institutions (MSI) Grant program, which for fiscal year 2021 would combine 11 discretionary and mandatory MSI funding authorities into a single institutional formula grant funded at \$336.3 million.

Title III funding for Historically Black Colleges and Universities (HBCUs) and Tribally Controlled Colleges and Universities (TCCUs) would continue to be delivered through existing authorities at the 2020 enacted levels.

In addition, the President's Budget would transform the Minority Science and Engineering Improvement Program (MSEIP) through a \$150 million investment—an increase of \$137.4 million. These competitively awarded grants would fund STEM activities led by HBCUs and MSIs located in Opportunity Zones, with the goals of both preparing the future generation of STEM professionals and promoting technology-based economic development in some of our Nation's most distressed communities. The expanded MSEIP would target \$50 million to HBCUs, \$50 million to Hispanic-Serving Institutions (HSIs), and \$50 million to all other MSIs.

The Request also renews last year's \$950 million proposal for a TRIO Student Supports Block Grant that would transition the TRIO programs from a complex and difficult to administer

set of Federal competitive grant programs into a single State formula grant program. Under this proposal, States would have discretion to use their funds to implement the best mix of activities, including those currently authorized under TRIO, Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP), and the College Assistance Migrant Program, that will improve postsecondary access and attainment for their low-income and disadvantaged students.

FEDERAL STUDENT AID

Finally, I want to talk about the challenges we face in rethinking and modernizing how students and families finance postsecondary education. Our 2021 Request includes proposals to simplify the Federal student loan programs and student loan repayment, establish reasonable loan limits for all Federal student loans, and afford postsecondary institutions more flexibility to help students avoid borrowing more than they will be able to repay. The Request also would expand Pell Grant eligibility to students enrolled in high-quality short-term programs offered by institutions that provide students with a credential, certification, or license in a high-demand field, make Pell Grants available to certain incarcerated students to improve employment outcomes, reduce recidivism, and facilitate their successful reentry to society, and make crucial reforms to the Federal Work Study program to support workforce and career-oriented training opportunities for low-income undergraduate students.

We hope you will continue to support our transition to the multi-year Next Generation (Next Gen) student aid platform, which includes building the technology and operational components that will help us deliver world-class services to postsecondary students and their families while continuously enhancing cyber security and improving accountability for taxpayer funds. Key enhancements include the development and implementation of an improved loan

servicing platform and the consolidation of all customer-facing websites into a single, user-friendly hub to complement our new mobile platform and the highly successful MyStudentAid mobile app. These changes will give students, parents, and borrowers a seamless experience from application through repayment. Our request includes \$1.9 billion for such improvements through the Student Aid Administration account, \$114 million more than FY 2020 enacted levels.

To carry out these reforms, we also need to ensure that the Office of Federal Student Aid has the professional leadership and independence needed to efficiently and effectively deliver each year more than \$120 billion in new Pell Grants, Campus-Based Aid, and Direct Loans, while managing a student loan portfolio of more than \$1.5 trillion held by over 42 million borrowers. In total assets, the Office of Federal Student Aid is the country's biggest lender. But unlike banks, it does not have a clear governing structure with deep financial experience to provide strategic direction and oversight. Instead, the Office relies mostly on the Secretary of Education, along with Congress and others, for these critical roles. In 1998, when the Office of Federal Student Aid was established as a performance-based organization, annual aid was less than half of what it is today, and the Office was largely tasked with overseeing and guaranteeing privately issued student loans. Many of the complex programs we are familiar with today—TEACH grants, Public Service Loan Forgiveness, most income-based repayment plans—didn't even exist. While just about everything in world of student aid has changed, the Office of Federal Student Aid's structure and governance has stayed the same. Moreover, we should all be concerned that political interference could distract the Office from what should be a laser-like focus on delivering world-class service to help students and their families finance postsecondary education.

For all of these reasons, we believe it is time to consider whether the Office of Federal Student Aid would be a stronger and more effective organization if it had a reformed governance structure. As part of this discussion, we also believe Congress should consider whether FSA would work better as a separate organization from the U.S. Department of Education. Managing one of the world's largest consumer loan portfolios requires a different set of skills than managing the distribution of grants to local and state educational agencies. Our Budget proposes to launch this overdue discussion by evaluating these issues in order to ensure that we best serve students and taxpayers alike.

Each of these bold proposals marks a significant change from the status quo. I know that will invite criticism and handwringing. But let me urge all of us to move beyond the immediate discomfort of change and instead focus on the needs of the rising generation. A generation who, by most accounts, will be less literate than the generation before it if we do not implement significant changes to our approach to education. A generation who will face unprecedented economic change and need more nimble education options. A generation who will be more mobile and more connected than any in history. What they need from American education is not the programs we fund today, simply because we funded them yesterday and the year before that and the decade before that. What they need is a complete rethinking and challenging of everything we do so that nothing stands in the way of their continued growth and success.

Thank you again for this opportunity to lay out our 2021 Budget proposals and related reforms. I look forward to discussing these proposals further with you over the coming weeks and months as we work together to improve educational opportunities and outcomes for all Americans.

Betsy DeVos
U.S. Secretary of Education

Biography

Betsy DeVos serves as the 11th U.S. Secretary of Education. She was confirmed by the U.S. Senate on February 7, 2017, after being nominated by President Donald J. Trump.

Secretary DeVos has been involved in education policy for nearly three decades as an advocate for children and a voice for parents. She is especially passionate about reforms that help underserved children gain access to a quality education.

DeVos' interest in education was sparked at an early age by her mother, a public school teacher. It grew when she sent her own children to school and was confronted with the reality that not every child in America is granted an equal opportunity to receive a great education. DeVos saw firsthand the work leaders in her hometown were doing to increase educational opportunities for students and choices for parents, and she has been involved in the fight to provide better educational options across the nation ever since.

For 15 years, DeVos served as an in-school mentor for at-risk children in the Grand Rapids (Michigan) Public Schools. Her interactions there with students, families and teachers, according to DeVos, "changed my life and my perspective about education forever."

A leader in the movement to empower parents, DeVos has worked to support the creation of new educational choices for students in 25 states and the District of Columbia.

As Secretary, DeVos will work with President Trump to advance equal opportunities for quality education for all students. DeVos firmly believes that neither the ZIP code in which a child lives nor a child's household income should be the principal determinant of his or her opportunity to receive a world-class education. As secretary, she will advocate for returning control of education to states and localities, giving parents greater power to choose the educational settings that are best for their children and ensuring that higher education puts students on the path to successful careers.

Prior to her confirmation, DeVos served as chairman of The Windquest Group, an enterprise and investment management firm. In addition to her leadership in the education arena, DeVos has also served on the boards of numerous national and local charitable and civic organizations, including the Kennedy Center for the Performing Arts, Kids Hope USA, ArtPrize, Mars Hill Bible Church, and the Kendall College of Art and Design.

DeVos is a graduate of Calvin College in Grand Rapids, Michigan, where she earned a Bachelor of Arts degree. She has been married for 40 years to entrepreneur, philanthropist and community activist Dick DeVos, and together they have four children and eight grandchildren.

SPENDING INCREASES AND EDUCATIONAL OUTCOMES

Ms. DELAURO. Thank you very much, Madam Secretary.

And I am sorry I was remiss in recognizing Larry Kean, who is the Budget Service Director at Department of Ed. So welcome to you as well, Mr. Kean.

Madam Secretary, to justify your cuts, you repeatedly claim additional funding for our public schools does not improve student outcomes. A claim that has no basis in reality. A 2018 review of recent research on education spending, student outcomes by Northwestern economist Kirabo Jackson found statistically significant positive results for students in 12 out of 13 studies, which is why, Dr. Jackson concludes, by and large, the question of whether money matters is essentially settled.

I don't understand, Madam Secretary, why do you continue to claim that additional resources to public schools do not improve student outcomes when the empirical evidence tells us the exact opposite?

I am just going to—I admittedly have not read through all of them. I have read some of them, but this is by education experts, people who understand the science of learning and development and how it improves. The data is overwhelming.

So I ask you again, how can you continue to make these claims that student outcomes do not improve when empirical evidence tells us the opposite?

Secretary DEVOS. Chairwoman, let me just refer back to the NAEP results. But before I do that, I just—there are a couple of things that you said in your opening comments that I need to comment to.

First of all, I am not out to privatize anything about education. I am out to make sure every student's education is personalized, individualized for them, that they find the right fit to unlock their potential. So let us talk about personalization, not about privatization. That is not the issue. That is not the goal.

And we have spent over \$1 trillion at the Federal level to close the achievement gap in the last 40 years. That achievement gap has not closed one little bit.

Ms. DELAURO. Well, that is not true.

Secretary DEVOS. In fact, for many poor students, it has only grown wider.

Ms. DELAURO. That is absolutely not true.

Secretary DEVOS. You look at the State-by-State results, you look at the overall results, and they are dismal.

NATIONAL ASSESSMENT OF EDUCATIONAL PROGRESS SCORES

Ms. DELAURO. I am going to—

Secretary DEVOS. Two out of three eighth graders cannot—cannot read or do math at their grade level.

Ms. DELAURO. And I would want to know where those schools are, what the environmental circumstances are, what kind of resources are going into those schools to the training of teachers and improving the lives of the families who live there, and making sure that the youngsters have that experience and have trained people

that they need. If you deny the resources to the most—to the schools that need the help most, yes, you will fail.

I am going to tell you NAEP scores—

Secretary DeVos. No, if you free—actually, if you free up the resources for people at the most local level, you see results. You can see it in Florida. You can see it in Mississippi, where they focused solely on improving reading outcomes.

Ms. DELAURO. And you can see in the District of Columbia, where the data from this administration has demonstrated that that is not the case.

And you know, we have got scores higher in 2019 for most racial and ethnic groups in both subjects and in both grades, compared to the early 1990s. This is the—the NAEP data, scores in math and reading are significantly higher than they were 40 years ago for all racial and ethnic groups. So the fundamental principle and the underlying philosophy on which you move forward and cutting all these programs and move to \$5 billion for vouchers flies in the face of the progress that is made.

Let us work together to understand the statistics, realize that where are, know that there is a difference, and we have got somewhere to go on an achievement gap. But let us not denigrate a public school system that serves 90 percent of our kids and that is making gains. Let us continue to make those gains. And quite frankly, the cuts that you have proposed is doublespeak. It is doublespeak.

So I am just going back to your words that are the NAEP study. And as I said, you have got more studies released in 2019 reached the same conclusion, including a study showing how extra money for Texas schools had a particularly strong impact on low-income and Hispanic students.

I am going to share the studies with yourself and with your staff and with the members of this subcommittee to take a look to see if, in fact, the data belies the direction that you are taking public education in this country.

And my time has run out. Let me yield to my colleague from Oklahoma.

PELL GRANT PROPOSAL

Mr. COLE. Thank you very much, Madam Chairman.

As I have said in my comments, Madam Secretary, I am really excited about your Pell Grant proposal and your additional investment in career and technical education. So I have got a couple of questions along those lines.

You actually say that we would give these grants to provide credentials in “in-demand fields.” So I guess I am sort of interested to know how would you define “in demand”? What would actually be covered? How would that work? Would all the programs—let us say a duly recognized State career and technical, would that be covered, or are you going to—do you have sort of selectivity in mind?

Secretary DeVos. Well, our proposal really seeks to work with Congress to determine what—the definition around those programs and the extent to which they would be a part of a short-term Pell program.

I know it varies by region, and I think it would behoove all of us to work closely with regions and States and to look at what those opportunities are. But we would look forward to working with Congress to determine that and to really address these opportunities for students.

Mr. COLE. Well, I actually find, certainly in my State, honestly, quite often young people or not so young—because obviously you can be any age coming for additional technical training—they literally end up with a job faster usually than somebody coming out of a 4-year education, and it is quite often a very high-paying job. Believe me, when you need a plumber, you really need a plumber. You know, you can't wait around.

Secretary DeVos. That is right.

Mr. COLE. And so, again, I applaud that. We get a lot of questions about this because a lot of the students that go to these facilities are comparatively low income, and frankly, just the cost of college or the idea of assuming the debt that is often associated with that, to them, doesn't make sense. This really does. So I am glad you put it on the table.

TRIO AND GEAR UP

I want to go to an area where, frankly, we don't agree, and that is on the TRIO and GEAR UP proposals that you have. I have got a lot of TRIO students in my State. We have historically been one of those States that has really benefited from that. We have really benefited from GEAR UP.

And frankly, I have never met a single student or instructor in these programs that didn't think they were worthwhile. I look at TRIO, for instance, and since its inception, it has produced over 5 million college graduates. And I think a lot of those young people, quite honestly, would not have had the opportunity or the support structure to succeed in college without TRIO or the preparation that is necessary. That is one of the great things about GEAR UP. A lot of families where nobody has gone to college before really are not in a very good position sometimes to counsel their own kids or prepare them.

And you want to—I don't want to send them to college and not have them successful. I want them to get that degree, not walk out of there with a few hours and thousands of dollars' worth of debt. So these programs, to me, seem to do that.

And I used to have this problem, quite frankly, with the last administration, which I thought underinvested in these programs, even though historically we were always doing Race to the Top or some, you know, New Deal, when we had a couple of programs here I think have demonstrated their utility over time again and again. So explain to me again the advantages you would see in the consolidation and the movement to formula grants as opposed to competitive grants in this area.

Secretary DeVos. Well, thank you, and I totally agree that these programs are beneficial and effective for many students. And our proposal does seek to essentially move GEAR UP into the TRIO program and block grant it to the States. The reality is that most of the awardees for the TRIO program are consistent year after

year after year, and it is very difficult for any new program to break into it.

We think that by allowing more flexibility—

Mr. COLE. So that would tell me we should put more money in TRIO.

Secretary DEVOS. Well, and that is certainly your prerogative. But I think coupled with our proposal to block grant the elementary and secondary education funding of the 29 different programs and, again, provide a lot more flexibility at the State and local level, the answer for one district might look quite different than an answer for the other district.

Mr. COLE. A fair point.

Secretary DEVOS. And I think, coupled, it could be a really powerful—

ESED BLOCK GRANT IMPACT ON CHARTER SCHOOLS

Mr. COLE. Fair point. I have only got about 30 seconds left, so let me just quickly ask one other area because I know you have historically been a great champion of charter schools. And I do worry. Not everybody shares that point of view.

I think if you block grant these to States, a lot of the money that has been set aside specifically for charters honestly is apt to be diverted into the public system, even though—well, to the normal K through 12 system. Particularly when the overall amount of money is coming down, well, let us concentrate within the K through 12 system. These are more experimental, or these are little bit more outside the “mainstream.”

So I have gone over my time, but just briefly, do you have that concern?

Secretary DEVOS. Well, let me be very clear. I totally support charter schools and think we need not fewer of them. We need many more of them. There are a hundred—I mean, sorry, a million families on the waitlist for charter schools across the country, and they—I actually view our consolidation and block grant proposal as one that is additive and positive for charters.

I have talked with a number of Governors about the block grant concept, and they are very excited about it. In States where they embrace this, there is going to be dramatic expansion and for—

Mr. COLE. I have gone over my time. So I want to—I don’t want the chairwoman to have to interrupt me. I will interrupt myself.

But thank you, and I would like to continue this discussion. I appreciate it.

Secretary DEVOS. Thanks.

Mr. COLE. Thank you, Madam Chair, for the indulgence.

Ms. DELAURO. Thank you. Sure.

Congresswoman Lee.

Ms. LEE. Thank you very much.

PRESCHOOL DISCIPLINE AND RACIAL BIAS

Thank you, Madam Secretary.

Let me go right to this because there is still—and this is increasing—in terms of systemic injustices toward our Black and Latino students. First of all, you eliminated the 2014 school discipline

guidance to help ensure that students of color are not subject to harsher discipline practices than their White peers.

Now let me ask you about your Office for Civil Rights proposal. Now this is a double whammy. To combine the counts of preschool children who received out-of-school suspension with those who received more than one out-of-school suspension and your proposal to eliminate preschool enrollment data by race and ethnicity.

Now without this distinction, it is going to be very difficult to understand whether and to what extent this trend persists. The ability to track this data is critical because while Black students—now you have got to hear this and understand this and why this is so important. Black students make up 20 percent of preschool children.

Now these are babies, right? They represent 50 percent of suspended, again, babies, preschoolers. Don't forget also that the Education Department's, your own data, in 2013 and 2014 found that Black preschoolers—again, babies—are three times more likely to receive one or more out-of-school suspension than their White counterparts.

So I requested in the last 2 years that this subcommittee receive language detailing school discipline in all preschool and K through 12 classrooms and to also include it in your 2020 budget justification. Here you are again without having submitted this data—we went through this last year—although your budget request says that you will brief us on your plan with a horrendous plan to significantly alter this data collection.

So why do you plan to change the data collection so that it really—and that is what it is going to do, it is going to mask the trends for out-of-school suspensions of preschoolers. And we should have solved this, and we shouldn't have to ask you once again for this data.

So that is my first question. What in the world is going on, it would take us so long for us to get this report that we required you to submit for the last few years?

And also do you believe that Black students are punished and suspended at greater rates than their White peers? Yes or no? I mean, do you believe that? The data shows this, and these are children. These are babies.

Secretary DeVos. Ma'am, I agree and love children, as you do, and want to ensure that all children have the opportunity to get a great education.

We have been focused on answering and responding to all of your requests.

Ms. LEE. But you haven't done that.

Secretary DeVos. I will check on that specifically—

Ms. LEE. But you said that last year, Madam Secretary.

Secretary DeVos. And what I know and what I am committed to is ensuring that all kids have an opportunity and equal access to—

Ms. LEE. I understand that. Madam Secretary, you tell us that every year. But what about Black and Latino kids? You don't even submit to us—

Secretary DeVos. That is exactly my point with opportunity for personalizing their education.

Ms. LEE. No, Madam Secretary, no. You are trying to mask this by saying you are now not going to collect the data by race. So how in the world are you going to be able to say that you care about Black and Latino kids?

RESPONSIVENESS OF THE DEPARTMENT

The other report we asked you, we asked you detailing the recommendations with regard to how to address adverse impacts of resegregation, including designating Title VI school monitors to ensure that every student has the opportunity for an equal education. Again, you said you were aware of this report. You would get it back to us as soon as possible. We still don't have this report.

We have tried and tried over and over again, Madam Secretary, to get these reports from your office. They are written into the bills. They are required. And you are just thumbing your finger at us.

Secretary DeVos. That is not the case.

Ms. LEE. Well, it is the case.

Secretary DeVos. We are—we are responsive. We have continued to be responsive to the many requests from Congress—

Ms. LEE. Well, where—

Secretary DeVos [continuing]. And we are committed to doing—

Ms. LEE. Madam Secretary, on Black and Latino kids, these babies, these preschoolers, you have not been responsive. These are children who don't even get Head Start because they are kicked out of school before they are even in kindergarten. Don't you think that is important?

Secretary DeVos. I think each one of them is important, and I care about each one of their futures. That is why I am suggesting we do things very differently than what we have been doing.

Ms. LEE. Now, Madam Secretary, this committee has asked you for this data, and instead of providing the data and the reports, you are now trying to mask it by saying you are not going to use race and ethnicity to even present the facts. So how can you sit there and say that? We ask you over and over and over again every year.

Secretary DeVos. I am committed to each of those children, as you are.

Ms. LEE. But you are not showing that. Could you submit—

Secretary DeVos. A report—a report does not solve—

Ms. LEE. Well, wait a minute. Let me ask you about—

Secretary DeVos. A report does not solve a child's problem.

Ms. LEE. But we are asking—wait a minute. We are asking—

Secretary DeVos. A report is not a child's future.

Ms. LEE. Madam Secretary, we are asking you for the report. We need the data to understand this. I would think you would want the data to understand it also. That is all we are asking for. This is basic.

So why wouldn't we get the information that this committee has asked you for for 2 years about preschoolers being disproportionately suspended from preschool? These babies, these Black babies.

Secretary DeVos. Let us talk about the lack of achievement—

Ms. LEE. When are we going to get the report?

Secretary DeVos. Let us talk about the lack of achievement and the lack of opportunity by being forced to go—

Ms. LEE. So we can't ask you for these reports, Madam Secretary?

Secretary DeVos. By being forced to go to schools that don't work for them.

Ms. LEE. I want to know when we are going to get the—Madam Secretary, are you just saying forget the reports? Just tell us that, if you are not going to give them to us.

Secretary DeVos. No, ma'am, I am not.

Ms. LEE. Well, then when do we get it?

Secretary DeVos. I will check on when that report will be available.

Ms. LEE. Both reports, on school resegregation and the suspension and expulsion of Black and Latino kids. You told us this last year. A year has gone by, and it is outrageous.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you very much.

Thank you, Madam Secretary.

What is outrageous is the 25 percent of our children, of our eighth graders can't read a grade-level passage. That is what is outrageous. And you are right. Money doesn't solve this problem.

DC OPPORTUNITY SCHOLARSHIP PROGRAM

You know, I had the privilege of being invited to the 15th anniversary of the OSP program at Department of Education, where we met the parents. All they wanted was a better life, a better schooling for their children.

Madam Secretary, you know that 90 percent of those students who took advantage of that program are Black students. The vast majority of the rest are Latino students. So to somehow suggest that you, as an advocate for programs like that, don't care about Black and Latino students just doesn't jive with the data.

Secretary DeVos. That is right.

Mr. HARRIS. Let us talk about the data. Significant progress on NAEP. Really? U.S. News and World Report headline about the last scores say "Across the Board, Scores Drop in Math and Reading for U.S. Students."

They dropped. They didn't go up. There is no significant improvement.

And with regards to the disparity, it is pretty clear the disparities existed between the highest and lowest performers for 30 years consistently. Now there are some people who would suggest that repeating the same thing you are doing that doesn't work is insanity. This is exactly what we are doing in the United States.

EDUCATION FREEDOM SCHOLARSHIPS

So I want to congratulate you on the suggestion for the Education Freedom Scholarships. Now I know it is a bold idea to somehow believe that you should put parents in charge of their children's education or maybe making the choice where to send their children to school because, of course, God knows, we know better. That somehow some bureaucrat somewhere knows better. Some

academic sitting in some ivory tower knows better than the mother.

Some of those mothers I saw at that Department of Education celebration, who really knew what was better for their children, and it was not to be sent to the same poorly performing public schools because there was no competition.

Now let me tell you what is interesting from the NAEP scores. There was one jurisdiction in the country where actually students performed better on three out of four of the measurements, Washington, D.C. Because for 13 years before that test was taken, Washington, D.C., instituted competition for a failing public school system.

And the academics go, oh, no, it doesn't—oh, no, we are going to compare the scores of the people who went to the voucher schools and people that didn't go to the voucher schools. Competition works, and the Education Freedom Scholarships will induce competition.

Now let me ask you, does a dollar for those scholarships come from the Department of Education budget? I think I saw it was the Department of Treasury budget, wasn't it, where those dollars—

Secretary DeVos. For Education Freedom Scholarships?

Mr. HARRIS. Yeah, for Education—right.

Secretary DEVOS. Yes, that is part of the Department of Treasury budget.

Mr. HARRIS. Right. So this wouldn't really take a dollar from our public schools, would it?

Secretary DEVOS. No. No, it would be voluntary contributions.

Mr. HARRIS. So let me see. So what could the possible opposition to voluntary contributions to a program, and I think I have the facts right, about three-quarters of parents favor that idea? The idea of actually giving choice.

In fact, the statistics I see, 68 percent of African-American parents, 82 percent of Latino parents. Specifically about the EFS program, 83 percent of African-American parents, 83 percent of Latino parents actually want that choice.

Secretary DEVOS. That is right.

Mr. HARRIS. Why in world would we deny it? Can you come up with any reason why? Other than teacher union opposition, could you come up with any other reason why we would deny that?

Secretary DEVOS. I see no reason to deny these kids that opportunity.

Mr. HARRIS. Madam Secretary, thank you for putting up with what you do, what you put up with to stand up for the idea that every child—and as an educator for the 30 years before I came to Congress, for the idea that every child in America and every parent in America deserve a choice where to get sent to school.

And if they are unfortunate enough to live in a geographic area or school district where their school is just plain lousy, that they should have the opportunity to go to a charter school. And it could be a public charter school. It could be nonpublic charter school, a charter school, or get a voucher, especially under the Education Freedom Scholarships. So these are voluntary contributions to get a voucher to help those children go to a better school.

I just don't understand the argument against it. I never will understand the argument against it. It is about time we get raw politics out of education because it is standing in the way. Because you know, if you look at the statistics, yes, there was improvement in the NAEP. We went from 31st to 30th in the world in the last NAEP, 31st to 30th in the world, and it wasn't math or reading. I guess it was science. That is pathetic.

In the 21st century, we can't afford to be anything but first in the world, and I just want to congratulate you on what you do to see to it that that could happen.

I yield back.

Secretary DeVos. Thank you, Congressman.

Ms. DELAUBRO. Congressman Pocan.

PUBLIC SCHOOLS WEEK

Mr. POCAN. Thank you very much, Madam Chair.

Thank you, Madam Secretary.

Easiest question you will get today. We have something in common, five-letter last name that gets mispronounced a lot. Is it DeVos or DeVos?

Secretary DEVOS. It is generally DeVos, but I have heard it lots of different ways.

Mr. POCAN. Just my name, too. So I appreciate it. So, Secretary DeVos, thank you for being here, and I want to thank you, first, for not having cuts this year to special education and not cutting the Special Olympics. The fourth time is the charm, and I just want to say thank you.

And also happy Public Schools Week. I am sure you are around the country advocating for public schools this week. Thank you. We had a strong bipartisan resolution with 90 people, including our ranking member, on that, and very proud of the public schools we have in this country.

CHARTER SCHOOL PERFORMANCE

I do want to pick up on where our ranking member started talking about charter schools, though, because this is where I think we don't have as good information. First of all, on academic performance, we know on charter schools, about one out of six does better than public schools. About half are about the same. But two out of six perform worse than public schools on academic performance.

But I think there is something even worse. You mentioned what we bought with the spending. When you look at charter schools, there was a report last year that said 1,000 charter school program grants were given out by the Department of Education were given to schools that never opened or later closed because of mismanagement, poor performance, or fraud.

And another report just last December said it is actually worse than that. It was 2,127 schools out of 5,286 that actually never opened or failed. That is 40.5 percent failure rate on charter schools. I looked it up. That is an F grade when you are below 60 percent, and yet you are advocating for doing more Fs rather than more As, like we get with public schools. Or Bs in some cases and maybe a few Cs. But Fs certainly don't seem to be the grade we want to advocate for.

Also there was a School of Idea charter chain that have been awarded about \$200 million in Federal funds. Over the years, they got a \$67 million grant, another \$116,000,000. Yet this is some of what they have spent their money on.

WASTE, FRAUD AND ABUSE BY CHARTER SCHOOLS

They had \$400,000 going to a luxury box and tickets for Spurs tickets. I don't think you would see public schools getting a luxury box. They purchased a property from one of their board members for \$1.7 million. I don't think a school board member would sell their property to a public school.

Another board member got the commission on that sale on over millions of dollars of property, and only after a lot of scrutiny did the CEO back off of a plan to lease a private jet for \$2 million a year over 6 years.

So I guess my question on this terrible failure rate we have with charter schools that you are still advocating for, just a yes or no, do you think charter schools who receive Federal funding should be allowed to use those funds to purchase private jets?

Secretary DeVos. Well, Congressman, I am not—

Mr. POCAN. It is a yes or no question.

Secretary DeVos. No, it is not a yes or no question.

Mr. POCAN. Well, actually, it is. Actually, it really is. It is the definition of a yes or no question.

Secretary DEVOS. Actually, I have a few things to say about the things that you said about charter schools.

Mr. POCAN. Okay, but can you answer my question, please, Secretary.

Secretary DEVOS. I have a few things to say—

Mr. POCAN. Do you think Federal funds—

Secretary DEVOS [continuing]. About what you have said about charter schools.

Mr. POCAN. Okay. Reclaiming my time, Madam Secretary. Reclaiming my time—

Secretary DEVOS. The report—and I am sorry.

Mr. POCAN. It is a yes or no question I am giving you.

Secretary DEVOS. The report that you referenced has been totally debunked as propaganda.

Mr. POCAN. I didn't ask you about the report.

Secretary DEVOS. Fewer than 2 percent of the schools didn't open.

Mr. POCAN. Madam Secretary, reclaiming my time. I gave you the courtesy of making sure I could even say your name correct. Give me the courtesy of answering my question.

Secretary DEVOS. I appreciate that, but if you are asking me a question, I need to have a chance to answer.

Mr. POCAN. A yes or no question. Yes, but I am asking you a question with a yes or no answer. It is really that simple. If the Secretary of Education can't answer a yes or no question, I don't know why you can be the Secretary.

Do you think Federal funding should go to a school that uses it to buy a private jet? That is a yes or no question.

Secretary DEVOS. It is a very hypothetical question—

Mr. POCAN. Oh, my God.

Secretary DEVOS [continuing]. That is obviously a no—no answer.

Mr. POCAN. No, it is an actual question. It is an actual question.

Secretary DEVOS. There is no funding going to charter schools that would even address something like that.

Mr. POCAN. You think—another yes or no—that they should be able to put money to a box at a professional sport—

Secretary DEVOS. Let me just say charter schools are public schools—

Mr. POCAN. Madam Secretary, reclaiming my time.

PERFORMANCE OF CHARTER SCHOOLS

Secretary DEVOS. Charter schools are doing a great job—

Mr. POCAN. Reclaiming my time.

Secretary DeVos—for the families that are choosing them, and there are a million families on the waitlist to go to charter schools.

Mr. POCAN. Madam Secretary? Madam Secretary, just talking over someone isn't an answer, just so you know. And yes or no often is when it is asked in a yes or no format.

We also know that the same group gave such incomplete information over 3 years, didn't report accurate information, reported no information on performance data. Would you think—would you give your staff a paycheck if they didn't perform 84 percent of their tasks? Yes or no?

Secretary DEVOS. Of course not. But everything you are citing—

Mr. POCAN. Thank you for answering it in a yes or no. That is progress.

Secretary DEVOS. Everything you are citing is debunked, ridiculous. So I don't accept the premise of your—of your question.

DEVOS FAMILY INVOLVEMENT IN CHARTER SCHOOLS

Mr. POCAN. It is actually—it is actually not. Let me ask you this. Do you think it is odd when people think—your family runs a charter. Correct? That is a yes or no.

Secretary DEVOS. No.

Mr. POCAN. Your husband doesn't have a charter program?

Secretary DEVOS. He founded a charter school.

Mr. POCAN. He founded a charter. So when people think that you may have a conflict of interest because of that, what do you—

Secretary DEVOS. Absolutely not.

Mr. POCAN. I will let you not do a yes or no. You can respond however on that one.

Secretary DEVOS. I will respond in that my husband founded a charter school which is meeting needs of students all over West Michigan. And he is on the board, but he does not run the school. It is organized as a not-for-profit charter school, and it is a public school serving all comers.

CHARTER SCHOOL PERFORMANCE

Mr. POCAN. Well, Madam Secretary, I think just the fact that you couldn't answer yes or no, and you look at this terrible rating of

charter schools, this is why people have a worry that there could be a conflict or something else—

Secretary DEVOS. And you are wrong about charter schools.

Mr. POCAN [continuing]. Because if they are not performing academically. Yeah, but 40 percent are closing down that you are giving grants to.

Secretary DEVOS. That is not true.

Mr. POCAN. That is a waste of public taxpayers'—

Secretary DEVOS. That has been a totally debunked report. It was nothing but propaganda by an individual who has it in for charter schools.

Mr. POCAN. So what percent of charter schools are failing? Do you have an idea, a number, any number?

Secretary DEVOS. I don't have a State—any national—

Mr. POCAN. You are the Secretary of Education, and you don't have this. You know this report is wrong, but you don't have the numbers?

Secretary DEVOS. Charter schools are chartered by States. They are not chartered by the Federal Government.

Mr. POCAN. You know that that number is not right, but you don't have the correct number? Is that what you are telling us?

Secretary DEVOS. What I know is parents and families are choosing—

Mr. POCAN. So you don't know. So you don't know the answer.

Secretary DEVOS [continuing]. To send their children to charter schools.

Mr. POCAN. That is a yes or no. So you don't know the answer?

Secretary DEVOS. Parents and children are going to charter schools by choice.

Mr. POCAN. A yes or no. So you don't know the answer?

Secretary DEVOS. And there are a million more families on charter school waitlists.

Mr. POCAN. I think I have the answer. I think I have the answer. Thank you.

[Gavel sounding.]

Ms. DELAURO. Congressman Moolenaar.

CONCERN OVER TONE OF QUESTIONS

Mr. MOOLENAAR. Thank you, Madam Chair.

I do want to say that I am very troubled by the tone of this hearing, and I feel like our Secretary is being badgered, and I would ask the chair to consider that as we move forward. Because I feel it is very unfortunate that we have come here to help meet the needs of our children, the Nation's children, and I think the tone of this hearing is very disappointing in that regard.

And I also want to say, as a person who is familiar with the Secretary's record, I don't know of a single person who has been more engaged in policies to help minority students across the country than this Secretary from all of her work throughout her career. So I am very disappointed right now, but I do want to talk about some of the priorities.

And also, as someone who has been a former school administrator, a charter school administrator, and someone who has chaired a State education budget, I will say that the focus that you

have on helping people closest to the student and who care most for the student, making decisions to me is the right direction. So I want to compliment you on that. I know there are a lot of issues we could discuss, but I just want to say that at the outset.

SECOND CHANCE PELL

There is a few specific things I wanted to ask you to talk about. First, the Second Chance Pell. I think one of the high points of Congress working with the administration has been to look at prison reform and to help those who have been in prison come back into the community and contribute.

And I wondered if you could talk a little bit about your plans going forward. I know there is interest in community colleges in my area in participating in this, but if you could talk briefly about the Second Chance Pell program.

Secretary DeVos. Well, thank you, Congressman. And I think this is an area where there is actually broad-spread support and a lot of great evidence. I have had opportunity to visit three different prisons and see students that have—I visited Tulsa Community College and prison in Oklahoma last summer and was just thrilled to see all of these mostly young men graduating with associate degrees, with certificate program recognition. Some of them completing their high school requirements. But it was a thrill to be there, and I think there is so much promise with making a Second Chance Pell program a permanent one that is going to provide hope and opportunity for returning incarcerated individuals and give them a really hopeful future.

FEDERAL WORK-STUDY

Mr. MOOLENAAR. Wonderful. Thank you.

And then I also wanted to talk with you. You mentioned preparing students for successful careers, and I know the Federal Work-Study proposals that you have really are aimed at inviting the private sector to participate more. And I understand there are 190 institutions that would be invited to participate in a pilot program.

I know in one of my areas, Mid Michigan College is interested in participating in that. Could you comment on that briefly?

Secretary DeVos. Well, we think that there is a real opportunity to help students get much more relevant work experience while they are attending college and in a Federal Work-Study program. Instead of working in the college cafeteria, if they are doing student teaching perhaps or clinicals in a health profession or perhaps it is in a business that has a relevance with the program they are taking in their college, we think extending this opportunity and helping students get really relevant, almost apprenticeship-like experience while they are in school studying is an important step in the direction of helping students succeed.

STUDENT LOAN DEBT

Mr. MOOLENAAR. Thank you.

Also I think, as parents, everyone is concerned about the higher cost of college education when you see the debt that students are

taking out and then just the burden that places on them in the future. Can you comment about just what the administration can do to help alleviate the high cost of education, but also the student loan debt?

Secretary DEVOS. Well, this is a huge issue, and I am not sure I have got enough time to answer it fully. But I will start with a couple of things.

We have taken important steps administratively to add a lot of light to what students can access through the College Scorecard, and now students can go and look up an institution and then go down to the field of study or program, find out what it is going to cost to attend that program and complete, and then, importantly, what their first year earning potential is after that.

They can compare between schools. They can compare programs within schools. And this is going to, I think, help them be more discerning prospectively. I also think it is going to help schools look more critically at what they are offering and what the realities are of what they are offering. Perhaps it is going to make some changes—prompt some changes at higher ed institutions, and that is one way, bringing light to what has been a very murky kind of reality. And so that is one way we have taken a step.

Another way, we have put the FAFSA form on the myStudentAid mobile app. We are continuing to add more and more information for students to model what their debt and what their student loan debt would mean and how they could pay off and have real-time information for that right on their app. And we are going to be continuing to add more and more to give them more tools for financial literacy.

Mr. MOOLENAAR. Thank you. And thank you, Madam Chair.

Ms. DELAURO. Let me just say—I beg the indulgence of the subcommittee because I would like to address, Congressman Moolenaar, your comments, if I can. And I have a great deal of respect for you and your work on this subcommittee.

REPORTING FROM THE DEPARTMENT

I think what you are hearing is a level of frustration about very, very important issues and the two issues that have been addressed in a strong way when we cannot get reports. We are an appropriations committee. We put in a bill that required the Department of Education to get us reports on the data with regard to babies being expelled from preschool. We don't have that report, nor was there an answer as to when we would get that report. That is a level of frustration. You would experience that as well.

CHARTER SCHOOL MANAGEMENT

Further, with regard to charter schools, may I add that we held a hearing last year on charter schools. The OIG raised issues that we need to examine, including findings that States mismanaged charter school closures and that the Department failed to provide adequate guidance or oversight on the issue. We are the Appropriations Committee. We have appropriated serious money, more than \$400 million last year alone. We need to conduct oversight.

And so there is a level of frustration. And I might add, when you can say about charter schools that God is in his heaven, all is right

with the world, and you cannot do a serious evaluation of which ones work and which ones don't work, that means that the Department is not doing the evaluation that we need to hear about. So therein lies the frustration, Congressman Moolenaar.

Sure, please.

Mr. MOOLENAAR. Okay. No, and I completely respect that. And what I heard the Secretary say is that she will find out the information on the report and get back to the committee, and I think any Secretary deserves that courtesy to get.

CHARTER SCHOOLS

And on the charter school, I just would ask the chair to consider that charter schools, many have different missions. Some charter schools have the mission of educating adjudicated youth. And so the idea that we are going to start comparing a high-standard education with educating adjudicated youth and somehow evaluate them the same, that is a very different mission.

And so I think this committee would be well served to kind of look at the unique missions of charter schools. And where there are inappropriate—

Ms. DELAUBRO. I would also say to you that not our information, but the Office of the Inspector General at a public hearing that we had in this room last year claimed that there were serious difficulties. We have to look at that. We have to ask the Department about that.

So, again, there is—

Mr. COLE. May I, Madam Chairman?

Ms. DELAUBRO. Yes, sure.

Mr. COLE. Because we are obviously a little off topic here. And thank you for the indulgence.

Look, I have to speak up in defense of my member. I think Mr. Moolenaar was right to say what he said.

Ms. DELAUBRO. I don't have a problem with that.

TONE IN ADDRESSING WITNESS

Mr. COLE. And I have zero problem because I agree with my friend Ms. Lee. We asked for a report, and we ought to get it. Nothing wrong with that. And we have some tough questions about charter schools. Nothing wrong with that.

But anybody thinks the tone was appropriate toward the Secretary, it was not. And that, you know, we had a lot of people in 4 years that came before this when I was the chairman of this committee that I didn't agree with from the other administration. I don't think I ever addressed anybody the way I heard the Secretary addressed here, ever.

Ms. DELAUBRO. Well—

Mr. COLE. And I don't think any of my members ever did. So that, I think, is a legitimate point, and that is what I think there is concern about. Not the points—

Ms. DELAUBRO. Well, there—as I say, that is a result of the frustration that people are feeling here. And quite frankly, to my friend, there have been members of your side of the aisle who have addressed folks who have come before this committee with a very big lack of respect. That doesn't say that it is right, but what we

want to do is to get through the frustration. We need to get answers.

We are an appropriations committee. This is a serious amount of money that we are looking at. And there are deep concerns as to the direction of public education in this country, and you know—

Mr. COLE. I will say that I agree. There are deep concerns. I respect the frustrations. They are real. That is part of legislating. But it is a little bit different in terms of how we treat our witnesses.

Ms. DELAURO. Well—

Mr. COLE. So thank you very much, Madam Chairman. I appreciate it.

Ms. DELAURO. And it applies to both sides of the aisle, as you know, as well.

Mr. COLE. It certainly does on occasion.

Ms. DELAURO. Congresswoman Bustos.

Mrs. BUSTOS. Thank you, Madam Chair.

And thank you, Madam Secretary, for being here. I promise to apply a combination of Midwest nice—

[Laughter.]

Mrs. BUSTOS [continuing]. And a little bit of my former investigative journalism background. But anyway, so interesting conversation.

YOUTH VAPING EPIDEMIC

Thank you, again, for being here.

So we are in the middle of a public health crisis, not just the coronavirus, but youth vaping. And my folks in education back home asked that I call it e-cigarettes because they think “vaping” makes it sound nicer than it is. So I will say e-cigarettes.

But the numbers that we have from the Centers for Disease Control and Prevention show that back in 2011, we had 1.5, 1 and ½ percent of our high schoolers were doing e-cigarettes. Now just last year, 2019, we are at 27.5 percent. So about a third of our high school students are now doing this. Just alarming. That is why I call it an epidemic.

At junior high, in middle school, we are now at about 10.5 percent of our middle schoolers. So I just couldn’t believe these numbers when I learned these.

We did a series of roundtable discussions in my congressional district in downstate Illinois. And the one that just really alarmed me was that we had a school resource officer said that there was third graders that were doing this. Third graders.

And you know, this is easy to hide. They can put it in watches. They can put it in clothing. They can do it on these fake jump drives. So they are doing this.

And that is why we wrote a piece of legislation out of my office called the Resources to Prevent Youth Vaping. It is part of a bill that we—a package of bills that we will be voting on on the floor tomorrow.

And so what I wanted to ask you, I promise I am bringing this totally into your Department. I am wondering if the Department of Education is coordinating with the Centers for Disease Control and Prevention to make sure that we have information that we can get

out to our parents. Make sure that we have resources that the teachers know about, that the school nurses know about, and just wondering if there is any kind of coordination going on with your Department and the Centers for Disease Control and Prevention?

Secretary DeVos. Thanks, Congresswoman, for that question.

I know that there have been participation in task forces. I would be happy to check on the extent to which those are happening and get back with you on that.

Mrs. BUSTOS. Okay. Yes, if you could work with our office and make sure that we are aware of this. I think it is really just a commitment on your part. We were just with Secretary Azar yesterday, but I think working together will just be absolutely critical to help address this.

Again, this is a public health epidemic that is impacting our students, our children. So I think that would be great.

[The information follows:]

E-CIGARETTES—COORDINATION WITH THE CDC ON PREVENTION

The Department has teamed up with the Centers for Disease Control and Prevention (CDC) in working groups, in coordination with the Office, of National Drug Control Policy (ONDCP), that have addressed drug prevention as a whole, including vaping as part of the discussion. For example last year ONDCP's Prevention Inter-agency Working Group (IWG) developed a Substance Use Prevention Resource Guide for School Staff (available at <https://www.whitehouse.gov/ondcp/additional-links-resources/resource-guide-for-school-staff/>). The website has links to Federal resources and information that include tobacco and vaping. The Federal agencies that participated in the IWG included, in addition to the Department of Education (Office of Elementary and Secondary Education), the CDC (Division of Adolescent and School Health) and the ONDCP, the Department of Health and Human Services' (HHS) Office of Adolescent Health; HHS' Substance Abuse Mental Health Services Administration's (SAMHSA), Center for Substance Abuse and Prevention; and the Drug Enforcement of Administration.

TEACHER SHORTAGE

Switching gears, the other issue. I liked that Lois Frankel was saying I am guessing you are going to ask something about Illinois because I like to—I stay pretty focused on my own congressional district. Really, really severe teacher shortage that is happening all over the country.

In the congressional district that I represent, we are 14 counties, and we have seen the teacher shortage problem actually increase over the last year, actually increase by about 20 percent that we are seeing now. So in 2019, there were 195 teacher vacancies in these 14 counties that I represent. Now there are 235. That is just over the last year. So this problem is getting worse, not better.

PROPOSED CUTS TO ELEMENTARY AND SECONDARY EDUCATION

So I know in the President's budget, just a few things I want to point out for the record that are concerning to me. The Public Service Loan Forgiveness Fund has a proposed cut of \$50 million. Teacher Quality Partnership Grant Program has a cut, proposed cut of \$50 million.

The funding of the Supporting Effective Educator Development Grant, proposed cut of \$80,000,000. Supporting Effective Instruction State Grants cut of \$2.1 billion.

Secretary DeVos. Can I just interject?

Mrs. BUSTOS. Please.

Secretary DEVOS. Because a number of the programs that you have cited are actually the ones that we have proposed to include in the block grant and would actually be very appropriate in your case and in your district. If there is a drastic shortage, the district could—the districts could target more of those resources and have the flexibility to use more of them for programs that would address the teacher shortage issue, teacher retention, teacher development and, in fact, give them a lot more flexibility than the current scenario.

Mrs. BUSTOS. So talk me through then, if you could in the 17 seconds we have left, talk me through about how specifically. So you got the block grant proposal. This is a mostly rural district I represent, 7,000 square miles, again a lot of smaller schools. How will these block grants help specifically recruit, retain, and fill all of these vacancies in a very, very rural congressional district?

Secretary DEVOS. Well, what it would do is allow for the districts to prioritize what portions of these 29 different programs would be most effective and most important for the needs in their district to meet the needs of the most disadvantaged students. And it would allow them, again, to personalize and prioritize where those needs lie more specifically than the approach of having 29 different programs, all with their own rules, all with their own regulations. These would be block granted to the State, and then 90 percent of them would go out directly to the districts under the Title I accountability and formula so all of the accountability provision is there, but much more flexibility for every district to be able to target the resources where they need the most.

Mrs. BUSTOS. I will yield back the time that I don't have left.

Thank you. [Laughter.]

Ms. DELAUBRO. I thank the gentlelady. Congresswoman Herrera Beutler.

SECLUSION AND RESTRAINT IN SPECIAL EDUCATION

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

Thank you, Madam Secretary, for being here.

The first thing I wanted to mention, and we talked about this a little bit. I have a few questions. So I am going to try and bang on through them. The practice of seclusion and restraint, we have talked about this before, of special ed students I think is extremely detrimental to these young people, and the stories I have heard are—they are horrific.

What is the administration doing to stop the practice and ensure that all students are treated with respect?

Secretary DEVOS. Thanks, Congresswoman.

As we have talked about, we have an initiative going proactively through all 12 of our regional Office for Civil Rights offices to bring light to this subject, to ensure that schools and districts and States know what their responsibilities are, what the law is, and to really make sure that they are doing right on behalf of kids.

And so this was a prospective initiative, conducting audits and also conducting a lot of proactive informational sessions to ensure that schools know what they should be doing or not doing.

Ms. HERRERA BEUTLER. One of the—and some of it, as I hear, it is a lack of reporting. Is there any enforcement mechanism to say so you have been doing the education and they should, a lot of them should know by now what the rules are around this. What type of enforcement mechanisms do you have, or do you not have any? What should we be doing to make sure that schools are adhering?

Secretary DEVOS. Well, where there are infringements on students' rights and requests for investigation, we are doing—we are investigating. And I think that is where the important piece comes, on the follow-up.

But we think and we hope that, again, proactively taking this initiative and bringing more light to this subject is going to bring about laudable results in terms of reporting and in terms of actual activity and action.

MENTAL HEALTH RESOURCES

Ms. HERRERA BEUTLER. Thank you.

One of the things I hear a lot about from educators at home in Southwest Washington is lack of resources to address mental health needs. This is probably the top issue I hear about. It is actually more I hear about the mental and emotional health of the students more than I hear about math achievement and reading achievement. I mean, it is ground zero. These educators are doing everything they can, but these kids are coming in with a whole set of challenges that generations before them seem to have navigated or navigated differently.

Who knows, right? I don't know why they are at where they are now. We are trying to figure that out. But these kids are, a lot of them are in real distress. What is or can the Department do to help? I mean, this is not in anybody's scope, right? This is not in our scope of practice, but this is the reality of where the kids are at right now.

Secretary DEVOS. A couple of things I would say. First of all, I think our proposal to block grant to the States and then, ultimately, the local districts all of these different programmatic funds would allow each district to address this issue in the way that they prioritize. And if this is, indeed, the most important issue for their most vulnerable students, that would allow them the flexibility to tap into more of those—a higher percentage of those resources than otherwise through the formula or through the programmatic approach.

Ms. HERRERA BEUTLER. So they would be able to maybe hire like an in-school mental health counselor, for example?

Secretary DEVOS. If that is what they thought would be—

Ms. HERRERA BEUTLER. I have heard—I have asked—I have heard requests for that, or SROs, and some of our funds are flexible, and some of them just aren't. Or if they are using money for this, they can't then use it for this is what is the feedback.

Secretary DEVOS. And that is why I think the block grant proposal is really sort of transformative in that way because it would allow for all of the uses of those programs, but for them to prioritize the dollars in a way that is going to really meet the needs of the most disadvantaged kids in their district.

Ms. HERRERA BEUTLER. And I got to believe there would be an—is there an administrative savings? I think one of the problems we have is we send everybody's tax dollars back to D.C. and headquarters, and headquarters skims it off—and this is in every department. Skims off the top and then sends back a lesser amount.

Secretary DEVOS. Well, there are—yes, I think, ultimately, there would be. And I think, importantly, that flexibility at the State and local level would really allow those closest to the students to target those resources in the ways that are going to be most meaningful for the kids that they seek to serve.

CAREER AND TECHNICAL EDUCATION

Ms. HERRERA BEUTLER. Okay. With my last 20 seconds, I am a big supporter of the Running Start programs, would like to see the Department support them. In addition, I just wanted to say thank you for the increase in the focus on career and technical education. We should not sell students down the river that you have to go to a 4-year liberal arts school, and that is what success is.

Because we all know if you live at all in life, that is not the only definition of success. In fact, I know a lot of people who are happy and fulfilled have good, living-wage jobs with full benefits and are able to provide for their families on a career and technical type of education tracks. So thank you for the emphasis on that.

Secretary DEVOS. Well, the President and myself and this administration are really committed to advancing that and supporting multiple pathways for adult success.

Ms. HERRERA BEUTLER. Thank you. Yield back.

Ms. DELAURO. Congresswoman Clark.

PRESCHOOL DISCIPLINE AND RACIAL BIAS

Ms. CLARK. Thank you, Madam Chair, and thank you, Secretary DeVos, for being with us today.

I want to go back to a topic explored by my colleague Congresswoman Lee. Do you think that the disparity in discipline for preschoolers of color could indicate a racial bias?

Secretary DEVOS. I suppose it certainly could, and again, I think the bigger issue here is that we make sure that every child has the opportunity to pursue an education that is going to unlock and unleash their personal and fullest potential.

Ms. CLARK. Okay. Isn't it, however, the official policy now of the Department of Education that the cause of these disparate rates of discipline that we see with students of color is explained by the fact that these children are just inherently predisposed to misbehave and disrupt the classroom more than White children? Isn't that your policy?

Secretary DEVOS. No. No, it is not.

Ms. CLARK. That is the conclusion of the research you cited in your school safety report of 2019. Congress specifically asked you to strike all references to this report, which interestingly appeared in the Journal of Criminal Justice.

Your official response within this budget is that you stand by this report and its conclusions. Isn't that right?

Secretary DEVOS. Congresswoman, do you have a question about the budget?

Ms. CLARK. Yes.

Secretary DEVOS. Because we are here—we are here to talk about the budget.

Ms. CLARK. That you did say in your fiscal year 2021 budget, you responded that “Department of Education stands by this report” that says children of color are just more inherently inclined to misbehave, and that explains the disparate rates of discipline.

Secretary DEVOS. I don’t know where that would have fallen in our budget narrative. I would—

Ms. CLARK. We will get you the exact section because it is—

Secretary DEVOS. I would be interested in that.

Ms. CLARK [continuing]. Right in your budget. And in fact, I don’t see any other way to interpret this as your new policy because then you went on and eliminated the data collection that could help us solve this problem because you don’t see a problem because you have adopted as the policy that this is just a race-based problem. That these kids are inherently—

Secretary DEVOS. In fact, Congresswoman, the CRDC question—the data collection questions are open for public comment now. They have not been concluded, and if you do have—

Ms. CLARK. But this is what you proposed, to no longer collect—

Secretary DEVOS. If you do have input, we would be very happy to take that.

Ms. CLARK. We certainly would like you to go ahead, undo what you put in your budget, strike this racist research, make sure it is crystal clear that you do not buy into this theory that children of color are disciplined because of who they are and that they come to school with disruptive tendencies. That is what you put in your official report. In your budget, you say you stand by it.

Let us move on. I want to give you a chance to correct the record. Because I think we have had some testy exchanges in the past. And in 2018, you agreed that private and religious schools receiving Federal funding would have to have nondiscrimination policies.

But I think I browbeat you into that answer. Is there any requirement that private and religious schools must have non-discrimination policies under your EFS voucher program?

EDUCATION FREEDOM SCHOLARSHIPS

Secretary DEVOS. The Education Freedom Scholarship program, first of all, is a tax credit. They are not Federal funds—

Ms. CLARK. Is there any nondiscrimination? I did not see it in your budget proposal.

Secretary DEVOS. And—and the reality is that every student that would take advantage of an Education Freedom Scholarship would be protected. Their civil rights are protected, and that is true of students no matter where they are, in whatever school.

Ms. CLARK. But I am correct that you do not have that non-discrimination requirement in your budget proposal?

Secretary DEVOS. The budget proposal is part of Treasury’s budget, and it is only mentioned in our budget.

Ms. CLARK. But you agreed that it would, but it is not there.

In September, you visited a religious school in Harrisburg that as a private religious institution, it is certainly allowed to do what

they do. They have policies that transgender children can be expelled or denied admission based on that status. They also have different tuition rates depending on the religion of the children.

My question to you is if Pennsylvania adopted your scholarship program, your voucher program, would this school be eligible for Federal funding with these policies in place? If approved—

Secretary DEVOS. Ma'am, I need to correct you on the nature of the Education Freedom Scholarship proposal. It is a Federal tax credit that would be the recipient of voluntary—

Ms. CLARK. Are you saying that Federal taxes—

Secretary DEVOS. Can I finish? Can I finish?

Ms. CLARK. I just want to—we are out of time. So I just want to be clear that—

Secretary DEVOS. Well, and I want to make sure that you have full understanding of what the proposal is. A Federal tax credit—

Ms. CLARK. I understand tax credits are Federal funding.

Secretary DEVOS. No, they are not.

Ms. CLARK. Yes, they are.

Secretary DEVOS. Because they are voluntary contributions in advance of paying your taxes to the Federal Government.

Ms. CLARK. That would be a—

Secretary DEVOS. They are direct contributions to 501(c)(3) charitable organizations, as designated by States that choose to participate.

Ms. CLARK. We are out of time, and I am going to leave you with this. You said in your testimony you wanted to expand educational freedom for students. I certainly hope that making these inherently discriminatory policies part of the Department of Education is not what you meant by that statement.

Secretary DEVOS. We don't discriminate against anyone at any time.

Ms. DELAURO. Congresswoman Frankel.

Ms. FRANKEL. I am going to follow up. Thank you for being here. Appreciate it.

TAX CREDITS AND EDUCATION FREEDOM

I want to follow up on these voucher questions. So I was trying to just calculate in my head because, for me, I think this is a program for wealthy people to get free private school. Because my understanding of a tax credit is you actually—if you owe \$10,000 in taxes and under your scenario, and you pay, let us say, \$10,000 for private school, then you owe no taxes. Is that right?

Secretary DEVOS. No, Congresswoman, can I just interject?

Ms. FRANKEL. Yes, please.

Secretary DEVOS. Because that is—

Ms. FRANKEL. Okay, explain it to me.

Secretary DEVOS. That is absolutely a misunderstanding of the proposal.

Ms. FRANKEL. Okay. Well, just explain so we know.

Secretary DEVOS. The proposal is voluntary contributions from individuals or businesses to 501(c)(3) scholarship-granting organizations that would then give scholarships to families, as defined by the State that decides to participate. And in most States where there are education freedom school choice programs, they are

geared and targeted to primarily low-income families, many times also students with disabilities, and they are programs for students who are most vulnerable and most disadvantaged.

And so it would be individuals who choose to help other students and other families who would voluntarily make those contributions. It is not a program for people of wealth.

Ms. FRANKEL. Okay.

Secretary DEVOS. People of wealth already have choices.

Ms. FRANKEL. Correct.

Secretary DEVOS. People of wealth already—people of power already have choices. All of these policies are designated for and are targeted toward individuals and families who don't have that power, who are assigned to schools that are not working for them.

Ms. FRANKEL. Okay. I want to reclaim my time to follow up on Representative Clark's question.

Is there anything in your proposal that requires nondiscrimination? So, for example, can they—can somebody keep a gay student out, or can they discriminate on the basis of religion? Or—or—

Secretary DEVOS. The key with school choice and education freedom is families and students voluntarily choose the place that works and fits for them.

Ms. FRANKEL. So, okay. All right. I just want to understand this. So they can choose to go to a school that only allows a certain religion or a certain gender or a certain race? Is that correct?

Secretary DEVOS. Many schools have unique missions.

Ms. FRANKEL. Is that the answer?

Secretary DEVOS. Different missions.

Ms. FRANKEL. The answer is yes. Thank you. I answered it for you.

TITLE IX

Okay. So I have another question. I think coming out soon is a new rule in reference to Title IX on sexual harassment and violence in colleges. Is that rule going to be published soon?

Secretary DEVOS. I expect it will be soon, yes.

Ms. FRANKEL. So I think you probably know that there is a lot of concern from folks about what this is going to mean. Because all the statistics so forth show that there is still a lot of sexual violence on campuses, and there is a lot of concern that your new rule is going to actually discourage victims from coming forward.

There is one particular point that I do want to ask you about, and maybe you can just clarify it because I cannot—I don't understand it. I read that rule. It is so long.

Under the proposed rule, alleged harassment must occur within the school's own program or activity. So my question is whether or not that would cover off-campus, for example, frat houses. Would it pertain to online sexual harassment?

Secretary DEVOS. Well, ma'am, because the rule is not yet finalized nor published, I can't comment on it. It would not be appropriate to comment, and it would not be appropriate to—yes, you are going to ask a first question, and then you are going to ask another. It is not appropriate to comment. The rule is not yet final.

Ms. FRANKEL. So is the rule, as you understand proposed, as it is proposed, is it going to cover, for example, a sexual assault at a frat house that is off campus or online harassment and bullying?

Secretary DEVOS. Again, I cannot comment on the specifics of the rule.

CORONAVIRUS AND SCHOOL CLOSURES

Ms. FRANKEL. All right. Well, that is really sad.

Okay. My final question is we just read that Japan is closing all its schools because of the coronavirus. So I would like to know what plans you are making in regards to coronavirus?

Secretary DEVOS. Good question. I have convened a task force within the Department and have asked my Deputy Secretary Mick Zais to head that task force to ensure we have our continuance policies and every plan in place for work in and through the Department. And we continue to work with the other agencies across Government to ensure that we are prepared to respond and react and do as we should, depending on—

Ms. FRANKEL. Okay, and thank you. I am happy to hear that you are doing that. I just hope that you will keep us informed.

And I yield back.

Ms. DELAURO. Congresswoman Watson Coleman. I can have Congresswoman Lowey go first for this first round if that would—is that what you want to do?

Mrs. WATSON COLEMAN. Actually, I would. If you—yes, I just need a moment.

Ms. DELAURO. Congresswoman Lowey.

FULL-SERVICE COMMUNITY SCHOOLS

Mrs. LOWEY. Thank you.

I mentioned the Full-Service Community Schools before. I think that they are so critical to bringing together health, social support, family-community engagement, early childhood development opportunities to really help students and their families thrive.

Yet you propose eliminating dozens of K through 12 programs, including community schools. We came together on a bipartisan basis in this Congress to authorize the Full-Service Community School program in 2015 because we know its value in the districts.

First of all, I would like to know have you ever visited a full-service community school.

BLOCK GRANT PROPOSAL

Secretary DEVOS. I visited many schools. Maybe one of them has been termed that. But Congresswoman—or Chairwoman, if I could just say it is inaccurate to say that we have proposed eliminating these programs. We have proposed rolling them all up into a block grant.

And I think your example of the school that you have cited and admire is exactly why we should consider the block grant proposal. Because it would allow schools and districts in your State to actually expand on those and target those resources in that direction if that is the right answer for the students in that district or in that region.

It would give a lot more flexibility to States and communities not eliminating anything, but putting it in one big pool—

Mrs. LOWEY. With less money.

Secretary DEVOS. Well, the request—the request is at the level that it is. You are the appropriators. You will decide at what level to fund.

Mrs. LOWEY. Not that level.

Secretary DEVOS. I think the important—I think the important thing is the policy here, and the proposal—the policy proposal is to put all of those programs together in one block grant that would then allow the most local level, those closest to the students, to target the resources to meet the needs of the kids that are most vulnerable in that school district in a way that is going to uniquely meet their needs.

Mrs. LOWEY. However, you are decreasing the amount of money in the pot so that you are making schools really compete against each other for these dollars. So I am hoping as we go through the budget we will increase those dollars so we can sustain programs like this.

And I think you would be interested in visiting one of those schools. I would be happy to give you a tour if you come up to Westchester.

Secretary DEVOS. Thank you.

AFTER SCHOOL PROGRAMS

Mrs. LOWEY. Now after school program. Your budget eliminates funding for after school programs?

Secretary DEVOS. No, it includes it in the block grant.

Mrs. LOWEY. So, oh, you are decreasing the pot of money and putting everything—

Secretary DEVOS. Putting it all into a block grant to allow for flexibility at the local school district level.

Mrs. LOWEY. But if you are cutting the budget, you are cutting the budget.

Secretary DEVOS. Well, again, you are the appropriators. So you decide at what level to fund it. But I think the important thing is the proposal to put all of them together in a block grant and allow for States and local districts to make decisions on which—

Mrs. LOWEY. Okay—

Secretary DEVOS [continuing]. What programs are most effective and what is going to work best to meet the needs of the most vulnerable students in that district.

Mrs. LOWEY. With less money. I get it.

But let me just say this because I think it is important, and you probably know it. The amount of Federal funds going to districts is usually about 10 percent. I don't know if it is—

Secretary DEVOS. It is actually—it is actually less than 5 percent.

Mrs. LOWEY. Less. Probably about 9 percent of the budget.

Secretary DEVOS. It is less than 5.

Mrs. LOWEY. And you are saying putting all these programs in a pot, decreasing the funds, everything is going to be fine. But I think that is where we have a real disagreement. And you are saying we are the appropriators, but if you are the Secretary of Edu-

cation, your opinion is valued. And it disappoints me that you would take all these good programs, say put them in a pot, and then, okay, decrease the dollars.

But we will move on because it is almost completed. Did anyone ask this one? Okay. [Laughter.]

I am sorry. There are a couple of hearings going on.

Secretary DEVOS. I understand. I think I was in the hold room in the other one.

CHILD CARE ON CAMPUS

Mrs. LOWEY. Yes, okay. Now another favorite program of mine, maybe this is in the pot, too, but I think it is really worth your seeing, is the CCAMPIS program. More than one in five college students is a parent.

For those with a young child, accessing childcare on campus can really make all the difference, and the struggle to get good childcare is reality, frankly, for a growing number of college students. Not every college campus—I have to get to the question. Oh, yes. Sorry about that.

What do you think? Are you aware of the value of—

Secretary DEVOS. I am aware of it, and I know what our budget proposal has advanced. But I also know that the Health and Human Services budget really contains the increased funding around childcare. This is certainly a priority of the administration, and we believe that those programs through HHS would definitely be able to meet the needs of the program that you have cited as well.

Mrs. LOWEY. Well, I am out of time. But let me just say if the \$3 million cut you have proposed were to take place, programs like this would disappear because the locals have the major responsibility, and our work is invaluable and our money is invaluable in supporting their efforts.

Oh, that is 30—did I say that? A \$38 million cut.

But thank you so much.

Secretary DEVOS. Like I said, HHS has the bulk of the childcare budget proposal funds, and that is where—that is where the administration has put the priority around childcare.

And let me just say, if you are going back to the Transportation, I like the color to look at in Transportation better than here, just a little aside. It is a really pretty green on the wall.

Ms. DELAURO. We will take it into consideration and put some pictures up.

Mrs. LOWEY. I was so busy focusing on the issues that I didn't notice the color.

Ms. DELAURO. Congresswoman Watson Coleman.

DISCIPLINE AND RACIAL BIAS

Mrs. WATSON COLEMAN. Thank you very much, Madam Chairman.

And thank you, Secretary DeVos.

I am going to ask you a couple of questions regarding the reduction in the investment in our children under your proposed budget. I am really concerned about the achievement gap, as well as you are, and I just maybe don't agree with our approach to it.

The achievement gap that you talk about exists, I think, in part because schools lack equitable discipline guidance in addition to other resources. And students of color are disproportionately targeted for discipline and kept out of school, which prevents their learning.

Further, there is a gross lack of accountability from your Department in ensuring that the school districts across the country live up to their missions.

Let us talk first about the discipline piece. Just this week, a 6-year-old girl in Florida was arrested and taken from her school, even though school officials maintain they did not want the girl arrested. This is an all too common issue for our Black children.

According to the Civil Rights Data Collection, Black K through 12 students are nearly four times as White kids to receive out-of-school suspensions. Black students are nearly twice as likely to be expelled from school without education services, compared to their White counterparts.

This data is disconcerting because students who were suspended or expelled for a disciplinary violation were almost three times as likely to be in contact with the juvenile justice system in the next year.

How do we reconcile this disparity with the percentage of population black students represent get the percentage of discipline? And given that you have rescinded the guidance that was intended to give to schools to break the school-to-prison pipeline—I hope that is what it was intended for—what are your plans to ensure that schools are a safe and welcoming environment that don't necessarily punish or discriminate children?

Bottom line is what kind of resources do you envision providing through your request to schools to address this issue?

Secretary DeVos. So, Congresswoman, thank you for that question, and you have cited up at the top your concern about the achievement gap, and I share that concern and have shared that concern for the three-plus decades that I have been working to change policy to free up children who haven't been able to achieve because of being stuck in a school that doesn't work for them.

And I think you may have misstated when you said you don't agree. You don't agree with our approach, meaning your approach. I, too, don't agree with your approach with continuing to do the same thing with more and more resources and expect a different result.

That is why our proposal has suggested taking all of—virtually all of the elementary and secondary education funding from the Federal level and block granting it to the States. And then they, in formula to the local districts, to allow for the greatest amount of flexibility to directly address the needs of the students in that district and in that school. And I think this is an important—

Mrs. WATSON COLEMAN. Excuse me. Excuse me. Did that include alternatives to public options?

Secretary DeVos. No. This would be the funding from the Federal Government for all of the elementary and secondary education programs, and it would be granted to the States and formulaed out under the Title I formulation. So 90-plus percent of it going to local districts.

But it would allow the local districts the kind of flexibility they don't have today. It would free up tons of hours, literally 225 years of time, in complying with and writing reports and would allow them to target those resources directly to the kids who need it most.

ESED BLOCK GRANT

Mrs. WATSON COLEMAN. Well, I certainly agree that teachers are required to do a lot of paperwork that just takes time away from their teaching.

I want to talk to you about something else that concerns me in the budget, which I think is a reflection of our values or your values or the President's values. The budget eliminates 41 programs and cuts a number of other—

Secretary DEVOS. No. No, no, it doesn't. It takes them all and puts them into the block grant and allows flexibility at the State and local level. So it is not eliminating them.

Mrs. WATSON COLEMAN. So it is—

Secretary DEVOS. Twenty-nine of them.

Mrs. WATSON COLEMAN. It is putting more programs in one box with a limited amount of money, asking them to already compete with one another for—

Secretary DEVOS. No. So they wouldn't be—

Mrs. WATSON COLEMAN. Are you putting more money in the block grant?

Secretary DEVOS. They wouldn't be competing. They wouldn't be competing. They are formula granted out, 90 percent of the funds.

TRIO AND GEAR UP

Mrs. WATSON COLEMAN. Let us talk about the TRIO program. Talk to me about the TRIO program. Oh, all right. I am sorry. I can't hear you.

Ms. DELAUBRE. No, no. I was going to say the question was TRIO and getting a quick answer.

Secretary DEVOS. Sure. We have proposed—we have proposed combining the TRIO and GEAR UP functions in the TRIO program. And again, coupled with the flexibility that the block grant for the other 29 programs would afford State and local districts, if there is more desired to be spent in the area of what the TRIO programs are doing, it would allow, again, more personalization for the students that are closest, for those closest to the students in each school district.

Mrs. WATSON COLEMAN. All right. I seek unanimous consent to enter some testimony from our students in the TRIO program, which has been so vitally important, which I think is not getting the appropriate attention that it should.

Thank you, Madam Secretary.

Ms. DELAUBRE. I think in a bipartisan way, there is agreement on your comment, and we will, so ordered, put the information into the record.

Ms. DELAUBRE. We are going to do another round, but it is 2 minutes so that we can move quickly.

I just might add if you have not seen the video of the 6-year-old child being put in handcuffs, pleading, pleading for not to have

handcuffs. That is just a visual of what my colleagues are talking about, which is what is happening to particularly African-American kids and kids of color in preschool. Sobbing not to be put in handcuffs at 6 years old. Anyway.

ACCREDITING COUNCIL FOR INDEPENDENT COLLEGES AND SCHOOLS

A quick question. The Accrediting Council for Independent Colleges and Schools, ACICS, lost its accreditation 2016, demonstrated extraordinary lack of compliance, weak record in monitoring enforcement, standards below the Department's requirements.

2018, you reinstated it. It is in financial peril, lost its former accredited institutions, not recognized by the Council for Higher Education, uncovered by USA Today that ACICS accredited Reagan National University, an institution, no campus, no staff, students, or alumni.

What is the Department doing to ensure that students are not being duped by deceitful, for-profit colleges accredited by an agency that you reinstated? Will you consider reversing your decision to reinstate?

Secretary DeVos. Well, Chairwoman, I was troubled by reading that piece as well and have directed that an investigation ensue to see what is going on there. I was—I was not happy to read that.

Ms. DELAURO. So you would be willing to—

Secretary DEVOS. We have an investigation launched, and we are on it.

Ms. DELAURO. Okay. And decision to reinstate, I thank you for you that.

I tell you what I am going to do. I will yield back. Mr. Cole, go ahead.

Mr. COLE. Thank you very much. I know we have got just a little time here.

So just quickly, Madam Secretary, information—I had some questions on charter schools. I would like to submit them for the record. You made your position very clear, and I appreciate that very much, and your record is well known. But I do have some concerns on just what would happen to the money that we have drawn so far.

STUDENT LOAN CRISIS

Second area that—and I have enormous sympathy with you in terms of this whole student loan problem and commend you, honestly, for trying to think through different ways to deal with that. In full disclosure, I was not very happy when we moved away from the loan guarantee approach. It sort of kept this out of your bailiwick, and we have really saddled you with an enormous problem, an under resourced problem, frankly, for a number of years.

Again, as I said in my earlier comments, I am not sure we really have the power to do much here. I mean, it is really an authorizing function, I think, for the most part. But I am very curious about what you are doing now to try and combat this. I know you are doing some technology things. So I would like to know what those are.

And again, if you would like to expound longer term as to what you think the ideal solution would be. Because we sort of put the

Federal Government on the hook in a way that I don't think we ever should have in terms of this, and we have turned this into an extraordinary political issue that presidential candidates kick around. And I would like to get the Department out of the middle of this crossfire if there is some way to do it going forward.

So your thoughts would be most welcome.

Secretary DEVOS. Sure. Well, as I mentioned earlier, I mean, it is a very large and complex issue. And I think we spend a lot of time talking about the loans and the debt that students are taking on, not quite as much time challenging why the cost of higher education continues to skyrocket.

And you know, there is a lot of theory around that, but our budget proposal does suggest capping off the amount that graduate students can take out in student loans through the Federal Government and capping out the amount, importantly, that parents can take. We know that there have been all too many parents that have taken out loans greater than they are able to really afford, and Social Security being garnished as a result.

But graduate students, we have over—yes.

Mr. COLE. Thank you. I am again out of time.

Thank you, Madam Chairman.

Ms. DELAURO. We can continue the conversation.

Congresswoman Lee.

Ms. LEE. Thank you very much.

First, to my colleagues on the other side, let me just say this to you, and I appreciate your comment. But when many of us started public schools, schools were segregated. We could not go to public schools. Got it?

In 2017, we asked the Secretary to submit a report about the re-segregation of our public schools. To date, that report has not been submitted. So I cannot be nice when I ask about this because this is serious for our Black and brown students, and many of us understand the role of the Federal Government in desegregation of public schools.

SECOND CHANCE PELL GRANTS

Now, Madam Secretary, let me ask you about the budget as it relates to expanding Pell Grants for incarcerated students. You said you supported that, but I can't find in your budget request any line-item for that. Have you estimated how much it would cost, and do you plan to request funding for this?

Secretary DEVOS. Well, we have made the request to have Congress consider a permanent expansion. Because it is not a program other than a pilot through the Department currently, there isn't a specific piece of budgetary guidance to suggest with it.

Ms. LEE. So what do we need to do to get you to do that, to submit a line-item for us?

Secretary DEVOS. Well, I think Congress needs to act and make Second Chance Pell a program. It is currently—

Ms. LEE. So we have to authorize it? Okay.

Secretary DEVOS. It is currently just an experimental program through our authorities in the Department.

HISTORICALLY BLACK COLLEGES AND UNIVERSITIES

Ms. LEE. Okay. So we will work on that. Let me ask you about HBCUs because this budget doesn't increase funding for HBCUs except those that are in the opportunity zones, which leaves out about 50 percent of the HBCUs.

So let me ask you about that because we know that the President has touted his support for HBCUs, yet we see a budget that level funds our Historically Black Colleges.

Secretary DEVOS. Well, I would just say that that is definitely indication of continued support for the important role HBCUs play. And that we also—

Ms. LEE. But 50 percent won't be included in this.

Secretary DEVOS. But the level funding for the remainder of the HBCU-related programs is also an indication of the priority that we have placed on that. And then a \$150 million plus-up for HBCUs and other Minority Serving Institutions for STEM-related programs in opportunity zones, which Opportunity Zones are all across the country in rural and urban areas.

Ms. LEE. I know, and leaves out 50 percent of HBCUs.

Thank you, Madam Secretary.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you again, Madam Secretary.

And Madam Chair, without objection, I would move to include the May 2019 Harvard Kennedy School poll, EdNext poll, into the record.

Ms. DELAURO. So ordered.

EDUCATION FREEDOM SCHOLARSHIPS

Mr. HARRIS. Good. Madam Secretary, let us just clear up something about these Education Freedom Scholarships. Just like when I write a check to my church every week, it is tax deductible. I am assuming my church is using it, you know, there is something religious associated with it. So the idea of having some tax preference for someone who actually has a religious bent is not a new concept. Is that right?

Secretary DEVOS. That is correct.

Mr. HARRIS. Thank you.

Okay. Now let us talk about the May 2019 Harvard Kennedy School poll that looked at school choice and looked at tax credits and, most importantly, vouchers for low-income students. Fact of the matter is that by 49 to 41 percent, all the people they sampled approve it.

But the most interesting thing, and I am ashamed that Republicans only have 44 percent, Democrats 52 percent. But the reason why the Democrats actually prefer it more is because African-American Democrats have 70 percent approval for low-income vouchers, and Hispanic Democrats 67 percent.

Secretary DEVOS. That is right.

Mr. HARRIS. Now the fact of the matter is, is that these parents, the people who actually are most concerned with their students—with their children's education outcome actually want low-income vouchers, and I would suggest it is a soft bigotry of low expecta-

tions that somehow we are not going to provide it to them because we know better.

You know, to quote a candidate who is now the President, I have a suspicion that a lot of those parents are asking themselves the question, "What do I have to lose?"

I yield back.

Ms. DELAUR. Congressman Pocan.

Mr. POCAN. Thank you very much, Madam Chairman, and thank you again.

APPRECIATION FOR PUBLIC EDUCATION

I am going to try to channel my inner John Moolenaar, who always has grace in his demeanor. So I will try to do that. I think the difficulty is I am a product of public schools. I grew up in a lower middle class neighborhood.

Recently, we sold my mom's—my aging mom's house for about \$115,000. People like me got our opportunity to get where we got because of public education.

So I am very passionate about public education, and many of these schools, because they discriminate, as a gay kid, I wouldn't have been able to go to, or I would have been beat up. So, honestly, I take that very personal, and I think I am going to enter my—

Secretary DEVOS. May I just comment to that as well?

Mr. POCAN. Sure, please.

Secretary DEVOS. I also am very passionate about public schools. I am passionate about all schools, all schools that serve kids and that are good fits for kids. I am agnostic to what comes before schools.

RECOVERING FUNDING FROM CLOSED CHARTER SCHOOLS

Mr. POCAN. Sure. I got you. If I can just ask my question because I have the 2 minutes, less than 2 minutes, 1 minute left. What are we doing, though, to go after those tax dollars that we have lost that have gone to these failed charter schools, the ones that haven't opened or have failed? Are we doing anything to get that money back?

Secretary DEVOS. Well, again, that report has been totally debunked. There is—

Mr. POCAN. But there are failed schools. Correct?

Secretary DEVOS. It is riddled, riddled with inaccuracy.

Mr. POCAN. Sure, that is not my—this is the frustration, right? When I ask a question, don't answer a different, please, Madam Secretary.

Secretary DEVOS. It was like 1.5 percent of the total number of schools that didn't open, and I will be happy to get back with you.

Mr. POCAN. Do we go after those dollars?

Secretary DEVOS. I will be happy to look into that further and get back with you on the disposition of those.

Mr. POCAN. I accept that as an answer. Thank you very much.
[The information follows:]

**CHARTER SCHOOLS FUNDED UNDER THE CHARTER SCHOOLS PROGRAM THAT HAVE
CLOSED OR DID NOT OPEN**

As noted in a June 28, 2019 letter to Congress on the Department's administration of the Charter Schools Program (CSP), of the 5,265 charter schools that since 2001 have received CSP funding through a State entity or directly from the Department, 634 did not open and are unlikely to open in the future. In addition, the Department's data indicate that only 1.7 percent of CSP-funded schools close before their second year of operation. More information on how the CSP supports the successful opening and expansion of charter schools can be found in the June 28 letter.

FOR-PROFIT COLLEGES

A follow-up on the for-profit colleges. I know that you got rid of a program that was in the Obama administration that protected students who had these failed colleges on their loans. Eighteen States have had to sue the Department of Education about this loan forgiveness.

A Federal judge recently said we were—the Department of Education was not following that order and was fined \$100,000. I guess my question is what are we doing to collect those payments? Are we still collecting payments from defrauded students, and are we going to try to take care of those students under—

Secretary DEVOS. So every student that has filed what is called the Borrower Defense claim was put in forbearance at that time. Like when I got to my job, there was no process, and I said it is going to take a while to figure out the process. Let us make sure these students aren't incurring any more interest, aren't having to pay any more on their student loans as long as their claims are in process. And so that has been the case on all of those claims that are not yet closed.

Now we have been stymied at a couple of steps along the way by procedural rulings in court. We are still waiting for the Ninth District to rule on a methodology. But nothing pains me more than to not be able to resolve those completely.

Mr. POCAN. Great. I will follow up. Thank you.

Ms. DELAURO. Congressman Moolenaar.

ESED BLOCK GRANT

Mr. MOOLENAAR. Thank you, Madam Chair.

And again, thank you, Madam Secretary, for being here.

I want to talk with you a little bit about the block grants because I think that is an important concept that it is kind of hard to get our hands around. So if I understand what you are saying is you are taking some of the federally mandated spending programs. You are consolidating it together into a flexible spending program that States and local school districts are going to have the ability to determine.

So, for instance, if one local community said they wanted to focus on school safety, they could use those funds for that?

Secretary DEVOS. Correct.

Mr. MOOLENAAR. And if one said, hey, we think career and college counseling should be part of it, they could use it for that?

Secretary DEVOS. Correct.

Mr. MOOLENAAR. Mental health counselors, as my colleague had mentioned, you could use it for these needs that are identified kind

of on the ground where people are saying this is really what our school district needs?

Secretary DEVOS. Well, and recalling that most of these programs, and including and especially Title I, were created to really help the most disadvantaged students. And I go back to my opening statement, where I said \$1 trillion spent over the last 40 years to close the achievement gap, hasn't closed one bit. Has opened in many cases for lots of kids, particularly at the low end of the spectrum.

And so let us do something different. Let us allow for that flexibility to translate down to the local level so they can target those dollars where the students need it most.

Mr. MOOLENAAR. Thank you. And then in terms of the dollar amount, because I know whenever we are talking budgets, people are upset about different spending levels. Ultimately, your point is Congress is going to determine what spending level is in that?

Secretary DEVOS. Correct. From—yes, the administration has advanced this budget proposal. The important part, the policy part here about the block grant I think is the really important piece to consider.

Mr. MOOLENAAR. Okay. Thank you very much.

Thank you, Madam Chair.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chair.

NON-DISCRIMINATION AND EDUCATION FREEDOM SCHOLARSHIPS

To follow up, your last statement to me is we do not discriminate against children. Is that correct?

Secretary DEVOS. We uphold all of the laws of this land, and yes.

Ms. CLARK. Okay. So if we are operating on a nondiscrimination basis, which I think is the absolutely appropriate role for you to take, I hope that you will rescind on page E-8 of the Safe Schools and Citizenship Education Fiscal Year 2021 budget request where you said you stand by that racist research. I will look forward to you reversing course from that position in your budget.

And we can have a long discussion about tax credits and Treasury, and I understand tax credits. And you and I disagree, apparently, that tax credits are Federal funding. But will you, as Secretary of Education, who has just said you will not allow children to be discriminated by race, religion, transgender status, sexual orientation, will you guarantee to me, to the children of this country that however funded this program that is in your budget that is \$5 billion of taxpayer money, when it is rolled out in States, will you guarantee that every single school will have a nondiscrimination policy in order to qualify for that?

Secretary DEVOS. Well, Congresswoman, this is not proposed to be a Federal program. This is proposed to be a Federal tax credit. That doesn't—

Ms. CLARK. Will you guarantee—

Secretary DEVOS. Let me finish. The legislation is specifically for States to create programs that are going to meet the needs of the most vulnerable and needy students in their State.

Ms. CLARK. So we are right back to where we were.

Secretary DeVos. We are right back to the reality of the fact that this program is to be implemented and designed at the State level, voluntarily contributed to by Federal taxpayers.

Ms. CLARK. So I am going to be clear that you have corrected the record. When you said to me that you, as Secretary of Education, would ensure that this program would only go to schools with non-discrimination policies, that is no longer your stance. This is a State's choice that you—you will not do that as Secretary of Education.

Secretary DeVos. Ma'am, may I just suggest that you are mixing up and you are not staying clear on the purpose of this program, which is—

Ms. CLARK. I am. I am perfectly clear—

Secretary DeVos [continuing]. To help students get a great education in a place that fits for them.

[Gavel sounding.]

Ms. CLARK. And your inability to say that you would stand up for kids is appalling, and you really should resign.

Ms. DELAURO. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

EDUCATION FREEDOM SCHOLARSHIPS

I would love to have a little bit more clarification on the Opportunity Scholarship, or the Federal Freedom Opportunity Choice Program. Because I do want to make sure it is on the record very clearly whether it is a new program or whether it is Federal funding and whether there are strings attached. And actually, too, whether by somehow, you know—and I recognize it is Treasury's program—but is there some way that this is not under the laws of the land, our civil rights, our constitutional rights somehow abridged with starting this program?

Secretary DeVos. Let me respond to that directly first. No, civil rights are not abridged in any way, period.

What this does is it is not a new program to be administered at the Federal level. It is merely a vehicle to effectively and efficiently get voluntary contributions directly to scholarship-granting organizations as decided by States that choose to participate. With the idea that they are going to turn around and create one or more programs that are going to specifically address the needs of K-12 students in their State.

Ms. HERRERA BEUTLER. So no more than giving money to Planned Parenthood, which is a 501(c)(3), or your church, which is tax exempt. I mean, this is no more Federal funding than it is any money that—

Secretary DeVos. Correct.

Ms. HERRERA BEUTLER. Right? Because churches aren't federally funded, right?

Secretary DeVos. Correct.

Ms. HERRERA BEUTLER. I think there is a pretty big divide there. The other—oh, it has gone down. Is it going up or down?

DUAL ENROLLMENT AND CAREER AND TECHNICAL EDUCATION

The other thing I wanted to ask about is, are there opportunities in the Department with regard to encouraging students to partici-

pate in dual credit programs like Running Start? That is one way I think we are going to help them with their college costs.

Secretary DEVOS. Well, I think our proposal is to dramatically increase funding for career and technical education. And I think, importantly, this comes at a time when States have been writing their Perkins V plans and are about getting ready to implement it.

I have visited a lot of schools that have fledgling dual enrollment programs, many that want to have many more and expand them dramatically. I expect that that is going to continue to be a growing reality, and certainly those places that are being forward leaning and recognizing the opportunities for their students are going to get that right.

Ms. HERRERA BEUTLER. Thank you.

Ms. DELAURO. Congresswoman Frankel.

Ms. FRANKEL. Thank you.

EDUCATION FREEDOM SCHOLARSHIPS

I am going to follow up on Ms. Clark's question. First of all, I just want to say one of my colleagues compared the tax credit to a tax deduction. I think it is a big difference. I mean, you would agree with that. A tax credit is you take your certain percentage of what you owe and instead of paying it to the Federal Government, you are giving it to a private school?

Secretary DEVOS. No, you get to give it directly, effectively and efficiently—

Ms. FRANKEL. To a private school.

Secretary DEVOS. Not to a private school, to a scholarship-granting organization.

Ms. FRANKEL. Okay. Okay.

Secretary DEVOS. It is a 501(c)3().

Ms. FRANKEL. Got it.

Secretary DEVOS. A nonprofit scholarship-granting organization. And a State that chooses to participate—

Ms. FRANKEL. Exactly.

Secretary DEVOS [continuing.] Could decide to expand the career and technical education.

Ms. FRANKEL. Let me tell you something. The State of Florida, where I am from, they have been having this program and—

Secretary DEVOS. Very successfully, I might add.

Ms. FRANKEL. No, not very successfully. In fact,—in fact, I just read an article where three banks that had been contributing have now pulled out because they found that there were 156 schools in Florida that are discriminating against people who are LGBTQ.

So just here is what I am saying. We have a different philosophy. I just want to say this. It is a mistake, I believe, for you to come in here to cut \$6 billion, to ask for a cut of \$6 billion out of public education, and then at the same time, ask us or ask this Congress to set up a program so that whether it is a corporation or a person, a total of \$5 billion can now go, instead of to the Federal Government to pay taxes, to some scholarship program that they could put money into a private institution that discriminates against people.

So I think that is a mistake.

Secretary DEVOS. Ma'am, isn't education about kids?

Ms. FRANKEL. No—yes, education is about—

Secretary DEVOS. Okay.

Ms. FRANKEL. I want to tell you something. The great equalizer in life is a good public education. I want to say—

Secretary DEVOS. It is a good education, yes.

ON-CAMPUS VIOLENCE

Ms. FRANKEL. One other thing I want to say, which is this. I am very disappointed that—I want to try to say this nicely. Okay. I am very disappointed that you feigned ignorance today about a dangerous new policy about on-campus violence. I am very, very worried about that, and I really—I don't understand why you couldn't—

Secretary DEVOS. Well, ma'am, I am not ignorant about it. I told you we have not released the final rule, and it would not be appropriate for me to comment.

Ms. FRANKEL. Okay. Thank you. I yield back.

Ms. DELAUBRO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Public education is a great equalizer, and the reason the Federal Government has a role in public education was to guarantee that children were protected, that opportunities were available, that there was equality and equity of the educational delivery system. And it is not about alternatives to that system.

DISPROPORTIONATE DISCIPLINE

We have a responsibility to make that system work for all the children, and it concerns me, I asked you a question. How do you reconcile the disproportionate discipline of minority students in schools, the suspensions, et cetera? And even the arresting of a 6-year-old in schools without your questioning why that is happening.

And one other thing, Madam Secretary, any time the Federal Government puts money into one of these school districts, you can require that there be a nondiscrimination program. You have got a responsibility to require that there is not discrimination against children, whether or not they are Black, Latino, or part of the LGBTQ communities. That is your responsibility.

But you don't seem to give one good hoot about public education. Every time we talk about public education, you talk about education. And when you talk about education, you talk about the alternatives that you think work.

Well, let me tell you, one of the reasons that our children are not achieving to the extent that they are intellectually capable of doing so is because we are not putting the resources where they need to be, in the public school system. And until we can reconcile that, you all don't have any right to talk about improving the system.

I yield back.

Secretary DEVOS. Madam Chairman, could I just comment on that?

Mrs. WATSON COLEMAN. I don't need a comment because I didn't ask a question.

Ms. DELAUBRO. Congressman Cole. If you want to just try to wrap up your comments, and I will wrap up, and then we will bring this hearing to a close.

Mr. COLE. Well, it has been another eventful day at Labor-H, Madam Chair.

I want to begin, Madam Secretary, by thanking you. I want to thank you for the service that you render this country each and every day.

Secretary DeVos. Thank you.

Mr. COLE. I have known you for a long time. I agree with my friend Mr. Moolenaar. I don't know anybody that cares more about young people getting a good education than you, and you have a lifetime of commitment, service, and generosity, as does your family, to demonstrate that.

And so while we may have disagreements on particular programs, many of us up here—you and I have a couple—that doesn't diminish one whit from the enormous sacrifice and service that you and your family have given people of all races, all colors, every ethnicity, every background for many, many, many years. And I consider your service as Secretary to be an extension of that, quite frankly.

CAREER AND TECHNICAL EDUCATION

Second, I really want to applaud you on this career and technical education initiative, both the additional money for the institutions in question that you propose. I think it is a very wise investment, and I particularly appreciate you taking the lead and putting on front that we have got a lot of students that would benefit from this kind of education that can't afford what are even very modest fees, as a rule.

HIGHER EDUCATION

So your willingness to look at the Pell Grant as an extension, we all want kids that want to get college educations to have that opportunity. It is one of the reasons why I am fierce about TRIO and GEAR UP and some of these other programs. But I also recognize the vast majority of young people aren't going to go for a 4-year college. They either don't want to, or that is just not the right approach for them.

And I think sometimes we forget about them a lot, and in this proposal, I think you are actually putting the focus on folks that are too often forgotten. And you and the President are to be commended for that. Because he has been a leader, he actually took things like the apprentice program, which was a good Obama proposal, and put more money into that. This has been a very consistent theme in his tenure and in your tenure, and I appreciate that.

Finally, again, I want to continue to dialogue on a variety of programs and would love to invite you—sometime I would love for you to—I was particularly pleased with your proposal on Second Chance Pell. I have been to Tulsa Community College and seen that program. They do outstanding work. Thank you very much for mentioning them. It will surprise, delight, and thrill them no end.

But I think, more importantly, it is part of our population, again, that gets neglected and left behind. And you putting a search light on it and say let us help people that have had misfortune and

made mistakes get back on the right track in life and give them an opportunity to make a decent living. It is really a good thing.

STUDENT DEBT CRISIS

Last thing I will commit to you. I am going to wrestle with this student loan problem because I see it as real issue, and I am glad you mentioned the telling point about the cost of college as well. This isn't just a matter of the Federal Government, we have a lot of private institutions that need to think very carefully about how they counsel students and what they encourage them to do. And frankly, the advice sometimes they don't give them as to what the appropriate level of debt, if any, should be for them.

And then, finally, the administration of this. And you rightly point out, it frustrated me when I was chairman. I am sure it frustrates our chairman the amount of resources that are getting put into looking after this.

Again, my personal view is we made a big mistake when we got out of the loan guarantee business and dumped this over to the Department of Education and asked you to take on a mission that really, in my view, probably should not be your mission. So your thoughts as you grapple with this are very valuable.

Finally, Madam Chairman, I want to thank you. You are always a great working partner, and I appreciate the way that you manage our committee. And we occasionally have differences, but we very seldom have deep disagreements about the tasks in front of us.

So I look forward to working with you as we craft this budget and the other budgets that are under our jurisdiction, and I know, as always, we will find a lot more common ground than we do differences. Can't commit to vote for your first bill, if but we can come to an agreement in conference, I think we can do it again.

Thank you. Yield back.

NON-DISCRIMINATION AND EDUCATION FREEDOM SCHOLARSHIPS

Ms. DELAUR. I want to thank the gentleman. It really has been an extraordinary positive—it is a working experience, but it is a friendship. For that, I am deeply, deeply grateful because it is that friendship that allows us to get the business of the country done, and that is why we are all here. And we believe in that.

I just want to say one thing, Madam Secretary. I got a couple of items. But the couple of comments that my colleagues have made with regard to this notion that States can take—they are taking public money in whatever form, and they discriminate, that that will be up to the States.

You may not want to take on that issue, though we all believe you have that authority. But we are not going to stand by and watch States discriminate against our children in terms of proceeding to get an education.

PUERTO RICO RECOVERY

Let me mention on Puerto Rico, if I can. I want to take time to acknowledge the continued struggles of children in Puerto Rico. They have been really dealing with trying to recover from earthquakes, from all kinds of disasters, still from Hurricane Maria.

I have been told, and we will look into this, that kids are going to school in tents. I don't know if you have been or your staff has been to the island. But I would ask you to do that and to see these conditions and really to urge the administration to support the House supplemental bill. It is really imperative.

When I was there for Maria, children were afraid to go to school because if they went to school, they were fearful that when they went home, their parents would not be there. We are dealing with both education and we are dealing with mental health issues regarding these children, and I think we all believe we have a moral responsibility in this area.

BLOCK GRANT CONSOLIDATION PROPOSAL

And finally, let me just say there has been a lot of discussion about the K through 12 education program. My view, I think the view of my colleagues, is that you propose to eliminate these programs, replace them with one block grant, in your words, eliminate Federal burdens that have been and "have inhibited innovation." I am concerned, Madam Secretary, that you confused essential protections for children across all the formula programs as burden.

One of this Nation's most urgent charges is to address the achievement gap between English learners and their Native English-speaking peers. As a condition of receiving Title III, States' districts need to provide effective language instruction programs, professional development for teachers, English learners, parents, family, community engagement.

From the testimony, it appears that you look at the Elementary and Secondary Education Act, and you see a law for a formula grant that placed burden on States. However, I look at the Elementary and Secondary Education Act, I see a law full of vital protections for the most vulnerable students in our Nation's care. English learners, homeless children and youth, migrant children, children in the juvenile justice system, and the list goes on.

We need to be absolutely clear, and the Department—and you are the Department—should be straight with the Nation's parents and educators. Let them know which one of the vital protections and safeguards are going to be rolled back.

My final comment is, and the ranking member mentioned this, that maybe not your budget, but an OMB budget. But it is your job, you defend the budget. And year after year, you defend cuts and question the effectiveness of Federal investment in public education.

And this year, defending the proposal to eliminate, we can have all the words possible, but we eliminate 41 programs. Last year, we talked about the 2020 request. I asked whether, you know, your request to OMB in September included cuts to Special Olympics, and we didn't get a straight answer then.

The long and the short of it, Special Olympics is not cut this time around. But examine the cuts. What the Department and what the administration are doing with regard to them. And it is not so much, and this is where I come down. I am, quite frankly, tired of just saying \$40 million in a cut here, \$26 million in a cut there.

It is about the consequences. It is about what the effect of those cuts are on our children. And I think we both, from your perspec-

tive and from ours, have to be understanding of that opportunity to achieve your dreams and your aspirations through education are being curtailed. And in particular for the most vulnerable of our kids and kids who are in rural districts, kids who are in high-poverty areas that won't get the kind of attention that they need.

And I do believe it is a moral responsibility that we utilize all the power of the Federal Government to engage with these communities and these students. So my hope is, is that we will come forward with a bill in the education area that will meet their needs, and we can do that on a bipartisan basis.

Thank you for being here, and thank you for the work that you do on behalf of this country's children.

Secretary DeVos. Thank you, Chairwoman.

Ms. DELAUBRO. Thank you. The hearing is concluded.

TUESDAY, MARCH 3, 2020.

REDUCING CHILD POVERTY

WITNESSES

KATHRYN EDIN, PROFESSOR OF SOCIOLOGY AND PUBLIC AFFAIRS,
PRINCETON UNIVERSITY
DOLORES ACEVEDO-GARCIA, PROFESSOR OF HUMAN DEVELOPMENT
AND SOCIAL POLICY, BRANDEIS UNIVERSITY
DOUGLAS BESHAROV, PROFESSOR, UNIVERSITY OF MARYLAND'S
SCHOOL OF PUBLIC POLICY
AUTUMN BURKE, ASSEMBLYWOMAN, 62ND ASSEMBLY DISTRICT, CALI-
FORNIA STATE ASSEMBLY
MATT WEIDINGER, ROWE FELLOW, AMERICAN ENTERPRISE INSTI-
TUTE
IRWIN GARFINKEL, PROFESSOR OF CONTEMPORARY URBAN PROB-
LEMS, COLUMBIA UNIVERSITY
CHERYL BRUNSON, BROOKLAND MANOR TENANTS' ASSOCIATION, D.C.
POOR PEOPLE'S CAMPAIGN

Ms. DELAURO. The subcommittee will come to order.

Good morning, and let me welcome all of our guests. Today, we are examining child poverty in America and the immense physical toll and financial strain it puts on our young people, our families, and our Nation.

Our ranking member, Congressman Tom Cole of Oklahoma, would love to be here, but we are all doing double duty on our various committees. He is held up at the Rules Committee. So I am going to ask unanimous consent to enter his remarks into the record.

Ms. DELAURO. To frame the impact of poverty on our children, I want to mention the work of Dr. Pamela Cantor, a psychiatrist who specializes in childhood trauma. After 9/11, New York City Department of Education asked her organization, the Children's Mental Health Alliance, to assess the impact of the attack on the city's public school children. She found children were traumatized, but much more so by growing up in poverty.

Poverty was a daily attack on their well-being. So it is for millions of children across our country who go to bed hungry, wake up cold, grow up with less, and struggle in communities that provide few chances to succeed, to grow, and to make mistakes without destroying lives.

Let us remember that poverty has a pernicious impact on the development of children. It is a lifelong scar, and I know that our panelists will elaborate on this.

The subcommittee provides some of the largest sums of discretionary funds in the Congress for the well-being of children, especially those in poverty. Early childhood programs, from the Childcare Development Block Grant to Early Head Start, Head

Start, and Preschool Development Grants; education programs like Title I, Title II, GEAR UP, TRIO, and the Education for Homeless Children and Youth Program; and Labor programs that help connecting people to the training skills they need to make ends meet, such as WIOA training grants, Job Corps, and apprenticeship.

In fact, the budget for the Administration for Children and Families in the Department of Health and Human Services is larger than the entire budget for either the Department of Justice, the Department of Interior, or the Treasury Department. So measures to address child poverty are an apt and fitting topic for us to review.

In fact, this hearing is a next step in the process started by the Appropriations Committee years ago. It was in 2015 that the full committee accepted by voice vote an amendment that was introduced by our colleagues, both of whom serve on this subcommittee, Congresswoman Barbara Lee of California and Congresswoman Lucille Roybal-Allard of California.

What they wanted to have, to fund—and which is what we did on a bipartisan basis—a comprehensive, nonpartisan, National Academies of Sciences study of child poverty in the United States. The evidence-based report was to “provide its assessment of the most effective means for reducing child poverty by half in the next 10 years.”

I want to commend again. You won’t find two more committed individuals than Congresswoman Barbara Lee and Congresswoman Lucille Roybal-Allard. And I can tell you they are indefatigable. They do not give up for one second, and they have demonstrated their leadership in this regard.

The results of their leadership and this subcommittee’s investment bore fruit last year when the National Academies of Sciences, Engineering, and Medicine released their report, “A Roadmap to Reducing Child Poverty.” Because we invested in this report from HHS’s Administration for Children and Families social services and income maintenance research, it is only fitting that we see it through to actually discuss the findings and let us put the dollars to work.

The National Academies report is exhaustive and demonstrates the immense national cost of childhood poverty and outlines how we can halve child poverty in 10 years. Let me quickly run through some of the take-aways on the scale and the demographics of child poverty in America.

2015, 9.6 million children lived in poverty. That is about the size of the population of the State of Michigan, living in households with inadequate economic resources. Two-point-one million were living in deep poverty, households with grossly inadequate resources. That is about the population of New Mexico.

With regard to race, and I quote, “The poverty rates for black, 17.8 percent, and Hispanic, 21.7 percent, children were more than double those of non-Hispanic white, at 7.9 percent, children.”

The report also notes that child poverty is not an individual problem. NAS estimates that childhood poverty costs the United States between \$800,000,000,000 to \$1,100,000,000,000 annually from increased crime, worsened health, lower earnings when poor

kids become adults. That is the scale and the scope of the problem, then the solution.

As the NAS report states, and I quote, “Poverty alleviation can promote children’s development, both because of the goods and services that parents can buy for their children and because it may promote a more responsive, less stressful environment in which more positive parent-child interactions can take place.”

Study after study has shown that the first few years are essential to long-term outcomes for kids. But for our children to thrive, we have to support them at this vulnerable time of crucial development. The report does not identify a silver bullet. Instead, it measures the effectiveness of four different packages of policies.

I will note that the NAS task force, which represents the consensus in the scientific community, found that “Work requirements are at least as likely to increase as to decrease poverty.” Instead, to actually reach the goal of cutting deep poverty in half, we need to employ one of three policies—a universal child tax credit, increases in the SNAP food stamp program, or housing vouchers.

Other policies matter, like SSI, Social Security Insurance, but do not get you there. While these are not in our specific jurisdiction, they are worthy of our attention as appropriators. In particular, the task force said the single policy that would do more than any other to reduce child poverty is a universal \$2,700 child tax credit, which would single-handedly cut child poverty by a third.

To expand and strengthen the child tax credit, I am proud—and I hope this doesn’t sound self-serving, but I am proud to have introduced the American Family Act in the House of Representatives with Congresswoman Suzan DelBene of Washington.

The Family Act makes fully refundable the child tax credit and the new young child tax credit. And according to Columbia University’s Center on Poverty and Social Policy, doing so would cut child poverty nearly by 38 percent and deep child poverty in half.

Let me close so that we can turn to our witnesses. I believe today’s hearing is so important because it is vital that we delve into the problems that so many of our programs aim to solve. As we have said, the Labor-H bills makes opportunity real for families so that everyone has a better chance at a better life.

This report, our report that we secured on a bipartisan basis, identifies how much is left to do. Millions of children remain prisoners of their parents’ poverty. Not all of the policies may be in our jurisdiction, but what is in our jurisdiction, as the Congress and as the Appropriations Committee, is to be advancing policies that can help, that can help immensely, and then can help immediately.

I am reminded of the words of Bobby Kennedy, and he said, and I quote, “I believe that as long as there is plenty, poverty is evil. Government belongs wherever evil needs an adversary and there are people in distress.”

There are people in distress. There are children in distress. There is no time to delay.

I thank you very much, and now what we will do is we will proceed to the opening statements from our panelists. And let me briefly introduce our panelists.

First is Kathryn Edin, professor of sociology and public affairs at Princeton University. Next will be Cheryl Brunson of the

Brookland Manor Tenants' Association, a representative with the D.C. Poor People's Campaign. Next is Dolores Acevedo-Garcia, professor of human development and social policy at Brandeis University.

Next is Douglas Besharov, professor with the University of Maryland's School of Public Policy. Then we have Autumn Burke, assemblywoman for the 62nd Assembly District in the California State Assembly. If you don't mind, I just have to say the daughter of a Member of Congress Yvonne Brathwaite Burke, who we all remember as someone with a strong and determined effort to help people all over this country. Proud to have you here with us today.

Next is Matt Weidinger. Did I—okay. A Rowe Fellow with the American Enterprise Institute. And last, but not least, is Irwin Garfinkel, professor of contemporary urban problems at Columbia University.

I say this to all of you. Your full written testimony will be entered into the hearing record, and so you will be recognized now for 5 minutes. Kathryn.

Ms. EDIN. In the early 1990s, I traveled the country interviewing hundreds of single mothers about their survival strategies, culminating in the book "Making Ends Meet," which was published on the eve of welfare reform. But I then went on to study other topics.

However, in 2010, my work took me full circle when I came to knock on the door of the home of Ashley. She was a 19-year-old mother with a newborn. Now on that day, her hair was unkempt. She wasn't making eye contact. As she moved her baby from one shoulder to the other, she wasn't properly supporting her baby's head. And I was stunned to learn that there was no cash income coming into this household, not from work, not from welfare, or from any other source. I had encountered this situation once in my interviews in the early 1990s.

A thought occurred to me. Could it have been that in the aftermath of welfare reform, a new kind of poverty had arisen, one so deep we hadn't even thought to look for it?

At the end of that interview, we gave Ashley \$50, as we usually do. But I was worried about her and the baby, so I asked if we could come by the next day. Imagine our surprise when we found Ashley on her way out the door to search for a job. She had purchased a home perm and a used pantsuit. There was quite literally a spring in her step as she made her way down the sidewalk.

Another thought occurred to me. Could it be in that in the world's most advanced capitalist society, a mere \$50 cash could be the difference between the dispirited woman we had met the first day and the motivated job seeker we met the second?

To answer these questions, I teamed up with Luke Shaefer, an expert on the survey that best captures the income of the poor, and we documented a dramatic rise in the number of households with children living on virtually no cash income since the mid 1990s. We then replicated these results with data from the SNAP program, finding that about 1.2 million families on SNAP reported zero income in 2017, up from just a few hundred thousand in the mid 1990s.

Now for us, these numbers posed as many questions as answers. We knew we had to find other families like Ashley's and learn

more about their lives. So we followed 18 such families in 4 locations for many months and sometimes years. And from this work, we developed three hypotheses about what was behind the rise of this new form of poverty, extreme poverty.

The first was the virtual death of cash welfare. Only a small number of States, as you know, have anything resembling their pre-reform system. This program is now called TANF, and nationwide, only 20 percent of poor—sorry, 23 percent of poor families receive TANF. This is down from two-thirds in the mid 1990s. Most remarkably, when the families we followed had hit hard times, it hadn't even occurred to most of them to even knock on welfare's door.

Second, housing instability is a hallmark of life for the extreme poor. Our families' stories revealed that doubling up was what most often exposed their children to emotional, physical, and sexual harm. The number of homeless school children has doubled since the mid 2000s. We document a direct link between the decline of cash welfare and the rise of child homelessness. For every hundred fewer TANF cases within a State over a year, there are 14 more homeless students.

Third, low-wage employment has become increasingly perilous. Initially, we thought families in extreme poverty might be cut off from the world of work, but their stories were full of jobs held, lost, and searched for. Perilous work combined with unstable living situations created a toxic alchemy, which spiraled many of our families into a spell of extreme poverty.

How do families survive? Food pantry utilization has risen dramatically since the mid 1990s, but these and other private charities can't begin to cope with the scope of the need. Most families in our sample had to trade SNAP for cash, often at a steep discount, just to buy basics like socks and underwear for their kids and to keep the lights on.

Many bore a scar on the inside of their elbow from selling their blood plasma frequently. In the U.S., plasma donations have increased fourfold since the mid 1990s.

Some claim the U.S. poor are not poor. We constructed an index of deep disadvantage that combines measure of poverty, health, and intergenerational mobility. We find that average life expectancy in America's most disadvantaged places is roughly comparable to what is seen in places such as Bangladesh, North Korea, and Mongolia. And infant birth rate outcomes are similar to those in Congo, Uganda, and Botswana.

We can argue about the causes and consequences of poverty and what to do about it, but can anyone really argue that we have solved it?

Thank you.

Ms. DELAUBRE. Professor Acevedo-Garcia.

Ms. ACEVEDO-GARCIA. Good morning. Thank you, Madam Chairwoman DeLauro and members of the committee. Thank you for the opportunity to testify today.

I am a professor at Brandeis University, and I also have the honor of being a member of the committee of the National Academies that put together the report, "A Roadmap to Reducing Child Poverty." I want to thank Representative Lee and Representative

Roybal-Allard for their critical role in creating the National Academies committee.

My role today is to summarize our main findings. First of all, we found that poverty is a very serious problem for the United States. It is very serious, of course, for the children that experience poverty. It compromises their health, their learning, their development, and also their outcomes as adults, including their employment prospects and well-being.

It also costs the Nation between \$800,000,000,000 and \$1,100,000,000,000 per year. So it affects all of us.

Thirteen percent of children today live in poverty. That is 9.6 million. And 2.9 percent of children live in deep poverty. That is 2.1 million children. Just to have a sense of what families are experiencing, the threshold for poverty in 2017 was \$25,000 per year for a family of 4.

Poverty, of course, has very harmful consequences throughout the life course for any child that experiences poverty, but it has a stronger effect for some children because they are more likely to experience poverty. Particularly Hispanic children have the highest poverty rate today, about 22 percent. Black children have second-highest poverty rate, 18 percent. White children have a poverty rate of 8 percent.

Our statement of task directed us first to examine the research evidence that child poverty compromises child well-being. Our main conclusion is that the weight of the evidence is that income poverty causes negative effects on children, especially when poverty starts early in childhood or occurs during a large proportion of childhood.

The second aspect of our statement of task was to identify the major assistance programs that today help reduce child poverty. The committee concluded that poverty will be much higher without our major programs. Specifically, the EITCs, the child tax credit, and SNAP have major effects on reducing poverty, and SNAP and Social Security have major effects on reducing deep poverty.

Despite the very important poverty-reducing effects of these programs, still 13 percent of our children live in poverty today, and 2.9 live in deep poverty. So our statement of task, the core ask of it, directed us to examine programs and policies with the potential to reduce child poverty by half in 10 years. That is, we were asked to try to reduce poverty to about 6.5 percent and deep poverty to about 1.5 percent.

We examined 20 different individual policies and programs and found that none of them on its own would achieve the goal of reducing poverty by half. However, we found some promising possibilities.

One of them was to increase the EITC by 40 percent, which would reduce child poverty from 13 to 10.9 percent, but it will have modest effects on reducing deep poverty. Another very promising approach is a child allowance that my colleague Irwin Garfinkel, who was also a member of the committee, will explain during his presentation.

Because none of these individual policies achieve the goal of reducing child poverty by half, we also considered policy packages, which are combinations of policies and programs that together can

achieve the goals. We specifically identified two packages that can achieve these goals.

Package 3, which we named means-test and work package, includes expansion to the EITC, the child and dependent care tax credit, the Section 8 voucher program, and SNAP. We also identify a package, Package 4, whose core element is a cash allowance for children of \$2,700 per year per child. It has some other elements that we can discuss later, but that is the main component. These two packages not only reduce child poverty by half, but also increase employment substantially.

In sum, our main finding overall is that child poverty today is not an intractable problem. We can reduce child poverty today by 50 percent, and we know how to do it. We have two specific packages that will allow us to do that today.

Thank you.

Ms. DELAUBRO. Thank you. Mr. Besharov.

Mr. BESHAROV. Thank you. Chairman DeLauro, nice to see you again. Members of the committee, I am delighted to be here.

This is an important topic, and I was delighted to be invited to speak. I know many of the members of the committee. They have produced an impressive report, but here comes the "but." And the "but" is I think it takes too narrow a view of the causes of poverty and too narrow a view of what we should do about it.

I think it adopted that view because of the charge given to it, a combination of the legislation and HHS instructions, which said you need absolute support for the proposal before you make it. And let me explain the two examples of why the report is too narrow.

It addresses the problems of single mothers but makes no recommendations that I saw—and I am happy to be corrected—about dealing with single parenthood by itself. I was raised by a single mother. I think I sort of came out okay. But there is no doubt that being raised in a family with a single mother adds extra stresses and makes it much more difficult to be—for a child to grow and prosper.

Childcare, income support, they are only part of the answer, and I would have loved to see the report talk about more. And the report didn't because the evidence we have about single-parent programs is not as strong as giving money to people. You give money to people, and you can measure that they have more money every day. You give someone a better education, and it is extremely difficult to measure that. So my advocacy to you is when you consider implementing this report, please think about problems like single parenthood.

The other thing the report talks about, but I think had no specific recommendations is about race and discrimination. Congressman John Lewis says it is a different America today from 1960 and before. And of course, that is correct, but racial differences are still great.

This morning, I saw in the paper that the racial differences in schools, in the Boston public schools are so great that the advocates are pressing for the State to take over the entire school system of the City of Boston. I think that is a sign of the problems that go beyond putting more money into the system alone, alone here.

But we have to address these other things. I used to say this to Senator Moynihan, and he would say, "But I am in the Senate Finance Committee. I don't have jurisdiction." You have jurisdiction over some of these programs. So please, whatever you do on the rest, think about programs for single mothers. Think about programs that address the racial and ethnic differences that we have in our society because those are the things that are going to make a long-term difference for the families that we are talking about.

So let me kind of be fancy about it. This is what I wrote in my testimony. I said, "The result of the committee's approach, because of the mandate attached—" so this is nothing personal—"was to exclude recommendations of new or promising ideas that either had not been tested or, at least in their initial iteration, had not been found successful."

That was one heck of a limitation for the proposals that should be made and adopted by this committee and this Congress. And it is the equivalent of saying to Silicon Valley, come up with a plan for 10 years from now, but assume no additional scientific breakthroughs. Just use what you have on the table. Don't think about anything new. Don't think about anything fresh.

The members of the committee didn't write that, but that is what these—where these recommendations take us. And I think that will dry up energy in other areas. So in these conversations, I hope we talk about the broad range of causes of poverty.

The last thing I will say in 56 seconds is that in their proposals about expanding cash benefits, I think they minimize the problem of benefit reduction rates, which is the phase-out rate on many of these programs. Many of us on the left as well as the right think they discourage work, discourage marriage. The penalty for cohabiting parents to marry in most States is between 10 and 40 percent of their income between \$30,000 and \$50,000 of income.

We don't need that. We could fix it. We fixed it in the income tax code. We could fix it in means-tested benefits, and it would make it easier for people to marry, and they wouldn't face the same kind of penalties if they worked.

Thank you very much.

Ms. DELAUBRO. Thank you. Assemblywoman Burke.

Ms. BURKE. Thank you, Chairwoman DeLauro, the committee members, and their staff for giving me this opportunity to testify before the committee.

My name is Autumn Burke, and I am the California State Assemblywoman representing the 62nd District, an ethnically and economically diverse area of Southern California.

California is the fifth-largest economy in the world, and it has the highest rate of child poverty in the Nation. One in five children, or 1.9 million children, live in poverty, equating to almost one-third of African-American and one-third of Latino children.

Child poverty alone is estimated to cost the U.S. economy more than \$600,000,000,000 annually in lost productivity, increased healthcare costs, and higher criminal justice expenditures. High cost of living, income inequality, and the ongoing impacts of institutional and economic racism all contribute to the high poverty rates not just in our State, but across the country.

Historically, efforts to invest in measures to reduce child poverty have been hampered by a lack of sustained focus and defined holistic plan for addressing the problem. In 2017, I partnered with the Grace Institute, and with the introduction of my bill, Assembly Bill 1520, we launched an “End Child Poverty in California” campaign. And I would like to thank Congresswoman Lee for her support of that measure.

AB 1520 did away with the traditional budgetary formulations and instead embraced a whole person approach when considering the needs of those living in poverty. This, in turn, produced an innovative comprehensive framework of recommendations for the Governor and the legislature to consider with the objective to lift an estimated 1 million children out of poverty in California. AB 1520 received overwhelming support from both sides of the aisle and was signed into law by former Governor Jerry Brown.

The 2018 State report served as the foundation for additional legislative efforts that were undertaken this past year. Chief among those was the expansion of the California earned income tax credit and the creation of a young child tax credit.

Specifically, my bill, Assembly Bill 91, expanded eligible for the CalEITC by raising the maximum allowable income to \$30,000 a year. This provision dramatically broadened the number of families eligible to receive the CalEITC. The act also created a brand-new \$1,000 refundable young child tax credit for families with children under the age of 6.

The work of this task force served as a policy guidance specific to California and was the first of its kind. Since then, more work has been done, both nationally and in other States, the most significant being the 2019 report “A Roadmap to Reduce Child Poverty” by the National Academies of Sciences, Engineering, and Medicine.

The ground-breaking Federal study analyzed several poverty reduction policies and in general recommended the following programmatic changes—expanding EITC, make the child and dependent care tax credit fully refundable and concentrate those benefits on families with children under the age of 5, increase SNAP benefits, and increase housing vouchers.

While we did not make the California child and dependent care tax credit refundable, as recommended by the Federal report, our \$1,000 refundable young child tax credit largely accomplishes the same goal. These changes are expected to deliver about \$1,000,000,000 to working families or about \$600,000,000 more than it did the previous year.

As chair of the Revenue and Tax Committee for the State Assembly, I am acutely aware of the direct impact tax policy has on the lives of Californians. However, many of the existing tax benefits that the State and Federal Government provide are only available to those who file itemized tax returns.

Additionally, credits are often not refundable, which means low-income families will receive little or no benefits. It is important that any attempts to address childhood poverty be a combination of Federal and State tax policy changes and direct expenditures like increasing SNAP and housing benefits.

It must be noted, however, that the fight to end child poverty would fall short in California if it does not affect homelessness. California's homeless population has reached over 151,000 people. The vast majority on the streets are not residing in shelters. African Americans are disproportionately affected, making up 6.5 percent of our total population, but accounting for 30 percent of our homeless.

We can enact new tax policies and make additional expenditures, but we cannot stop the momentum of poverty until we make sure that every child and family has a home. That is why I have introduced Assembly Bill 2405, which would establish a right to housing for children and families in California, beginning 2026.

Housing should be a fundamental right, like education and having access to clean drinking water. If the only place you are guaranteed a roof over your head in America is a prison, we are failing as a society.

In short, I agree with the recommendations made by the National Academies of Sciences. However, there is only so much we can do at the State. If we are going to reach the goals outlined in the study, we are going to need the Federal and State governments to take much needed, coordinated action. California has expanded the EITC, and it has created the young child tax credit, and we are working to establish a right to housing.

The closer we get to eradicating child poverty, the closer we come as a nation to achieving the prosperity and equity promised to every American. An endeavor such as this requires a partnership between both Federal and State government, a partnership that transcends elections, partisanship, and term limits, and it is only this way that we can truly end child poverty.

Thank you.

Ms. DELAURO. Mr. Weidinger.

Mr. WEIDINGER. Thank you, Chairwoman.

Chairwoman DeLauro, members of the subcommittee, thanks for inviting me to testify.

My name is Matt Weidinger. I am the Rowe Fellow in poverty studies at the American Enterprise Institute. Previously, I spent over two decades working for the House Ways and Means Committee, with jurisdiction over a number of the policies and programs that are the subject of today's hearing and the NAS report.

So let me start by recognizing Representative Lee and Representative Roybal-Allard for their work leading up to the report and today's hearing. The report is a valuable resource that includes, as we have heard, a number of possible packages, but it also includes tremendous background information about these important issues and how to take a look at them and evaluate them going forward.

What I will do is try to review some important lessons from past efforts to reduce child poverty, which offer important context for the Roadmap's recommendations.

First, reducing child poverty is a goal that taxpayers have contributed significant resources towards addressing. Figure 4.5 in the Roadmap displays how annual Federal spending on children grew eight-fold in real terms between 1960 and 2010, which the report notes is many times larger than the 15 percent increase in the child population during that time.

So taxpayers contribute significant help. It may not always be as well targeted as we would like, but there is significant assistance that is being provided.

Second, as the Roadmap notes, recent efforts to reduce child poverty have focused on promoting parental work and earnings and have resulted in sharp reductions in child poverty. The shift from welfare toward work supports generally has been bipartisan and has included a number of policies designed to make work pay. Those policies include an expanded EITC, welfare reforms premised on promoting work, and increased childcare and extended eligibility for Medicaid for families making the transition to work.

Those resulted in the parents who were least likely to be working before welfare reform, having the most significant gains in work and earnings in the years immediately after the welfare reform law, which have generally been maintained. As the Roadmap notes, rising earnings and work support benefits like those, like the EITC and others, contributed to reductions in child poverty.

Here is what the report says, "Between 1993 and 2016, the supplemental poverty measure," the measure used by the report, "fell by 12.3 percentage points, dropping from 27.9 to 15.6 percent." That is a substantial 44 percent decline in child poverty, as the report measures.

A third lesson is how we measure poverty matters a lot. The official poverty measure, as the report notes, ignores a growing share of anti-poverty assistance, including EITC, other tax credits, and various other anti-poverty assistance like SNAP, in its count of who is officially poor. Since 1999, spending on benefits that are not counted, the spending that is not counted has grown 16 times as fast as the spending on benefits that are counted under the official poverty measure.

So to its credit, the report uses the supplemental poverty measure that actually takes account of all those benefits and the increased support that has been provided. Using the supplemental measure reduces the child poverty rate from 19.7 percent under the official measure to 13.0 percent in 2015. Again, a substantial drop just from using a more accurate measure of what is being provided to help low-income families. That is about 5 million children different between the official poverty measure and the supplemental poverty measure.

Fourth, the Roadmap includes, as we have heard, several different policy packages, including universal supports, means-tested supports, work-oriented benefits, and so forth. The work-oriented proposals, such as expanding the EITC and adjusting the child and dependent care tax credit, are more consistent with recent efforts to promote work and make work pay. The work-oriented package is also the only package expected to increase earnings more than it increases spending on benefits, which I would say is an important factor.

In contrast, means-tested support and universal support proposals, such as expanding SNAP and housing benefits, creating a new child allowance payable regardless of parental work, are significantly more expensive, and they also are projected to reduce somewhat employment and earnings.

The final lesson is the relative cost of all these packages matter, including for the prospects for enactment. The most expensive package would cost an estimated \$109,000,000,000 per year, and similar proposals have been made in the past decade and failed to have been enacted. The Roadmap doesn't identify potential offsets, and the current fiscal environment, as you all know, is very, very challenging, especially because senior entitlements are going to claim a rising share of the Federal budget going forward.

So this may cause policymakers looking to pursue some progress using the Roadmap's recommendations to seek the more incremental changes whose lower costs and greater consistency with recent successful work support policies could improve their chances of enactment.

Outside of the policy packages, the Roadmap also proposes more testing of efforts to promote work and strengthen families, like Dr. Besharov suggested, which would be beneficial and also would likely earn bipartisan support.

Thank you for the opportunity to testify. Happy to answer questions.

Ms. DELAUBRO. Thank you very much. Professor Garfinkel.

Mr. GARFINKEL. Good morning.

Ms. DELAUBRO. Good morning.

Mr. GARFINKEL. Chairwoman DeLauro, Ranking Member Cole—thank you—and esteemed members of this subcommittee, I was privileged to serve as a member of the National Academies of Sciences, Engineering, and Medicine's committee on building an agenda to reduce the number of children in poverty by half in 10 years.

Thank you, Representative Lee and Representative Roybal-Allard, for your critical role in creating the committee.

Professor Acevedo-Garcia has summarized the major findings of the report. I am happy to answer questions about the report, but my testimony focuses on policy and does not represent the committee. I draw on my own research on the benefits and costs of alternative income-transfer programs.

The committee found two program packages that could cut poverty in half. One relies primarily on increases in means-tested benefits, food stamps and housing subsidies, while the other relies primarily on universal and nonmeans-tested benefits, primarily child allowances or refundable tax credits. Either package would achieve a great deal of good. The child poverty reduction and fiscal cost of each package are virtually equivalent.

The universal approach is, in my judgment, vastly superior in general and specifically for child allowances. What are the benefits of universality? First, human dignity. Means-tested programs benefits stigmatize beneficiaries. If everyone, rich and poor alike, get the benefit, there can be no shame. Universality eliminates stigma.

Second, universality promotes social cohesion. Benefits limited to the poor or near poor create a sharp division between beneficiaries and taxpayers. Lower middle class families, who are just barely better off than the near poor, are resentful of poor beneficiaries. Universal programs reinforce the notion that we are all in this together.

Third, universal programs promote social cohesion by including the poor and the rich in the same programs. And fourth, and most important, universal benefits promote equal opportunity and mobility. Benefits targeted at the poor reduce benefits as income increases. Benefit reductions are equivalent to a tax on income. Means-tested benefits place higher tax rates on the poor and near poor than tax rates faced by the more affluent.

This creates what the late Tony Atkinson labeled a “poverty trap.” You can’t earn your way out of poverty or near poverty because benefits are reduced steeply as earnings increase. Universal benefits, by not eliminating benefits as earnings increase, avoid the poverty trap and promote opportunity and mobility.

In short, the benefits or virtues of universal benefits are great. What are the costs? The fiscal costs of universal benefits are generally much higher than the fiscal costs of targeted benefits.

Indeed, this is the only cost or vice of universal benefits. But as the Roadmap report clearly explains, in the case of child allowances in the U.S. today, the extra costs are small. Both the means-tested and universal packages cut poverty in half at about the same cost. Why are child allowances so cheap? Because the U.S. today nearly has a \$2,000 per child allowance.

Most families in the country get \$2,000 per year via the Federal income tax. The exception are a small group of the very richest families and a much larger group of the poorest families, those with very low or no earnings. Excluding the poorest third of families is both inequitable and unwise. The children in these families will become more productive citizens as adults earning more, paying more in taxes, less likely to commit crime, and less likely to be unhealthy.

In short, a child allowance of \$2,000 per year is a clear policy winner because it has all the virtues of universality and none of the extra cost. But increasing the child allowance beyond \$2,000 does entail all the extra costs of universality. The lower middle class, the middle class, and even the upper middle class all receive greater benefits from a larger child allowance than they will pay in taxes to finance those benefits. Only those in the top fifth experience higher net cost, with the highest cost experienced by the top 1 percent.

So are the extra costs really a vice? Or in the current context, where inequality is as great as during the Gilded Age and the Roaring Twenties, is this vice actually a virtue?

This concludes my testimony. Thank you for the opportunity to testify, and I look forward to your questions.

Ms. DELAUBRO. I now would like to introduce Cheryl Brunson of the Brookland Manor Tenants’ Association, representative of the D.C. Poor People’s Campaign. I want to just welcome you, Ms. Brunson. Lived in the Washington, D.C., area her entire life. First time into any building on Capitol Hill.

Ms. BRUNSON. Yes.

Ms. DELAUBRO. So we are delighted that you are here, and please know that you are always, always welcome.

Ms. BRUNSON. Thank you.

As you said, my name is Cheryl Brunson, and I am with the tenant association at Brookland Manor, and there are some things I

would like to touch on. But I would first like to say that I was born and raised here in Washington, D.C., and Washington, D.C., has been my home forever.

And you know, I just want to say that, you know, Brookland Manor is a very family-oriented neighborhood. That is what I pretty much—you know, when you are looking for places to live, you look for certain features. And the features that I saw was that it was very family-oriented. They have adequate place and space for the children to play without being in harm's way.

They had a lot of programs that were funded through the police department, and so the police department was running the Girls and the Boys Club, which was awesome because it gave the kids a sense of what they want to be when they grow up and what they could bring to the community when they grow up.

And you know, now I am parenting, raising my grandkids. My kids are older. My oldest daughter is 45, and my youngest daughter is 34. My baby is 33. And now I am currently raising my grandkids because my daughter, she suffers with psychosis. And she is schizophrenic, and she suffers from depression. And she wanders off for days at a time, sometimes weeks at a time, and I have to put out reports and fliers, you know, to see if anybody knows where she is at or she is out of harm's way, or what have you.

And a couple of times, we found her on Second and D Street at the shelter. She was lost. She couldn't find her way. So that is what we are dealing with, and I have to like keep my grandkids pretty much active so that they don't really feel the hardship that they are going through.

But it is kind of hard to do that because the school system is failing us as well as these developers. You know, they are putting all of these charter schools in low-class neighborhoods, I would say, you know? And the teachers are not as on-hand as it was when I was growing up. They jot some stuff down on the board, da-da, da-da-da, and then the next thing you know the kids are looking like, "Well, what do I do?"

And they are leaving this to other kids in the classroom to put the other kids on point with what is going on in their activities. They don't always get what they need that way because that child may have missed something along the way, you know? So I am really fighting because, you know, in our neighborhood, our neighborhood, they are jailing us. They are setting our kids up to lock them up.

Like if you all are running for the bus, you are not going to have a problem. But if our African-American kids or young adults run for the bus, the police is running after them because they think that he is up to something or they are up to something. They are tackling them down to the ground, macing them. This is true. This is so true.

And then we have in our neighborhood, they brought in our neighborhood, they brought security in our neighborhood as if the police wasn't enough. When they first brought the security in there, they said it was for our safety, and we are looking around, "Safety from who?" Because we are all family here.

And what I found out was they brought the security in to harass us, to move us around, to run up on us when we can't sit on our front. We can't lean on the fence. You can't smoke a cigarette out in front of the building. We have to stand in between—they say stand in between the tree box.

You know what the tree box is? It is the street and the sidewalk, between the street and the sidewalk, that is where we have to stand at in our community. We have to stand there when we are waiting on our Uber. We have to stand in there when we are waiting on our cabs. We have to stand on there when we are waiting on the bus to get our kids from school. It is disturbing.

Take, for instance, this is what MidCity and these developers are doing to these communities that they are rebuilding, redeveloping, they say, okay? One of the neighbors passed away. He had a heart attack. He had three daughters. One of his daughters was living with him to take care of him because they knew his heart was bad.

He passed away. Before they could bury him, Brookland Manor was giving them an eviction notice. They wanted them out in 3 days. They couldn't even bury their father in 3 days.

Mind you, Douglas Smith worked for Brookland Manor. He worked for Brookland Manor for almost 12 years in the Boys and Girls Club. I never seen my grandson break down like this and cry a day in my life. Douglas Smith was a martial arts teacher, and he taught the kids in the neighborhood martial arts out of his own money, out of his own time. He did that for the community.

They put that man's stuff out on the sidewalk like it was trash. They didn't even give the family enough time to grieve. And I see this constantly. I see this all the time, you know? People have been put out of the community for owing \$1. They will return your money back to you if you are \$1 short and charge you \$25 for being late.

Okay, these people in this community, we have a lot of single parents. We have single fathers. We have single mothers. We have grandparents, such as myself, raising our kids, and our kids can't even play. They can't even run through the community without being harassed by the security.

And our community is sitting on our front, that is an infraction. Leaning on the fence, that is an infraction.

Ms. DELAURO. Ms. Brunson, I hate to interrupt you, but you will get a chance to maybe continue in the questions. Everyone is given about 5 minutes to speak so that we can get to the questions, but thank you for the poignant testimony, and I promise you, you will get a chance to complete your thoughts and ideas as we move through the questions.

Thank you so much.

Ms. BRUNSON. Thank you.

Ms. DELAURO. With that, we will start the questioning. And as I mentioned in my opening, my bill, the American Family Act, would give the same full child tax credit to families earning the minimum wage, military families, rural families, families with young kids, all those left behind by the tax bill. It has been endorsed by scholars across the country. It is consistent with the NAS, what they showed us would be the most effective policy to reduce child poverty.

Dr. Garfinkel, is the National Academies of Sciences saying that if we had simply extended the child tax credit to the kids who were left behind, we would have drastically reduced child poverty? And in addition to including the left behind children, we also increased the credit to \$3,600 for young kids and \$3,000 for older kids. What would that additional income do for children and families?

Mr. GARFINKEL. So the committee talked about the costs of child poverty, and it is roughly \$1,000,000,000,000 a year. And those costs come from less—the children who grow up in poverty get less education. They are less healthy. So they incur more healthcare costs. They are less productive as adults. So they earn less, and they pay less in taxes. More likely to commit crime. So just the fiscal costs of poverty are quite high.

So reducing poverty by, in this case, if you were to have a child allowance of \$3,000 and \$3,500 for young children, we don't know. It is hard to say that that would exactly cut the costs in half or close to a half, but roughly speaking, whatever the reduction in poverty, we should expect that that would translate into a reduction in those costs.

Ms. DELAUBO. Let me just ask you this. Rates of single parenthood in the European Union are about the same as the United States. However, child poverty in the United States is much higher because of policy.

Also I believe that single parents get smaller tax credits than married couples because their earnings are lower, and families headed by women get lower tax credits likely because of pay inequity or other reasons. I was concerned about the issue of single parenthood and that effect overall on—

Mr. GARFINKEL. So one of the packages includes a child support assurance, a guarantee of a minimum amount of child support for all those who are legally entitled to private child support. So for low—for low-income families, the men who are nonresident parents—and I am speaking in gendered terms here because 85 percent of children where the parents are separated live with the moms. So the fathers, their pay is low and irregular. And when pay is low and irregular, child support is going to be low and irregular.

So the needs of single-parent families are greater than the needs of two-parent families, and one way to address that is to guarantee a minimum amount of child support. Sweden does that. Several other rich industrial nations do that. I have worked on that in my own research. I think that would be a very effective policy for addressing single-parent poverty.

But you can't make the benefit too big, and that is where a child allowance comes in. A child allowance is general. It doesn't favor single-parent families. But if you have a program that increases the total guarantee, the total security that is available to single-parent families, that would be an effective way of addressing that problem.

Ms. DELAUBO. Thank you very much.

With that, let me yield to my colleague, Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair. And thank you for holding this hearing today. And also for all of the participants, appreciate that very much.

I want to begin with Mr. Weidinger. You had talked about the work-oriented proposals, and you talked about a historical kind of examination of what has worked in the past and kind of guiding us to what might work better in the future. And I came from a fairly rural district. When you look at farms, small businesses, people are interested in hiring people. There is actually low unemployment and people looking for employees.

So I am kind of intrigued by the work-oriented proposals that you have identified that have been helpful. And I just wondered if you had any thoughts on maybe what we are doing now, but what we might want to do in the future to help people on the income side, as opposed to just focusing on the one aspect?

Mr. WEIDINGER. Sure. Well, as I recounted in my testimony, recent anti-poverty policy history has focused significantly on what are known as "work supports," the idea of making work pay, providing individuals with additional money if they are working. And as the NAS report shows, if you count those benefits, if you use the supplemental poverty measure, there has been significant progress in reducing child poverty as a result of that.

The report also devised different packages of benefits, and one of them focuses more heavily on basically promoting more of that work orientation. That includes things like growing the EITC, sort of compressing the current child and dependent care tax credit, and making it more generous and more available to lower income folks to help them with childcare costs.

If you do those sorts of things, if you do more basically of what we have been doing, you will make further progress against poverty. It is not as simple as saying where we encounter children, and especially low-income children, we will give them a check. It is basically more in line with what most American families experience, which is go to work, have earnings, keep your family out of poverty, and make progress. And fortunately, we also have an economy that is supporting those sorts of things.

I would note the Conference Board recently reported that we are actually in a labor shortage across the country in blue collar and manual service jobs. And that is where wages are rising fastest. So many of the types of folks that we are concerned about have increased opportunity now, and we should be taking advantage of that and helping them move into those opportunities.

Mr. MOOLENAAR. Thank you.

And I also wonder—you know, one of the other challenges in my district, the opioid situation that I think it is across the country, but I wondered if in your studies, kind of how we are addressing that challenge, and how that affects child poverty? Any of you want to comment on that?

Mr. BESHAROV. Many more years ago than I like to think, I was the Director of the U.S. National Center on Child Abuse and Neglect in HHS. And in those days, we worried about heroin addiction and its problems that occurred.

The opioids are more of an equal opportunity scourge, which is to say middle class, lower middle class, white, black, not so much Hispanic, are caught up in this. And the consensus is that it is partly because of the stresses and the changes taking place in the American labor force and also because of something in the air that

is just depressed. And it is reflected in our politics, and I won't get too philosophical with the amount of time you have, but it is a giant problem.

And in the context of today, to not talk about the drug treatment side, but I was really so moved by Ms. Brunson's testimony. And if you listened to what she was describing, it is not as if an extra \$1,000 a year or \$2,000 a year or, colleagues, more than that is going to change the conditions she described. And the same is true with the opioids.

There is something deeper going on, and we have to broaden the discussion to get to that, and it is affecting middle class kids. And just the last point I wanted to make, as a grandmother, she knows one of the big effects of the opioid crisis is, again, the renewal of grandparents coming to the rescue. I was raised by my grandmother. So I am allowed to say that.

It is a terrific resource, but it is not enough for what we have to do. And tax credits aren't going to do it. Sorry.

Mr. MOOLENAAR. Thank you.

And thank you, Madam Chair. I yield back.

Ms. DELAUBRO. Congresswoman Lee

Ms. LEE. Well, thank you, first of all, Madam Chair, for this really, quite frankly, historic hearing. Really appreciate your leadership and really I know your commitment over the years has been to end poverty, end child poverty. And so I am so delighted this comes under your jurisdiction, and I want to thank you very much for this.

And I want to thank all of you for being here, and it is very seldom we get to see really the results of our work on this committee. And it was a bipartisan effort, and so here we are. And I really thank all of you for being here today.

Let me say to Assemblywoman Burke, you mentioned being the daughter of Congresswoman Yvonne Brathwaite Burke. She was the first woman who was pregnant here on Capitol Hill with Autumn. [Laughter.]

So you made history, Autumn, before you even arrived. Tell your mother and your dad hello for us, and I am so proud of the work that you are doing. And you have a quite a legacy in your family, but you have stepped up and moved forward in your own right.

So thank you again for being here.

I wanted to ask, first of all, Assemblywoman Burke a question with regard to national policymakers. Because, yes, you took the lead in California, and let me just mention the Golden State of California, which we represent, my district—of course, Oakland-Berkeley, right next to Silicon Valley—African-American child poverty rates 32 percent, Latino child poverty rates 25 percent, Asian and Pacific American child poverty rate 16 percent.

Outrageous. It is disgusting. It should not happen anywhere in the country, but especially in California. So what would you suggest that we hear from the work—that we learn from your work in California?

And then my second question is—thank you, Ms. Brunson, for being here. This is your Capitol. Welcome. Glad you are here for the first time, but many residents of the District of Columbia don't

really feel connected to their Capitol. So maybe you can go back and remind people to come up here as much as they can come.

And you laid out the case and painted the picture of what we all understand and know in terms of systemic and institutional racism and what black people live with each and every day. And so there is a relationship between poverty, childhood poverty and racism. And so, Professor, I would like for you to kind of comment on that because we have, of course, the Fugitive Slave Act; the National Housing Act, which refused loans to black people; sharecropping, which tied millions of black people to their former masters. So there is damage that still has to be repaired before we could even complete this work of what the commission has done.

So I would like for any of you, especially, Professor, to comment on that. But first, Assemblywoman Burke, what should we know as we follow up from your great work in California?

Ms. BURKE. You know, a few things. Obviously, making sure that any tax credit is refundable. But I would also like to speak to—and earned income tax credits are important. They are an important part of creating the safety net and making sure there are no holes.

However, I would like to address the fact that even in rural communities—I don't come from a rural community. I come from a very urban community. But a lot of my colleagues, the reason they are so supportive of so much of the poverty packages, in rural communities there isn't that consistent work. And so there are times so many people not just in California, but across the country are a week or two away from becoming homeless or falling into poverty.

And so it is not always possible to have an earned income tax credit. Those are the holes. Those are the people that fall through the cracks. And so it is important, and especially in a rural community, where we have some of these other mechanisms where we can make sure that people are taken care of. If you focus solely on an earned income tax credit, refundable or not, you do not create the net that you need to really lift children out of poverty and to stop that constant cycle. So that is the number-one thing for us.

Obviously, in California, we are having a tremendous homeless issue. We have women in Oakland who recently—who have three jobs who are homeless and ended up having to take over a house and because—so that they could keep a roof over their children's heads. And people ask how could they do that? But what would you do?

What would you do if you were 2 weeks away from losing your home or becoming homeless and having your children on the street? You would fight and do whatever you needed to do to put a roof over your head.

And so although work is important, it is a very vital and important part of this, we really support career and technical education and making sure that those who have not had a chance to get a college education or community college education have an opportunity to do that. And that is all part of looking at a whole human.

But we cannot only look at earned income tax credits. But when we do, they need to be refundable.

Ms. LEE. Professor, can you talk a little bit about repairing this damage that underlies all of this?

Mr. BESHAROV. Real fast.

Ms. LEE. Okay, real fast.

Ms. DELAURO. Go on.

Mr. BESHAROV. So I think the debate in this country between left and right has gotten a little confused on part of this. People on the right tend to think, well, it is a different country. I quoted John Lewis. It is a different country from 50 years ago, but it is not a whole country. And that is what he was careful to say. That was what President Obama was careful to say, which is we have made progress. There is more to make.

Some of the proposals that you describe, Congresswoman Lee, I think are very needed. I was in Mississippi in 1968 doing civil rights work, and what we found was the U.S. Department of Agriculture basically didn't give farm aid to African-American farmers. Now that was our government, and there are loads of other programs like that.

But the average person on the right doesn't know that history and thinks this is 2020. Hey, you guys have the vote. Excuse me for being a little, you know, flippant about it. All is fine.

So there is a history, and my advice, for whatever it is worth, besides all this other stuff, is to systematically study the effects of this very recent discrimination, some of it that continues.

Now I don't think it is all just racial discrimination. I think there is good, old economics going on for some of the stuff, and I don't want to sound as if I am only on one side of this argument. But it is truly the case that if people understood all the obstacles created by Government for African Americans in every State of the Union, they would be much more amenable to some kind of corrective action, and I think public education is the first step.

Ms. LEE. Thank you. Thank you, Madam Chairwoman.

Ms. DELAURO. Thank you. I just might add, Professor Besharov, that not only did they discriminate against African Americans, they discriminated against Hispanic farmers, and they discriminated against women farmers who never did get any recompense for their work.

Well, now we are out of time here, but we will get back to you, okay?

Let me now yield to Congressman Harris.

Mr. HARRIS. Thank you very much, Madam Chair.

Mr. Weidinger, I read the submitted testimony with interest. I read the report with interest. My understanding is that if you look at the discrepancies between two-parent families and single-parent families, that the poverty rate is 22 percent with—child poverty rate, 22 percent in two-parent family, 9 percent in single-parent families.

If you look at nonwork—nonworking households, 62 percent non-working households' poverty rate, 7 percent full-time work poverty rate. It seems that if you are looking for a strategy to half the number of people in poverty that it is glaring that you should address these, and yet I think I am struck by how the Roadmap pays only little attention to that. It pays some, but little.

So I am going to ask you. I mean, do you believe that instituting family support policies—and other countries have done it. Institute policies that encourage families, encourage two-parent families, and the encouragement of—and I mean, being serious about a goal

of every able-bodied American being trained for a job, have a job, where do those fit into what your Roadmap would be?

Mr. WEIDINGER. Sure. So you are right. Those statistics are from the Roadmap, and they reflect on sort of the reality that Dr. Besharov was saying, that the Roadmap was given a charge of saying within 10 years, how are we going to lift half of children out of poverty, right?

The simplest way to do that and, as Dr. Garfinkel reflected, the most powerful way to do that is simply to provide a cash transfer to those households. It is sort of on the order of math, right? Somebody is low income. If you want to give them food today or cash or whatever that is, they are going to be less low income, less likely to fall below some threshold of deep poverty or poverty in general.

What the Roadmap doesn't do as much of, and I would argue that some of our Government programs currently don't do enough of, is focus on the bigger picture, which is why is the person low income? What can we do to help them go to work? What can we do to raise their income from work, their earnings?

We don't tend to hold programs accountable for success in that. What little we know about the actual outcomes of programs is most are unsuccessful when they try to do that. So in some sense, what the Roadmap provides is a challenge to current programs to do a better job in those things that we know are successful in most of our households in keeping people out of poverty.

The Roadmap has a very specific and narrow charge. It is different from that, but I don't think that should distract us from the broader, sort of more whole view that you are reflecting on.

Mr. HARRIS. Well, what do you—you know, look, this is a problem that has been around a while. And look, in my opinion, the Great Society failed. We have spent trillions of dollars, and we still have significant number of people who are in poverty.

So I understand that the charge was, look, how do we do this within 10 years? But this is a generational problem, and it is probably going to look for a generational solution. So two specific questions.

One is what policies do we have right now that actually discourage two-parent families? And what policies should we look for if we are going to do generational change, and we are going to create an expectation and make available policies that would provide for training and employment, what would they look like?

Mr. WEIDINGER. So policies that discourage two-parent families are things like the earned income tax credit. So if you are a single low-income person and you marry another low-income person, you may be bumped out of the range where you collect the EITC. That is a payment that is available today that can be up to \$6,000 per person. If you are not collecting, that is pretty significant change.

That may also knock out things like childcare, food stamps, housing benefits, you know, you name it, depending on the nature of the family. So we have programs that by their design include work disincentives, but the most pervasive of that and most powerful of all that is the disincentives to work, when you are basically adding a whole other earner to your household.

In terms of functional things to change, I think we should hold programs more accountable for actually being successful in their

outcomes, and that goes for things like the TANF program, right? The TANF program was supposed to be about moving people from welfare to work. It gave States tremendous flexibility. It also said States need to make a contribution on their own to support the costs and the effort of all that.

And what we found is in many States, States have basically defunded their State side, and they have absolved themselves through sort of rhetorical—or sort of mathematical gymnastics of the expectation of engaging people in work. We need to reinvigorate those sorts of efforts. So we are actually encountering the types of folks that Dr. Edin suggested want to work and, with a little bit of help, could go to work.

Mr. HARRIS. Thank you very much.

Madam Chair, I yield back.

Ms. DELAURO. Thank you. Congressman Pocan.

Mr. POCAN. Yes, thank you very much, Madam Chair.

Thanks to the panel. This was very interesting, and there is so much that you could cover, but I am going to try to cover one subject area, if I can, just because it is related directly to appropriations.

And I understood the tax credits were not going to do it all. I understand that line. But let me talk specifically about the SNAP program because that came up by so many folks. And I have done the home visits of people, the new mothers, and seen the despair and the conditions, you know, empty—I can't even call it apartments, but very small living quarters.

But on SNAP, when I first came here—I got elected in '12—that first session, a number of us lived on SNAP for a week. The benefits at that time were about \$31.50 a week. And I remember going to the grocery store, and I bought a bag of oranges, and that took up the biggest chunk of my SNAP benefit. Then I bought my ramen noodle soup, bought my peanut butter, my bread, and a few other things. And at the end of the week, my office told me I was pretty cranky because I wasn't getting that much food and certainly not that much healthy food at all, even at that \$31.50.

Since then, the benefit now, only because we gave it a boost in the last appropriations process, is around a little over \$29 a week. So we are actually down in real dollars, not even inflation dollars. Inflation since then—when I did that, it was 10.7 percent. So it should be, if it was at that \$31.50, it should go up \$34.80. We are about 15 percent down in real dollars from when I came in 2013 in that program.

Can you just talk about that a little bit? Because I find it pretty amazing. I was always told that is the number-one program to keep a kid out of poverty, and yet, you know, here we are fighting, struggling to keep it in. And I have a lot of ag areas in my district. I want to see all these ag bills get done.

And yet over and over, SNAP becomes this philosophical fight that I don't get because—maybe because I did it for a week, and I saw how little you could actually buy with that amount. But could you just address that one program in particular? And Professor Edin, I think you brought it up first. So thank you.

Ms. EDIN. So I have studied SNAP with the USDA and talked to hundreds of households using SNAP about what they use it for,

when they run out. I could summarize my research by saying in the last 2 or—last week and a half, families run on ramen. In fact, in one study I did, I was amazed at the number of ramen recipes—of course, ramen is not great for your health—that I collected.

But we often think about SNAP as sort of, you know, well, at least they have SNAP, as if cash doesn't matter. I mean, one of the reason that I have been so enthusiastic about the American Family Act is it actually provides this critical resource of cash. SNAP is actually intended to run out. It is not intended to cover your entire month.

Mr. POCAN. No.

Ms. EDIN. Families don't recognize this. They tend to, at the first of the month, spend all of their money on their other bills, leaving nothing for food. So it is a big problem. It leaves children hungry.

And of course, we have documented this rise in \$2 a day poverty where families really have no cash and only SNAP. And in those cases, it is the only semi-fungible resource they have. And so if you are spending \$600 in SNAP, as Alva May Hicks did in South Carolina—sorry, in Mississippi, just to pay your light bill, you know, getting \$300 in return, your kids are going to be very, very hungry.

It is a great issue. It is one that has I think really fallen—kind of is under the radar. But it is probably why or one of the reasons why we see an increase over time, even in this economy, in very low food security. So families are feeling it, and they are especially feeling in the last week and a half of the month.

Mr. POCAN. Yes, and actually, Ms. Brunson, you are nodding your head. So can you share your experience?

Ms. BRUNSON. Oh, yes. Yes, I would say like with SNAP, as Ms. Kathryn said, you know, it is definitely not enough for the kids to be able to eat. And I will tell you, a lot of these kids are looking forward to school. They are going to school so that they can get those meals.

And my granddaughter personally, you know, every Friday, she brings home a bag from school, and it helps. It really does help. They call it a “welcoming bag.” It is a bag of food that she brings home every Friday.

And you know, it actually has like the little snacks in it, like Little Debbie's and stuff like that, little juices and that kind of thing. And they give her about two or three so she can share it with her brothers, you know, other people in the household.

But if it wasn't for that, I am telling you, I wouldn't be able to make it. I would not be. And thank God for ramen noodles because I am telling you the stamps go so quick, you know? To me, it is like where those \$50 would cover, would make at least 3 to 4 meals a week, it is only making 2 now because everything is going up. And just the other day, I was in the store shopping, and I am looking around like, “Oh, my gosh, everything in here is so—”

They are going up. Everything—it just seemed like everything is just sky high. And so I make a lot of soups. You know, I make a lot of stews, and I have this one particular one that kids say, “What is it?” I say, “Oh, this is my penny soup.” That means that I used every penny I had to make that soup. And they enjoy it. You have to come up with names and stuff like that so that the kids will eat it.

But most of the time, the kids—and I know in my neighborhood, they are barely eating. So I try to buy enough snacks so that I can share with them as well, you know? I mean, it is really hard.

Mr. POCAN. Thank you. Yes, thank you very much.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you very much. I truly appreciate this hearing today and thank all of you for joining us. It is so hard to capture all your stories and expertise in 5-minute segments, but here we go.

I really want to focus on trauma and how that plays into kids in poverty and has lifelong effects. And Assemblywoman Burke, we know that childhood trauma, adverse childhood experiences can have immense impact on adulthood, including one's ability to hold a job, physical health, higher rates of diabetes, and other physical conditions.

I have been very impressed with California's effort to begin screening. I am also very impressed with your State surgeon general, Dr. Burke, and her focus on this with the ACE scores for children. Can you comment on the importance of that screening and how California intends to support students and children who have those high scores?

Ms. BURKE. So we found, obviously, in California that—and I am sure everyone here is aware that African-American women are struggling the most from things like miscarriages, fertility issues, and a lot of that studies have shown is a result of stress. And that starts at the most beginning level of implicit bias and not being—and that stress that that creates in a woman as she is having a baby in poverty and creating that stress as well.

And so I think that as a legislature, I think we have become extremely aware of not just how that affects a woman as she is giving birth, but as the children are born. Malnutrition obviously—as we have heard Cheryl talk about today, malnutrition makes it very difficult for children to learn, almost impossible.

And as a legislature, I think we are starting to take that and Dr. Burke's studies and research very seriously and her work very seriously. We have not legislated on it as of yet, but I think that you will definitely see especially the black caucus is taking infant mortality as one of our number-one priorities for the year.

And that is really based on after some of our research and some of our work, with her coming to the caucus saying that a lot of that is the effect of implicit bias and the things that we have—the women have taken on that we have not acknowledged as a State or a country.

Ms. CLARK. Thank you.

And Professor Acevedo-Garcia, I know that you have done in this. Can you tell me about how you see anti-poverty measures actually being able to help and the connection between reducing trauma in children?

Ms. ACEVEDO-GARCIA. Sure. Thank you for that question.

So, of course, child poverty in itself is a very significant adverse childhood experience. So by implementing any of the measures that the committee concluded would be effective in reducing child poverty, we would reduce the prevalence of ACES because poverty, child poverty is a major ACE.

In addition to that, and I want to acknowledge Professor Besharov for his comments about the importance of race and racism and discrimination, we also know that there are many other stressors that affect families in addition to poverty. And one way in which the committee considered this is by examining the contextual factors that influence poverty. And by that, we mean factors that exacerbate the experience of poverty or the negative effects of poverty and also may influence the impact of anti-poverty policies.

We considered things like discrimination in housing and employment and the criminal justice system. We also considered the effect of adverse neighborhood conditions.

Although we were not able to incorporate this in the simulations, we reviewed very carefully the evidence that these factors tend to worsen this experience of poverty among children and also can limit effectiveness of anti-poverty programs. I think it is very important to recognize that we can make anti-poverty programs better if we acknowledge that we also have to deal with these contextual factors—again, your comment—and that we can do both at the same time.

So I am going to give one example of that that is very close to my interests and my research. We know that minority children, specifically black and Latino children, are more likely to live in poverty than other children. Also among poor children, black and Latino children are much more likely to live in neighborhoods of very low opportunity.

Just to give you a sense of the extent of the problem, about two-thirds and half of poor black and Latino children, respectively, live in very low-opportunity neighborhoods. Twenty percent of white children who are poor live in very low-opportunity neighborhoods. So although, of course, the experience of poverty is very bad for all children, Latino and black children are also dealing with a lot of problems in their neighborhoods, and I really resonated with your comments in that sense.

So we have a program, the Section 8 voucher program, that is an income subsidy to buy housing. But we can make it more effective by helping families, and we have programs that are doing this around the country, housing mobility programs that will help a family that has a Section 8 voucher to achieve a better neighborhood. And that way, that is a very concrete example of how we can tackle both poverty and ACES or multiple hardships at the same time if we are smart about how we use our programs.

Ms. CLARK. Thank you.

Ms. DELAURO. Thank you. Let me also, Dr. Acevedo-Garcia, I want to just get a look at what the study showed, that work requirements are at least as likely to increase than decrease poverty. I just would mention that in Arkansas, 18,000 individuals were kicked off the State's Medicaid program because of work requirement, and the employment rate dropped among Medicaid-eligible Arkansans.

Kentucky's work requirement was forecasted to force at least 95,000 Kentuckians to lose coverage. Their new Governor, Andy Beshear, has withdrawn the State's work requirement waiver.

I would like to give you the opportunity to respond to that assertion that work requirements are at least as likely to increase as decrease poverty, if you can.

Dr. ACEVEDO-GARCIA. Yes, it is very important to understand how a committee like our committee of National Academies works. For us, everything is driven by research evidence and the strength of the evidence.

Ms. DELAUBRO. Right.

Ms. ACEVEDO-GARCIA. So the criteria that we use to identify programs included the strength of the evidence on how they improved child outcomes, their likelihood to reduce child poverty, and other factors such as cost, as well as the importance of values that we held as a nation like social inclusion or work.

In regard to work requirements, we did examine the evidence extremely carefully, and we concluded that there is no evidence at this point to support that work requirements as part of social programs that aim at reducing poverty would help reduce poverty. So we did not include this approach in our policy simulations of either individual policies or packages because the evidence is not saying including them.

Ms. DELAUBRO. We can have access to what that evidence is because, as you know, we are in an environment where there is a very big focus on work requirement as it pertains to the SNAP program and other programs and where people are in real danger unless we can answer that, this question, which is why I just wanted to bring it up again.

Did you want to say something, Dr. Garfinkel?

Mr. GARFINKEL. Yes. So the evidence that is usually advanced for the efficacy of work requirements is the welfare reform, the 1996 welfare reform.

Ms. DELAUBRO. Right.

Mr. GARFINKEL. And most scholars would say perhaps about one-third of the increase in earnings was due to the welfare reform, but you have to understand that welfare reform was not just work requirements, and probably even more important was the lifetime limits on eligibility for assistance. And there were lots of other elements as well.

So the citing that evidence is very weak for saying the efficacy of work requirements. We do have experimental evidence on the efficacy, or lack thereof, in terms of reducing poverty for work requirements. So there were two different experiments—one in Canada, one I think in Minnesota—that we cite in the report. And the evidence from both is that work requirements increased work but had no effect on poverty. None, zero, zip.

Ms. DELAUBRO. Mm-hmm, yes.

Mr. GARFINKEL. And that is because people that were kicked off welfare lost the welfare benefit, and their earnings just made up for the loss in benefits. That is experimental evidence.

The last point, we were well aware or at the very end of our deliberations of what happened in Arkansas. I think it was Arkansas that you cite.

Ms. DELAUBRO. Arkansas, yes.

Mr. GARFINKEL. Yes. And the evidence there is pretty clear. So, and we have lots of other evidence that work requirements have

been instituted in a way that simply kicks people off welfare. I say this as being an advocate 25 years ago of not a work requirement, a broader requirement that all recipients of welfare should have a social responsibility to either work or do something to improve their own situation.

That—I am an optimist, a great optimist. My wife likes to say I am the greatest optimist she has ever met. So I thought that that could work, that we could implement such a requirement in a decent way, and when someone was having trouble getting to work, that would be a sign to us that person needs help. That is not what happened.

Ms. DELAURO. I will just add to that, and my colleagues bear with me, I can recall that debate very, very well. On the floor of the House, there was an amendment that passed which cut I think \$25,000,000 from the food stamp program, and in fact, there were no wraparound services that were provided at all with the welfare bill about getting to work, about what you do about childcare, what you do about any of these other areas that would facilitate a person's ability to be able to get to work and so forth.

And so we started behind the curve there. And I am proud to have voted against it. So I just use that.

Mr. GARFINKEL. Madam Chair, could I just add one—the idea that we would work-test Medicaid is just I don't get it. I just don't get it. It seems to me like such a bad idea that we—Medicare, Medicaid, medical care increases people's health. The idea that we would try and kick people off that program because they are not working. They may be on the program because they can't work.

And the administrative complications of enforcing the work test in Medicaid—

Ms. DELAURO. Thank you. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

I want to follow up on this discussion we are having on work because I fundamentally believe that there is dignity in work and that it is good for people. And when you think about generation after generation, I think there is real value in children seeing a parent or parents working and realizing that is sort of to your point of social responsibility.

I wondered, Mr. Weidinger, you had commented in your testimony that some of the impressive gains made against poverty after the 1996 reform continue to support promoting more work and earnings by parents as the better and more enduring solution to poverty. And that intuitively makes sense to me, although I also am sympathetic with the idea that if you get a certain point in your income and then you lose all the other supports, that may be a disadvantage.

And so I wondered if I am sure you looked at that sort of I don't know what you would call it, but that ratio. And maybe there are ways we could improve that so that people wouldn't be penalized for working but would also have the incentive to work.

Mr. WEIDINGER. Right. So just to follow up on the previous conversation, the work requirements in TANF or in other programs—but I know TANF best, so I will speak to those—there are actually 12 definitions of work. So it is not we are going to kick you off if you don't have a job. It is a progressive State, a smart State would

say how can we help Dr. Edin's person go to work by providing the supports that she needs to go to work, right?

And in effect, the TANF law permitted that to be the case. How States actually implemented that is a different thing, right? So I would tend to agree with Dr. Garfinkel that some of this translation to policy at the State level has devolved in a direction that the original law didn't really intend. It let the States somewhat off the hook for doing the type of engagement that we know is helpful to people to lifting their income and helping them escape poverty.

On the question of sort of the backside transition, Dr. Besharov sort of made reference to this on the phase-outs and some of the penalties, there is—I would refer you to a chart by Gene Steuerle at the Urban Institute. It is a crazy quilt of the marginal tax rate effect of the phase-out of welfare, the welfare package that many people receive.

SNAP phases out one way. Housing phases out another way. Childcare may have a cliff. The earned income tax credit phases up, is level, and then starts to phase out.

All those things can create marginal tax rate effects that in the \$20,000 to \$30,000 income range for households create a marginal tax rate that is much like that that applies to taxpayers in the \$200,000 and \$300,000 range. Because one day, they are receiving a package of benefits, but the next day, if they get a raise, and you know, heaven forbid that you marry and bring a second earner into the household, all of a sudden, that benefit package goes away.

So there are ways to try to address that and fix that. Typically, what they tend to do is sort of do the taper more. So have the phase-out be lower. That tends to raise the income eligibility for those benefits. It increases costs.

There are other things that you can contemplate doing. You could sort of hold people harmless for those phase-outs for a period of time, give them a couple of years, something like that to help them transition to work. Maybe get a raise, develop more skills, and things like that. So there are policy options for addressing those sorts of things.

Ms. DELAURO. Congressman Moolenaar, I know that Professor Edin wanted to respond, but I will give you extra time if you have different, other questions.

Mr. MOOLENAAR. Oh, no. Please go ahead.

Ms. DELAURO. Thank you.

Ms. EDIN. So I wanted to respond to both your comments about work and about family structure. In terms of work, if we look at the Survey of Income and Program Participation, we find that among children in—virtually in the spell of living in a virtually cashless household, during that year, 70 percent will have an adult that works. And the figure is 90 percent for other low-income children.

So there is a high degree now of engagement even among low-income mothers with very young children in work. I think that is good news. What we showed in our book “\$2.00 a Day” is it is much more the challenge of keeping people in very low-wage jobs in work because of all the challenges of an increasingly perilous low-wage labor market.

So Matt has talked about factors that discourage marriage. I have done a literature review with Sarah McLanahan, my colleague at Princeton, about what we know about what enhances marriage rates, especially among low-income parents.

The work of Christina Gibson-Davis has shown that if you give an unmarried couple a small additional increase in resources, this is through earnings, if their economic situation improves, they are much more likely to marry. So maybe a child tax credit won't do it all, but an additional \$5,000 to \$6,000 in a household could easily increase family stability a lot.

We also know that investments in excellent pre-K, 40 years later, show families with much greater family stability and fathers much more likely to live with their children and have raised them in their own household. We also see evidence from career academies. This program not only raises wages, 8 years later, but it dramatically increases family stability, especially for men.

So I think what we know about these days, right, about how to get young people to marry, especially low-income young people, is to support them from pre-K all the way through to college graduation. And even small increases in their economic stability have been shown to quite dramatically increase their family stability.

Mr. MOOLENAAR. Thank you.

Ms. DELAURO. Thank you. That really gets to the issue of dealing with the child tax credit and which I said at the outset, it is not the jurisdiction of this committee, though we are very supportive of this effort. And as well as what are the programs that are within this jurisdiction, which is pre-K and worker training and all of these other areas would come directly under our jurisdiction that we need to meld those together.

Congresswoman Lee.

Ms. LEE. Thank you very much.

Let me first to Dr. Edin. In your book "\$2.00 a Day: Living on Almost Nothing in America," you lay out the personal testimonies and survival strategies that Americans live in extreme poverty. Let me ask you with regard to the pre-existing Aid to Families with Dependent Children program and its relationship to lifting children out of poverty and the new welfare reform program under TANF.

Now personally, okay, I was on AFDC for years. But I could go to college also, and I was able to take care of my kids and finish college, get my master's degree.

Now when I was in the legislature, the welfare reform program came through the States, and I chaired the subcommittee that crafted a lot of the supportive services as it relates to welfare reform. But we couldn't get rid of these work requirements that were put into place, and a person like myself couldn't have continued to go to school because of the work requirements.

So I voted against it. I think that was the worst thing Bill Clinton ever did, quite frankly. So let me just ask you how you see that right now. In the Academies' report, I don't know if you address this specifically, but these work requirements now for young women especially who want to go to college and who want to take care of their families and earn a better income, what is the deal with that in terms of lifting children out of poverty?

And then to Assembly Member Burke, where is California now on our welfare on TANF and any of the terrible provisions that were put in early on? First, Dr. Edin and then Assembly Member Burke.

Ms. EDIN. So TANF has a couple of problems. One is that benefit levels have—the value of the benefits, even though in many States you just can't get on the rolls. Even if you did, in Mississippi, you would still live in \$2 a day poverty. I believe it is in 17 States you are below 20 percent of the poverty level if you get the full benefit. I believe it is in the majority of the States where you are under 30 percent of the poverty level.

Some States this last year raised their benefits for the first time, but it is still a dramatically reduced benefit. This means that people have to work under the table to survive. And so even if they were able to go to college, it would be much harder to do so because they are doing hair. They are selling their plasma. They are babysitting for neighbor's kids. Some of them are picking up tin cans on the sidewalk for about \$1—the return of about \$1 an hour.

I mean, people are really—if you pay people 20 percent of the poverty line, and you believe the poverty line is too low, how do we think people get by? And so I think there is that story of when people fall so low, when benefits decrease on average in value by a third since the late 1990s, it is mid to early 1990s, that is an additional point to the work requirements actually pushing people off and into low wage work, the short-term training, which earns them poverty-level wages.

But I would love to hear what is happening in California.

Ms. BURKE. Yes, so we are still—I have been working on this for a few years. We are trying to extend the time clock eligibility requirement for college from 48 to 60 months, and we are also trying to make sure that noncore activities like job training can maintain—you can maintain your participation.

It has been a struggle. I will be honest with you. We have been working on it, I think I have done this bill three times now, or a version thereof three times. It is one of the great challenges. You know, there are noncore activities that you need to do, and there are noncore things you need to do to be employed.

You know, whether that is—I am a single mother. So we keep talking about single mothers, and I am a black single mother sitting here. And I know that—and I have a good job, and I have a good career, but I struggle with childcare. And I have had to try to find time and space to continue my education.

It is not easy, and as a State, we are still—we are still working on it. We still have further to go in that and understanding that getting a job is not as easy as some of the folks seem to think it is here, especially as an African American or an African-American woman.

It is just there are a lot of hurdles, and there are a lot of hurdles for people in my district. Most people don't realize 70 percent of students in California enter a high school never see a community college or a 4-year university.

What happens to those 70 percent of young people? And they live in my district. And yet it is \$25,000 or \$26,000 to make sure a two-

bedroom apartment. It is \$70,000 for a child—for the L.A. County, \$70,000 to pay for a child in foster care. This is basic math.

Ms. LEE. Basic, yes.

Ms. BURKE. It really is. It is \$90,000 to incarcerate one man for a year.

This is not—this is basic math, but it is not a basic issue. It really does require that we look at a whole human being, and that is from the implicit bias of an African American, a Latino trying to enter the workforce, or trying to enter an educational facility. It is about making sure that CalWORKS is extended so that people can get the training and education they need while they still can do their nonconforming activities.

This is a complex issue, and to minimize it to just the basic ability of going to work, people want to work. I believe it is socially equitable, and I think it does give people pride. But it is not that simple.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you. To pick up on that theme, I often think of the Boston Globe report that came out a few years ago on the median net worth of families in Boston. Black families, it is \$8. White families, it was \$247,000. They had to reprint those numbers because everyone thought that \$8 had to be a mistake.

And when we talk about the dignity of work, and I would ask you, Professor Edin, if you could repeat the statistics of how many people are working on TANF and others. Did you say it was upwards of 70 percent?

Ms. EDIN. So for—what we did is we followed children in the SIPP over a year, and it turns out it is easier to follow children because family structures are so unstable. And we found that even among children experiencing at least a 3-month spell of extreme poverty, having no income in the house, 70 percent of those children had an adult who had worked.

Ms. CLARK. Yes.

Ms. EDIN. So we see that at 90 percent among other low-income children. Since the early '90s, the penetration of work in the lives of poor households, poor single moms, is just astonishing. You know, back—back when I first started doing this in the early 1990s, I am getting older, you know, mothers really thought there was a "Should I work? I am not sure that is good for me as a mother. I am not sure that is good for my kids." And now mothers will say, "Of course, I should work. How else do I model the value of education to my children?"

So people work. One of the things that was so striking in our research for "\$2.00 a Day" was the level of identification with work. "I am a worker. This is who I am." So work needs to live up to those aspirations that are held by low-income families.

Ms. CLARK. That is an incredibly powerful statement, and I think part of the problem with these work requirements is that it sets up a false paradigm that people are not working out of choice because they are getting a handout from the Government, when actually, I think we need to be focusing on exactly what all of you are advocating.

And Mr. Weidinger, when we talk about accountability in this programs, and we all want that, I think we also need to be looking

at accountability of our systems. Are we paying women equally for equal work? Are we insisting on a minimum wage that actually allows families to survive?

Are we addressing in a realistic way systematic racism, systemic racism, and the toxic vestiges we have of slavery? Are we looking at voter suppression? All of these issues come together, and they have really been drawn into focus for me this week with the coronavirus.

How are we going to make sure that we are able to keep Americans safe when there are people who do not have paid sick leave, who cannot afford to stay home from the job or multiple jobs they have that are allowing them to hold on? How are we going to be able to mitigate and have therapies for people who are sick if they are immigrant communities and afraid to come forward and get healthcare, or they have no insurance or are under insured, as we see tests for this coming in in the range of thousands of dollars in billing for patients who have needed to access testing.

So all of these policies are not just a theory and a feel-good, and we have to wrestle with this in a comprehensive way. And when we talk about the dignity of work, we have to make sure that those workplaces, those salaries are really giving people a chance.

And I could go on forever, but I won't. But I just want to thank you for your work, Mrs. Brunson, for being here today and sharing your personal experience. It is always people, and we all know how we feel about our grandmothers. And I miss mine every day.

But it is we have got to look at kids and say we can do better in this country.

Ms. BRUNSON. Absolutely.

Ms. CLARK. And it is the connection for all of us is so very important, and so thank you for your work. Thank you all for being here, and thank you for having this hearing.

Ms. DELAURO. I think the one thing that struck me, Professor Edin, when you were speaking is, you know, we all identify ourselves by our jobs. And I think so many of us, and I will just say this widespread, that oftentimes we just hear folks denigrate people who have fallen on hard times, do not have a job. But looking for a job, if you go to any of the Workforce Alliance Boards, and you see people at those computers looking, looking for a job, people identify who they are by their job. I don't care who you are.

And so when you don't have a job, the stigma of that for your own personal self-confidence and you are role model as a parent, where how do you explain to your children that you don't have a job? So the notion that somehow that people are dogging it, that they don't want to work is—it really is humiliating and denigrating to individuals and what their lives are about and what their set of values are about.

I want to—by the way, nobody is on the clock here. I just thought we would just have a conversation. But I do want to bring up because this is important. We are dealing with a budget that this administration has put forward. And I am asking everyone here. It requests to eliminate a block grant, more than 50 programs that benefit children and their families.

That includes Preschool Development Grants; the Low-Income Home Energy Assistance Program, LIHEAP; the community serv-

ice block grant program; foster youth programs, among others. It makes egregious cuts to Medicaid, to the CHIP program, and to TANF.

Now we can sit here and say all those things are not going to happen, but some of them are going to happen. And so what I really do—let me just open this up. What is the impact that these kind of cuts will make on whether it is California or other places? What happens when there are no longer the investments in preschool slots, childcare slots, workforce, homelessness programs, apprenticeship programs, internship programs that deal with 70 percent of the people in this country who do not have a 4-year liberal arts degree?

Let me just—you know, let me just throw it open here. What happens when we are faced with a budget like that? Go ahead.

Ms. EDIN. I think Matt could also—I think this is a point of agreement between us. What we know from the TANF block grant is that if you give block grants and you don't really supervise them, so to speak, you create really a race to the bottom. And Governors have been using the TANF block grant as a fungible stream of income for pet projects.

So we see in Michigan, we are giving away college scholarships to middle class students. In Louisiana, we are supporting crisis pregnancy centers. It is true that many States fund their State-level EITCs through TANF, but that again goes to the working poor and not the categorically needy, as you were saying. It misses a large chunk of families who are the most needy.

So, and also in reflection to Matt's remarks, only 8 percent of current TANF dollars are going to job training. How could a proposal that was supposed to support job training and job placement be spending so little on the program.

So I would say what is going to—and by the way, only of the \$16,500,000,000, only a tiny fraction now is going to cash benefits. So most States are figuring out ways to basically siphon off most of the money, and I think that is what we could expect in the future. That is our most current model.

Mr. WEIDINGER. So since you raised the budget, I would advise you think about this even more broadly. I included in my testimony a summation of the coming investments in the next—expected in the next decade, prepared by the Pete Peterson Foundation, and found that for every dollar of spending that we will do above our current levels, we will spend 67 cents of that on senior entitlements. We will spend 3 cents of that on children.

So I don't need to tell you, as appropriators, you are feeling the squeeze of the broader budget issues that we are facing as a country with some of this is demographics. It is understandable. It is the way it is.

But I think everybody on this panel can agree that children's programs are under increasing pressure because of the broader budget dynamics that we are facing as a country. And until we actually deal with those, these programs will continue to be under pressure.

Ms. DELAURO. Well, I just would say this, too, Mr. Weidinger, and I appreciate, and you know, in your testimony, you talk about using the supplemental poverty measure, et cetera, and where do

we go and what we do. But we literally do not focus on—and I just have to say this in response is that we provided the biggest tax cut, the richest one-tenth of 1 percent of the people of this country. We did that in 2017 without—you know, in an immediacy.

We are not thinking about a deficit. We are not thinking about anything else. And where we go all the time when we think of what economic pressure we have, we focus on seniors, as we contrast them with kids. Let us look at the top of the list here and find out who the beneficiaries, the real beneficiaries are of our current policy.

And when we can get to leveling that playing field, then we will have the kind of money that we need and the resources that we need to make sure that our kids are taken care of and that our seniors can retire and have healthcare and a decent way of life.

It is not you. I am not shooting the messenger here. I just get so frustrated with the notion that we never take up what happens at that level.

Dr. Garfinkel.

Mr. GARFINKEL. So if it is okay, I want to come back to the importance of cash for a moment.

Ms. DELAUBRO. Fine.

Mr. GARFINKEL. Because—

[Laughter.]

Ms. DELAUBRO. I always think that is important as well.

Mr. GARFINKEL. So, so as a long-run matter, capitalism is the best system we know for reducing poverty. But capitalism creates economic insecurity by its nature, and that has gotten worse recently as the labor market has changed and gotten more insecure. And several people have said, gosh, just what would \$2,000 or \$3,000 or \$5,000 or \$6,000 do to—how would that improve the lives of families with low income with children?

And the answer is it creates a base, a secure base. And it reduces economic insecurity. Most especially at the bottom, but I could tell you it extends well above the bottom. The most important finding that came out of the Poverty Tracker study in New York City, which is a random sample of the whole city, is only about 20 percent of the population is poor in any given year.

If you look over 4 years, it is close to half. And for those people who aren't—some of them who aren't poor, some who are poor, measures that we call hardship, but I like to think of them as economic insecurities, things like not going to a doctor because you couldn't afford it. Running out of money to buy food. Not being able to pay your housing, so you are possibly, in the worst case, thrown out of your housing. Not being able to pay bills, electric bills. Getting your heat turned off.

Those kinds of insecurities in any given year in New York City, it is like 30 percent. And over the period of 4 years, it is closer to 60. It is above 50 percent.

If we can find a way to stabilize the incomes, which child allowances would do, that is a huge contribution not just to the poor, but to the lower middle income, to the near poor, et cetera. Capitalism will do the work in the long run so long as we share the fruits of the capitalist system.

Ms. DELAURO. I know my colleagues want to get into this, but you had a comment you wanted to make, Dr. Besharov, and then we will get both of you.

Mr. BESHAROV. So I just want to point out—so I think many of us would agree with the kinds of things that you said, Chairwoman. But let me point out the following with this big, long report about ideas to reduce poverty, and most of the programs you described that you were feeling so angry about being proposed to be defunded didn't make it into the report.

Now, right? Wait, no. So, so, to me, I will just close in a minute or two.

Ms. DELAURO. Oh, no.

Mr. BESHAROV. So the challenge is both to make those programs that you listed work better and to get the American people to believe they work better. And I can tell you the consensus about job training programs is don't do them, right, among the technical people who look at this.

Yes, and the committees here aren't very excited about putting money in job training either. So, and I didn't see a big recommendation to increase job training in the report either because their requirement was to look at the research and say what works.

Now I was against that requirement. I think you should try all these things, but the necessary product, and I know politics I can't help here. But the necessary and part answer to what you said I would say is we have to improve those programs so that the American people believe more in them.

Sorry.

Ms. DELAURO. Everybody believes in the LIHEAP program, I am sorry, Mr. Besharov. And boom, it has been eliminated. Go ahead, Dolores, and then Barbara.

Ms. ACEVEDO-GARCIA. Yes, just very quickly because I am obviously here to represent the committee. So we did—we did examine work training, and we did include one promising program, WorkAdvance, in one of the packages. You are right that we did not look into other programs. Part of the reason, as everyone knows, is that the task was to look at programs that could reduce poverty within 10 years. So I just wanted to clarify that.

In regard to block grants, very important, we did examine whether they may be able to reduce—first, we look at the evidence carefully, and the evidence is not there to support that block grants could reduce poverty. And actually, the discretion that they give to States could very well work in the opposite direction.

We have been holding different sessions around the country to disseminate the report. In Boston, we had one that was focusing specifically on the intersection between child poverty and racial and ethnic equity. One of our centers has conducted very powerful research that shows that block granting the TANF program, one of the things that it has done, many people here know, is that it has increased the percent of funds that go to the other categories. That is not childcare and other things that are legitimate uses for the other categories.

And one of the things that we found is that States in which the caseload have a higher proportion of African-American clients are more likely to be using the other categories, again reinforcing this

idea that we have to be looking at these issues simultaneously. It is not only child poverty, but it is issues of racism that are very much present in our society.

Ms. DELAUBRO. Barbara.

Ms. LEE. Yes. And thank you all again for being here.

I wanted to just say a couple of things. First of all, child poverty rates right now constitute for me a state of emergency. It has so many different layers. You talk about systemic racism. You talk about early childhood development. You talk about homeless children. I mean, you know, in terms of just the ability for them to have a stable address and how do they go to school and going to five and six schools a year and moving around.

I mean, the next generation of children who are living now below the poverty line are going to have a very difficult time just negotiating living in America. And so I am at the point now where I am saying, and I am glad Andrew Yang mentioned this several times during his campaign, about going back to a guaranteed annual income, something that will help stabilize this state of emergency until we figure this whole policy thing out.

Because I am so worried at this point that this country is becoming a country again of it is two countries. One that is below—that is unequal, and the other that is just off the scale in terms of the 1 percent, in terms of the money and the greed in many respects that now we see at each and every level.

And so we have got to somehow—and I don't want to see another 20 years go by and more kids falling into poverty without something dramatic and it is something that is outside of the box. And so just can you comment on a guaranteed annual income or some level that we will not allow people to fall beneath, given the state of emergency with our kids?

Ms. EDIN. So the reason I am advocating for something like the American Family Act rather than guaranteed family income is I actually believe the insight of David Ellwood when he came to the realization that good social policy has to be attuned to American values. So what the American Family Act does, and I want to quote from my quote when I reviewed the proposal, is that it sends a clear message that society values and supports the essential tasks of parenting and recognizes the special burden that all parents of children, especially young children, face.

Low-income—the reason to give low-income parents with children essentially a guaranteed income is because they are doing something for society that is essential. Now my democratic self might like something bolder, but it seems to me that this is something all Americans can agree on. We value parents.

Right now, fertility is going down in the United States, and it could be bad. It is tough raising kids on a low-wage job. So to the extent that this act sends a powerful social message, "We value you." It brings dignity, right, just in the way that Professor Garfinkel described, and it reinforces the critical task of parenting.

So that was a little off topic, but I will turn it over.

Ms. BURKE. So we do in California have a bill introduced, and we will introduce a bill that will come to our committee. And so we will actually have the universal basic income conversation in Cali-

fornia this year. And it is an important conversation to have. That stability is incredibly important.

And you asked, Chairwoman, what would be the consequences to the State if, in fact, there was this kind of pull-away from these programs, and I am lucky to live in a State where our Governor values a lot of these programs, and so we would probably try to backfill a lot of that. However, we do have our own other crises. We have a housing crisis that we are trying to figure out, and we also have wildfire and other incidents.

And so how long we would have the capacity to do that, I don't know. But for others in other States, I think it would be more of a challenge. It would be devastating.

Ms. DELAUBRE. Congresswoman Clark.

Ms. CLARK. So much to discuss, so little time. But you touched on housing, and the affordable housing crisis is such a part of this and how we make sure that families have stable housing so they can build strong, healthy families that are employed. It is not easy when you don't have that fundamental housing component and are forced to move away from our job centers as we see gentrification, rising cost of housing, certainly something we are struggling with.

But I also wanted to ask you about the role of childcare programs like Head Start, programs making childcare affordable. In Massachusetts, one year of infant and toddler care can be more expensive than college tuition for families. And often the transportation voucher, if you are lucky enough to get a voucher, is so underfunded. And to say to parents and students—parents who are students that you have to have these requirements, but your voucher is only good for 8 hours is just an impossible balance.

So if anyone could just talk about the importance of making sure that we are having early, rich early education environments open to every child would be great.

Yes?

Mr. GARFINKEL. So the committee did not consider programs that would—of the kind you are talking about. Not because we didn't think they were important, but because the charge to reduce poverty in 10 years, just consider, for example, universal pre-K. I would say there was a lot of sympathy in the committee for that kind of proposal.

But if you start if someone is 3 years old now, 10 years from now they are only 13. So you don't see the reduction in poverty. We recommended that there be another committee that look at long-term investments in children. We think that is very—I would say everyone on the committee believed that was equally important, but focusing on cash programs also had a great virtue.

And I want to come back to your question about trauma because so I think insecurity potentially leads to trauma. And I must say one of my very favorite experiments, people love experiments. In general, I don't think social science experiments are the gold standard. But there are other kind of experiments, like with animals, that we would never do with human beings.

But, and now we are even pulling back with respect to monkeys. But I will tell you about an experiment that showed that insecurity was actually possibly more damaging than just simply poverty. And there were three conditions, and this was with Rhesus monkeys.

One was the monkeys had to work really hard. The mothers had to work really hard to find food. Second condition, it was relatively easy for them to find food. And the third condition was random alternation of those two conditions.

And the monkey mothers that had a poor environment, their mothering and their child outcomes, their offspring outcomes were worse than the monkeys growing up in the rich environment. But the ones in the insecure environment, where they didn't know what was coming because it was random, they were far worse, far worse.

And talk about trauma, and here I am going to anthropomorphize—or whatever the word is—the offspring would curl up, as if they are depressed, in the fetal position, leaning into their mothers for 15, 20 minutes at a time. That was not uncommon outcome.

So that is how I think insecurity potentially relates to trauma.

Ms. CLARK. And we have seen that with work that we have been doing around trauma, addressing it in early education in our school systems. And then we come back to so many of our teachers and early ed professionals have so much unresolved trauma, it is a very difficult position for them to become that person of trust.

So it is a generational problem, but I think we are beginning, and California is leading the way in putting this together as one of the markers that we have to look at. And we know that being in poverty is an inherently traumatic event and that like you said, that insecurity, that not knowing. Maybe one week, there is good meals, and the next week there isn't. Moving, whatever the change is, to adjust to a rapidly changing economic condition in the family, it has profound effects that are real and have—you know, if we really want to bend the healthcare cost curve, we better start looking at this.

Thank you all again.

Ms. DELAURO. Ms. Brunson.

Ms. BRUNSON. Yes, I want to speak on what he was saying about poverty as far as with the school system and the teachers. You know, the teachers, like I said, they are not teachers like we grew up with. And the teachers are being bullied—I mean they are bullying the children, you know? And that is where I think that the poverty comes in at with the kids that their mentality and everything, they don't really get everything that they really need from the school system.

Because one of the teachers told my granddaughter that he was going to make it his business for her to stay back. Now what kind of stuff is that to tell a child? The school system is failing our kids.

Ms. DELAURO. I just want you to know on that note, where I went to high school, the principal said to me—because I was a cut-up—she said to me, “You will never amount to anything.” [Laughter.]

Ms. DELAURO. So, but I had an unbelievably strong support system.

Ms. BRUNSON. Absolutely.

Ms. DELAURO. That I could fall back on and a support system that said, “You go, girl.” That is what it was all about. And that is what is critical.

I want to give you, what we want to do is just like very, very briefly, if you wanted to tell us something, what we should do, and I just want to go quickly down the line so we are going wrap this—we are going to wrap up the hearing.

Why don't we start with you, Professor Edin?

Ms. EDIN. So I would say, whatever you do, think about whether it incorporates the poor and brings dignity. I think the American Family Act, which is a little bit more generous version of what was in the report, does that.

Ms. DELAUBRO. Cheryl.

Ms. BRUNSON. I would like for you to think about the children and child poverty because in the middle class area and especially in Ward 5, the children are suffering.

Ms. DELAUBRO. Yes?

Ms. ACEVEDO-GARCIA. We have a responsibility to reduce child poverty by half today because we know how to do it.

Mr. BESHAROV. I am embarrassed to be so small bore. Ask the CRF to give you a report on marginal tax rates and work in marginal tax rates and marriage because you can do something with that.

Ms. DELAUBRO. Okay. Thank you.

Ms. BURKE. I would say prevention is key. Prevention includes universal preschool, and I would say that there is a new class of people. They are working poor, and the notion that they are stupid or lazy is outdated and ridiculous.

Ms. DELAUBRO. And demeaning.

Mr. WEIDINGER. The report provides a range of options. We tend to think in this town of all or nothing. We shouldn't. There are important incremental possibilities within the report that are flagged. So I would point your attention to those.

Ms. DELAUBRO. Thanks. Dr. Garfinkel.

Mr. GARFINKEL. So I understand that as an academic from Columbia University and heading of a poverty center, I can't endorse the American Family Act. But what I can say is that if something like the provisions that are in the act were enacted—

[Laughter.]

Mr. GARFINKEL [continuing]. It would be a good thing.

Ms. DELAUBRO. Okay. Thank you. Thank you.

And just to wrap up, by the way, also—and the personal stories that people tell—yes, do you want to make a statement?

Ms. LEE [continuing]. Oh, yes, let me just—

Ms. DELAUBRO. Yes, let us go.

Ms. LEE [continuing]. Thank you all for your presence, but also for your suggestions. And Mr. Garfinkel, Professor Garfinkel, you mentioned the report had recommended us look at what some long-term investments in alleviating child poverty would be. I think we have enough here to talk about some follow-up next steps from the report, but also I would add, Madam Chair, I think we need to take on looking at this issue and put into our report language, looking at the issue of systemic racism in child poverty.

Because everyone here has mentioned some of these underlying issues, and until we really bring that forward, sweep this out from under the rug, we are going to hold the line on some of the programs. We are going to maybe be able to do better with some. But

we will never be able to address the disparities with children of color as it relates to poverty.

So I think we need to have something in our report this year that addresses long-term investments as well as the issues of poverty and racism. And hopefully, the academy can be part of this.

So thank you again very much.

Ms. DELAUBRO. Those are great suggestions, and I also would like to ask all of you if you would bear with us as we try to look at some of the recommendations and also try to figure out how we craft the kinds of policy initiatives that we can moving forward. You all will be just an excellent resource.

What I was going to say is I don't remember all the details, but my folks were evicted many years ago, and our furniture was out on the street at 79 Pearl Street in New Haven, Connecticut. And I can only recall what the stories are about what that did and what that meant to my folks in trying to make sure that they could be gainfully employed and take care of their only child.

I would like to say this, that you know there are people in this country years ago who fashioned a social safety net. They were Democrats, and they were Republicans. They were not naive people. They were people who realized that as we moved down the road of industrialization and of moving forward, that they had the potential of people being left behind. And so what they tried to do was to put in place the social safety net that would keep people from falling behind.

And for those who would say that nothing has happened as a result of those social safety net programs really, quite frankly, don't look at the data. Let us just look at the data, and you have—this is in 2018—4.7 million children lifted out of poverty because of the EITC and the CTC, 1.47 million from Social Security, 1.38 million from SNAP, 936,000 housing subsidies, 800,000 school meals, 497 from SSI, 429 from child support, 216 from TANF, 160 from WIC, 103 from the UI program, unemployment insurance, 72 from LIHEAP, 27 for workers compensation. These programs work. They work.

And what we need to be doing is to strengthen these programs and adding on to them as we go forward and not fall into our own trap that says that people are not working as hard as they can and doing what they need to be able to have economic security.

And that is why what you have done here today, all of you, I thank you so very, very much for your contribution to this effort. It means a lot to all of us. And again, I want to thank Congresswoman Barbara Lee, Congresswoman Lucille Roybal-Allard for in 2015 having the vision that this would be a direction that we needed to go in to study what is going on with childhood poverty.

With that, the hearing is closed. Thank you.

WEDNESDAY, MARCH 4, 2020.

**NATIONAL INSTITUTES OF HEALTH BUDGET REQUEST
FOR FISCAL YEAR 2021**

WITNESSES

**FRANCIS COLLINS, M.D., PH.D., DIRECTOR, NATIONAL INSTITUTES OF
HEALTH, ACCCOMPANIED BY DIANA BIANCHI, M.D., DIRECTOR, EU-
NICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH
AND HUMAN DEVELOPMENT**

**ANTHONY FAUCI, M.D., DIRECTOR, NATIONAL INSTITUTE OF ALLERGY
AND INFECTIOUS DISEASES**

**GARY GIBBONS, M.D., DIRECTOR, NATIONAL HEART, LUNG, AND
BLOOD INSTITUTE**

NED SHARPLESS, M.D., DIRECTOR, NATIONAL CANCER INSTITUTE

**NORA VOLKOW, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG
ABUSE**

Ms. DELAURO [presiding]. The subcommittee will come to order. Good morning, all. Dr. Collins, welcome back to the Labor, HHS, Education Appropriations Subcommittee. Let me also welcome all of you. We have five institute and center directors who are joining in this morning. Dr. Bianchi, director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development. It is almost as long as the Subcommittee on Health, Education, Human Services, and Related Agencies here. So anyway. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases; Dr. Gary Gibbons, director of the National Heart, Lung, and Blood Institute; Dr. Ned Sharpless, Director of the National Cancer Institute; and Dr. Nora Volkow, director of the National Institute on Drug Abuse.

Again, welcome, welcome, welcome to all of you. Actually, Leader Hoyer asked me this morning, he said, do you have the NIH coming? I said, yes, indeed. He says, and are you ultimately going to be able to get all the institute directors to come up, and I said, we will. And he said it is one of the most remarkable hearings that we have, and we thank you for the great work that you do. And what a difference you make in savings the lives of the people of this great country.

At the start, let me just touch on the matter of the coronavirus. I want to just say thank you to the director, to all of the institutes. I want to just say a particular thank you to you, Dr. Fauci, and I want to say that our public health experts deserve our praise for what is the excellent work that you are doing on what is clearly a matter of national importance and national urgency, as you know, in so many ways.

Today we will be discussing the 2021 budget request for NIH, and I want to note that I intend to invite an additional panel of institute and center directors to testify in front of the subcommittee

later this year because I believe that we all learn a lot from all of you. That happened with us last September as well.

Before we get into the NIH's 2021 budget, let me just, if I can, bring you up to date. I think you know that the committee has been working hard to develop an emergency supplemental, you know, to be able to fund the response of this outbreak, and there are still one or two issues that remain, you know, open. But with all speed and deliberation, the intent is that, and the chairwoman can speak to that if she cares to. But we are looking at trying to move as quickly as we can between today and hopefully tomorrow, but before the end of this week, to get this finalized and voted on.

So the funding, you know, includes funding for the NIH. The funding will support research on diagnostics, therapeutics, and vaccines. For COVID-19, that will be critical to managing the outbreak and, again, to save lives. I also might want to note that NIAID is not starting at square one; rather, years of building research on coronaviruses and vaccine development. And I just want to say to the whole subcommittee, to my colleagues on both sides of the aisle, have invested sustained investments in biomedical research that the committee has made in recent years. And I am very, very proud that the Congress has increased the NIH funding by \$11,600,000,000, 39 percent over the past 5 years.

Last year alone, the Congress provided an additional \$2,600,000,000 increase over the Fiscal Year 2019 level for the NIH, and this was in a bipartisan, bicameral way that this was done, and we are very, very proud of that. I know certainly the ranking member is, and we worked closely together on this issue. I would just say to you that, you know, I think the President's budget would reverse this project. The budget proposes to cut NIH funding by \$3,300,000,000, 7.9 percent below the 2020 level. This would result in NIH making nearly 1,800 fewer new grants to research, a reduction of 16 percent.

This subcommittee will not be pursuing these cuts. We intend to move forward with a continued increase investment in NIH to build off that progress that we have made in recent years, and, again, that will be on a bipartisan basis. I know that, you know, as I know anything about where we are going and what we are doing. I am especially proud that the Congress provided \$25,000,000 for research on firearm violence prevention, including \$12,500,000 to the NIH. I was glad to see that the NIH budget request maintains funding for research on flu, including on the development on a universal flu vaccine. However, I believe we need to continue to grow this research as we did in Fiscal Year 2020, and I look forward to hearing more about what NIAID will accomplish with these additional funds.

I was disappointed to see a \$559,000,000 cut to the National Cancer Institute at a time of unprecedented promise in cancer research that has led to more and more promising researchers seeking NCI research grants. I think cutting the funding for NCI sends the wrong message. In fact, with only a few exceptions, the proposed cuts to NIH would touch every institute, almost every field of research.

Last year, in addition to new funding for several initiatives, we were able to provide a 3.3 percent increase to each NIH institute

and center. We need to keep up that momentum and not reverse it. I believe my friend and my colleague, Ranking Member Tom Cole, will concur. Biomedical research is one of the most important investments that a country can make because it gives the gift of life, which we need to support, and I promise you that we will.

Thank you again for everything that you do, and I look forward to our conversation today. And let me turn this over to my good friend from Oklahoma, the ranking member of the subcommittee, Congressman Tom Cole.

Mr. COLE. I want to thank you, Madam Chair, and thank all you for being here. Before I get to my prepared remarks, I just want you guys to know how you span the bipartisan divide that we have here. I actually made a statement, and it was tweeted out by Howard Dean last night, so I thought that was worthy of note. I very seldom get tweeted out by Governor Dean, so I was pretty proud of that. [Laughter.]

And the statement was, if I am buying real estate in New York, I will listen to the President of the United States. If I am asking about infectious diseases, I am going to listen to Tony Fauci. [Laughter.]

So I think that kind of sums up where we are as a committee. And I want to commend all of you and thank all of you for what you have been doing in the middle of a difficult national crisis, but, more importantly, what you just do day in, day out, every single day, and the amount of hope you give people around the world, certainly to our fellow Americans. And I think you have been extraordinary custodians of the investment that this committee has made on a bipartisan basis for multiple years, and I know intends to make again. If we can find any way to do it, we will do it, and I think we will find a way to do it.

The current challenge that we have, frankly, is a reminder that you need to do these things, and you need to do them on a regular basis. You can't just show up game day and think you are going to be able to deal with something. You have to have made the commitments, the investments over a long period of time to have the infrastructure to do it. I am very proud of this committee and our counterparts in the United States because we have done that. I am proud of Congress for this, quite frankly.

And this is no disrespect to anybody, but this committee has consistently in the last 5 years gone beyond what any President of either party asks it to do. And it did that because Congress, you know, we actually doubled the NIH budget many years ago. That was actually also a congressional initiative, if you will recall. I think Congress actually, because it is very close to the people, has a very keen sense of awareness of how much your fellow Americans value the endeavors that go on at the NIH.

So I will go to my formal remarks. After 5 years of sustained increases for the National Institutes of Health, I am pleased to welcome once again to this hearing Director Francis Collins. You must get tired of hearing this, but once again, I want to commend you, Dr. Collins, on your long and distinguished career in Federal service. You have left a legacy of excellence, and it is really an honor to work with you. And I have said this often, too. You have got to be the best politician in a town of politicians to get appointed by

Donald Trump and Barack Obama. I mean, that doesn't happen very often, but, again, I think it says something about the bipartisan nature of what you do and the national commitment there.

I have made no secret of the fact that increasing funding for the NIH is one of the proudest bipartisan accomplishments of this subcommittee. A sustained, steady commitment to increase NIH funding is critical to ensuring our Nation's future as a leader in biomedical research and unlocking cures to so many of the diseases burdening our strained healthcare system. The hard work and innovation this funding fosters is part of the sustaining force of the United States' economic growth.

Leaders in the House and Senate, Democrats and Republicans, have unified behind these increases over the past 5 years, and I ardently hope this trend continues for years to come. While I appreciate and sympathize with the fiscal restraint expressed in the President's budget, I do not think the reduction proposed for NIH is in the best interest of the American people. To reduce the NIH funding at this juncture would erode the progress we have made, as the chairwoman mentioned, over the past 5 years, signal to the research community instability, and, quite possibly, delay by years or perhaps decades advances in modern medicine, including curing diseases, finding better treatments for cancer, and unlocking the power of precision medicine.

I also want to caution against the budget request's proposed changes to the negotiation for indirect costs, are funds included as part of the grant to cover facilities and administration. This critical funding serves as a foundational element for research, and I support the enacted bill language. I hope, Madam Chair, we continue that restraint. This is a false economy that our friends in some quarters have pointed out, and it is one that will hurt research, not provide additional dollars. We simply, you know, need to protect the institutions that we have been investing in.

This past year, we had the opportunity to sit down with Nobel Prize winner, Dr. Jim Allison. His work on immunotherapy for cancer treatment promises to chart a course for a new direction for treatment for our deadliest cancers. The noninvasive nature and rapid time between treatment and resuming normal daily life is nothing short of remarkable. Moreover, these treatments are coming to market faster than therapies of the past and could take a decade before standard health insurance reimbursement. New applications for research in this area are overwhelming available Federal funding, and it is something I hope we look at very carefully going forward.

Companies have noticed the promise of such methods and are beginning to invest their own resources as well. Ten years from now, we may have thousands of cancer survivors that under today's treatment protocols would not have been helped. It is stories like this that remind me that support for the NIH has a real-life impact on life, and that every dollar investment is a direct downpayment to a better future for millions of Americans and tens of millions of others around the world.

I also want to highlight the progress we have made on Alzheimer's disease research. This deadly disease is creating an enormous strain on the healthcare system, families, and the Federal

budget. It is a rising cause of death and impacting more and more Americans each year. Total spending on Alzheimer's will exceed \$1,000,000,000,000 by 2050 if it remains on its current trajectory. We must make progress. Frankly, fiscally, there is no other option.

I am pleased to learn an international team of researchers, partly funded by the NIH, has made more progress in explaining the genetic component of Alzheimer's disease. Their analysis involving data from more than 35,000 individuals with the late onset of Alzheimer's disease has identified variants in five new genes that put people at greater risk of their disease. In order to tackle the fiscal, emotional, and financial toll that this disease is having on families, we must have a better understanding of the underlying genetics.

I do not want to take up additional time recognizing all the distinguished institute directors before us today, Madam Chairwoman, because, quite frankly, like you, I would rather hear from them about the exciting research that they are all involved in. However, I do want to thank each of you and your colleagues, and those institute and center leaders who are not with us for your passion, dedication, and hard work. I believe the work at the NIH has and will change the course of disease direction and treatment for many generations to come. I hope Congress continues to be a supportive partner in these efforts. Thank you, Madam Chairman, for holding this important hearing.

Ms. DELAUBRO. Thank you very much. It is now my pleasure to yield to the chairwoman of the full Appropriations Committee, and someone who has had just a major role in making sure that we respond in kind and with alacrity, Congresswoman Nita Lowey.

The CHAIRWOMAN. And I thank you, Chair DeLauro and Ranking Member Cole, for holding this hearing, and welcome once again our very distinguished guests. I don't know how you are awake, Dr. Fauci, but—

[Laughter.]

The CHAIRWOMAN. It is all those exercise routines. [Laughter.]

Thank you. Thank everyone because I know it is a team effort. Let me say at the outset, President Trump's disastrous budget is filled with deep cuts that tear at the fabric of our Nation. Instead of building on the historic investments in last year's appropriations bills, the President doubled down on partisan talking points. To propose investing \$2,000,000,000 for the wall and cutting \$3,300,000,000 from the National Institutes of Health really does expose the Trump Administration priorities for what they are: political rhetoric over public health. But as you know, this committee is on your team, and at a time with surging cases and costs associated with heart disease, cancer, Alzheimer's and related dementias, a vaping epidemic, and now the novel coronavirus, this panel's commitment to NIH will remain as strong as ever.

I would be remiss not to mention that with my retirement, this will likely be my last NIH budget hearing. I will have to come and be in the audience. [Laughter.]

And when I think about it, we have come so far since I joined this subcommittee in 1993. I was a kid then when NIH was funded at about \$10,300,000,000. We committed to doubling the NIH budget, then more than tripled it. Together, with the great leadership of this subcommittee, in the past 5 years, we have had increases

at \$11,600,000,000, for a total funding level of \$41,700,000,000. And, frankly, every penny was worth it, and we are so appreciative for all of you, for your talents, for your hard work, for your commitment. It has really been an honor for me to serve on this committee.

I do remember touring a lab with a young Dr. Francis Collins, who had a plan to map the human genome, and I remember that first map. There was nothing in it. [Laughter.]

And the advances in combatting breast cancer have revolutionized survivor rates as immunotherapy has given life to people who would have had a death sentence a decade ago. We know more about childhood development and the human brain, and we are witnessing amazing strides in precision medicine. And if you recall, we now even have some female lab rats. For those who weren't part of that humor at the time, we were convinced all the lab rats were male, so I am delighted to know that you have female lab rats.

Your work has filled me and millions of Americans with hope. Never in all of human history has medicine had more to offer, and yet with all these great achievements, we have so much more to do. I recently came across my questions from an NIH hearing in 1999 when I asked why women are more likely than men to have Alzheimer's. We still don't have the answer. In fact, we don't have many answers to Alzheimer's. I was on a panel. Lord knows why they asked me to be on a panel. And it was about 35 of us sitting around a table with one person who knew what he was talking about, a scientist from Columbia, and everyone was kind of quiet. And I said, Dr. Gibson, from Columbia, I said, so what are you recommending? You know, for many people around that table, there were experts, people who had been working on this for years and years. And he sat up and he said, diet and exercise. Dr. Fauci knows that, right? We have had conversations about that. Actually, so many of you.

But after all the investments, that is really all we are offering most people when it comes to Alzheimer's. We still don't know the answer, and we still don't have a method for early detection of certain cancers. We still don't know why treatments work for some patients but not others, and we still don't know why rates of autism are rising, and why there are higher rates among boys than girls. By the way, if you have answers to any of these questions today, feel free to share them with us. This may be up to date, I thought, as of this morning, but if you have some answers to these questions, we would love to hear them.

So there is so much we need to achieve, and I can think of no better people to do it than the people sitting in front of us today. You have saved lives. You have eased suffering. You are our superheroes. And with the polarization in our politics, if the American people could see how we could come together to fund such important work, I was going to say they would be proud. They would probably be shocked. But maybe we should invite more to really understand how bipartisan the NIH is and how bipartisan this committee is. And that is why we cannot let a partisan budget request stand in the way of saving lives.

So I thank you all. It is a pleasure for us to welcome you once again, Madam Chair.

Ms. DELAUBRO. Thank you. Dr. Collins, I am going to turn to you for testimony, and as you know, your full testimony will be entered into the record. And I would yield 5 minutes of time for your testimony. Thank you.

Dr. COLLINS. Well, thank you, and good morning, Madam Chair DeLauro, Ranking Member Cole, and especially Chairwoman Lowey. I did not realize you were going to make this announcement about 1993 to today. I think 1994 was the first time I appeared in front of this committee to defend the Genome Project, so thank you for that reflection.

On behalf of the National Institutes of Health—

[Disturbance in hearing room.]

Ms. DELAUBRO. Please.

[Disturbance in hearing room.]

Ms. DELAUBRO. Dr. Collins, please continue.

Dr. COLLINS. I do want you to know that the condition, ME/CFS, chronic fatigue syndrome, is of great concern to NIH, and these are obviously—

Ms. DELAUBRO. And if you need time to mention that, please go ahead and do it, okay, in the course of, you know, the proceedings this morning. Please, go ahead with your testimony.

Dr. COLLINS. I would like very much to talk about it at a later point.

Ms. DELAUBRO. Yes.

Dr. COLLINS. Okay. Let me continue. On behalf of the NIH, I want to thank you, this subcommittee, for that \$2,600,000,000 increase in last year's omnibus. The steady increases you have provided have brought new life to biomedical research and built a foundation for us to take on new and unexpected challenges, challenges like the one that is on everyone's mind right now, the global coronavirus outbreak. Your investments have enabled NIH to be at the forefront of action against this serious health threat, and I am quite sure you will hear more about what we are doing from Dr. Fauci a bit later.

In the meantime, I would like to highlight a few of NIH's other recent achievements, and maybe I could turn your attention to the screen. Science magazine announced its short list of breakthroughs of 2019, three of them supported by NIH. The first is the lifesaving progress we have made against Ebola virus disease, including the first effective therapies. Our second breakthrough, according to Science, was the development of kids getting specially-formulated foods to combat malnutrition, taking advantage of what we have learned about the microbiome. The third is development of a highly-effective triple drug therapy for cystic fibrosis, or CF.

I am among the legion of researchers who have been part of a long journey to develop targeted therapies for CF. Yeah, that is me on the left. [Laughter.]

Ms. DELAUBRO. Where is the guitar? [Laughter.]

Dr. COLLINS. It is off in the corner, on the left. Thirty years ago, when I led the NIH-funded team that co-discovered the gene for this devastating disease while I was at University of Michigan. Mutations in that gene lead to dysfunction of a protein that nor-

mally helps maintain the body's balance of salt and water, and without that, mucus builds up in the lungs, setting the stage for potentially respiratory infections. The new triple drug therapy kicks that protein back into shape.

And does it work? Well, take the case of Robin Petras, an Ohio woman with CF, who recently wrote to me. As these snapshots show, Robin slept in a mist tent as a child, and her parents spent hours each day loosening the mucus that clogged her respiratory tract. Later she became so sick, she had to give up her beloved teaching career. But just 5 weeks after starting triple therapy, Robin's lung function improved dramatically, and she now lives the active life she had always imagined. She has even set a new personal best: swimming a full mile in 60 minutes. I could not do that.

She told me this medicine has revolutionized her entire physical and mental life. What a transformation. Thirty years of research to get to this point, and a wonderful example of basic science, collaborations between public and private leading to his kind of breakthrough. So stories like Robin's inspire researchers to keep searching for innovative ways to help folks with all kinds of diseases.

Among the many exciting possibilities is a new generation of gene-based therapies. At past hearings, I have introduced you to just a few of those who have been helped by these therapies, people like Mateo with spinal muscular atrophy; Janelle, with sickle cell disease. And many of you have met cancer patients, like Emily, whose lives are saved by CAR-T cell immunotherapy for cancer.

But we need more breakthroughs. There are about 6,500 diseases for which we know the molecular basis. The pace of discovery has increased rapidly, yet we still have effective therapies for only about 500 of those. The latest development in gene-based treatments, the CRISPR gene editing system, promises to boost that number. CRISPR provides a precise find and replace function for DNA, allowing cells to be reprogrammed to correct disease-causing misspellings.

Five years ago, I never would have predicted this explosion of opportunities in gene therapy, but actualizing the potential poses real challenges. Today it can take 2 years to produce the materials needed for clinical trials of gene-based therapies, a new one just announced this morning. We can rely on the private sector to support trials for more common diseases, but for ultra-rare diseases, which involve tens of millions of people, NIH must do more to de-risk projects if we hope to enter as potential partners from the private sector. So to that end, the President's budget for Fiscal Year 2021 includes a \$30 million initiative for an NIH-led consortium to shepherd development of gene therapy targets for rare diseases from concept to clinic, customizing processes for gene delivery, manufacture of regulatory review, and testing.

To conclude, these are dramatic times for NIH research. Today I have focused on gene-based therapies, but many other remarkable advances are on the horizon, advances like developing vaccines for coronavirus and other infectious diseases, using science to address our Nation's opioid crisis, and applying the power of immunotherapy to even more types of cancer. None of this would be possible without your support. Because of you, we at NIH are working hard to turn dreams of healing and health into reality for

all. So thank you, and my colleagues and I look forward to your questions.

Ms. DELAUBRO. Thank you very much, Dr. Collins, and thank you for the slides and the stories because that makes it real in terms of how people's lives have been changed. I lost, growing up, two wonderful friends with cystic fibrosis, and it was extraordinary, you know, how we can now save lives in thinking about what you can do.

Dr. Fauci, I recognize that you have been very, very generous with your time in providing the subcommittee with information about NIH's current and proposed activities related to COVID-19, including basic research, development of diagnostics, therapeutics, and vaccine. Just kind of a two-part question. Would you give us a brief update on the latest developments in NIAID's work in this area? And because, as I mentioned, NIH isn't starting from scratch with regard to the research on coronavirus or on emerging infectious diseases, if you can tell us about how prior investments in NIAID, that research, have laid the groundwork for what we are able to do now with the coronavirus.

Dr. FAUCI. Thank you very much for that question, Madam Chair. Yes, in fact, if you look at the fundamental basic research on molecular virology and the ability, which really comes from NIH itself and NIH-funded investigators, to be able to identify a pathogen and sequence it extraordinarily rapidly allows us to do the things that I will mention in a moment. This goes back to fundamental basic research on molecular biology, virology, genetics, et cetera.

Remember, a major first coronavirus that caused the problem globally was the SARS virus in 2002, 8,000 people and 775 deaths, for a death rate of about 9 or 10 percent. Several years later, we had the MERS coronavirus, again, causing a problem in the Middle East. Now we have the third coronavirus. One of the things that we have been able to do, and the NIH, as you know, does many things, and we are studying very intensively the fundamental virology and pathogenesis of the disease. The things that we are doing right now in the form of interventions are in the arena of vaccines and in therapeutics.

It is really extraordinary that from the first time the sequence was made public by the Chinese when they discovered which virus it was, literally within days, we took that sequence off the database and inserted it into one of our vaccine platforms the messenger-RNA in the Vaccine Research Center at the NIH. And then what we did was a step-wise approach, to first determine is it immunogenic. Can you stick it in an animal, and would it make an immune response? The answer is yes. I predicted that it would be about 2 to 3 months to go into Phase 1 trials, and I think we are going to beat that. I think it will be in probably about 6 weeks, which, as a matter of fact, will be the fastest that anyone ever has gone from the identification of a sequence into a Phase 1 trial of any vaccine that has ever been done. That is the good news.

The sobering news is that since vaccines are given to normal individuals, what is paramount is safety and whether or not it works. So we will do a Phase 1 trial. We will do it in a number of our research centers, including our center at the NIH. That will take

about 3 to 4 months. And then if successful, which I believe it will be—there is no reason to believe it won't be safe—we will go into what is called a Phase 2 trial. The Phase 1 trial is 45 individuals. Phase 2 trials are hundreds if not a couple of thousand individuals. It would take about a year to a year-and-a-half to be fully confident that we would have a vaccine that would be able to protect the American people. And so although the good news is we did it fast, the bad news is that the reality of vaccinology means this is not going to be something we are going to have tomorrow.

In contrast with therapy, if I might say, we have a number of therapies that were effective in an animal model and *in vitro*. We don't know if they work in people, but we have already started a trial in the United States on a Gilead drug called Remdesivir in both Washington State, which is having a problem as you know right now, as well as at the University of Nebraska, where we have put the people who were repatriated and brought back. A clinical trial will be done, and if, in fact, it is shown to be effective, maybe not perfectly effective, but at least somewhat effective in bringing down viral load, we would imagine in the next several months, and it will take that long to do the trial, that we might have an intervention.

So going back from what you said, all the way to the molecular virology decades ago to where we are right now, I think that is what we call the proof of the pudding of investment in biomedical research.

Ms. DELAURO. Thank you. Thank you very, very much. As your grandmother and my grandmother would have said, lemon and honey is going to help your voice a lot, you know. [Laughter.]

So maybe a shot of bourbon, I don't know. But in any case, I have just about 13 seconds left, so I am just going to yield back my time and get around to my other questions second round.

Mr. COLE. In the spirit of bipartisanship, I want to assure you that a shot of bourbon can help you, Madam Chair. I have tested it routinely, and it works very well. [Laughter.]

Dr. Collins, you know, we all are always interested in stretching these dollars as far as we can and putting money behind research. But I think one of the smart things we did last year in a bipartisan and bicameral way was to set aside \$225,000,000 for infrastructure, frankly, and for facilities maintenance, and we know that does meet your needs. The idea, I think, the hope would be, we can see where our allocation is, what we could do. But that would be something we could sustain on annual basis for a number of years to let you catch up to where you need to go.

So, one, could you tell us sort of how that \$225,000,000 has been used? Two, what would you do if you had additional funds in the next year of comparable size?

Dr. COLLINS. Congressman Cole, I really appreciate you raising this issue because it is critical to the effective functioning of this remarkable engine of discovery, the National Institutes of Health and its intramural program. We have over the course of quite a few years been successively falling behind in terms of maintenance just because of the way the funding comes through. We are not allowed to spend money on buildings and facilities unless it is approximately designated as such.

And we now add up where we are. We are about \$2,100,000,000 in the hole in terms of the kinds of funds that would really ideally be necessary to keep the place in the kind of circumstances that you would like to see. And we have had a number of really major problems in our clinical center, which have caused quite a lot of difficulties in terms of being able to take care of patients. I can, if you would like, if it comes up here, show you a particular example of just some of the things that you can see have happened in the course of just the last few months in terms of floods. We have had to close down big parts of our clinic at times. So we have a big backlog of need.

The National Academy of Sciences was asked by the Congress to look at this issue and agreed that we need urgent attention to this matter. We also believe we need, in order for the clinical center to be fully effective, to replace our current operating rooms, which are at risk of having leaking in the ceiling in the middle of an operation, and that is obviously something you would never want to see happen. And so we have on the books already to go a surgery-radiology wing, the cost of which, though, is about \$500,000,000.

What you have done in terms of increasing the support for this has helped us hugely, and it will help us both with the backlog of maintenance that we need to pay attention to, but also to try to build up a sufficient amount of funds to start that new wing. And it will be greatly much appreciated if that can be also sustained in Fiscal Year 2021. You saw the President's budget actually did call this out as a special need by increasing that number for B&F to \$300,000,000. So I know this is not sexy in the same way as we are going to cure cancer or are we going to find a new answer for autism. But without the infrastructure, we can't take care of patients in the way that they are counting on us to do.

Mr. COLE. The fact that you showed up with slides might suggest that people coordinated this in some way. [Laughter.]

That would never happen.

Dr. COLLINS. I never want to miss the chance—

Mr. COLE. Never happen. Dr. Gibbons, heart disease and stroke are 7 times higher in American Indians/Alaska Natives than among their white counterparts, certainly in my State, which has a high concentration. Native Americans actually have the highest death rate from heart disease in the country. So could you tell us what the NIH is doing to address these health disparities and describe some of the progress you have made in recent years?

Dr. GIBBONS. Yes. Thank you for that question that addresses an important concern and an important health disparity. As you pointed out, we particularly have concerns about rural populations, and we recognize that and started a new cohort study. Our institute started the Framingham Heart Study over 70 years ago looking at communities to understand the driving factors in heart disease now taking us to a we now have a similar new program that is actually called RURAL that focuses on Kentucky, Alabama, and other areas with large rural populations. That is where we are seeing actually cardiovascular disease going in the wrong direction, as it is with certain populations, American Indians and rural Americans.

Similarly, we are engaged in a group of studies called DECI-PHER, that are taking community-based efforts to address how to

engage communities in the process of creating healthier communities, recognizing that often there are social and behavioral and cultural factors. And so that involves a community engagement strategy. In fact, Dr. Amanda Fretts is Native American and is now a principal investigator of our Strong Heart Study, which is based in Oklahoma, the Dakotas, and Arizona. She is engaged in a project to promote healthier lifestyles, particularly in American Indian communities, in fact, taking them into a more traditional diet of fruits and vegetables, whole grains that we know can help prevent heart disease. So this is very top of mind and a high priority.

Dr. COLLINS. Thank you very much. Thank you, Madam Chairwoman.

Ms. DELAURO. Congresswoman Lowey.

The CHAIRWOMAN. Thank you. I think I ask this question every time, Dr. Collins. Are we learning anything about the development of Alzheimer's? How far are we from even a temporary, I won't say a cure, but let me ask you. How far are we away from a cure or real prevention?

Ms. FRANKEL. Of what?

The CHAIRWOMAN. Alzheimer's.

Dr. COLLINS. I wish I had a crisp answer to that, but I would say progress in the last few years has been really impressively moving forward. We have identified pathways that are involved in Alzheimer's disease going well beyond the amyloid and the tau hypothesis, which has been so dominant. Genetic studies have revealed now about 100 different places in the DNA that provide a risk for this. And it tells you that there are things we didn't appreciate, such as that the immune system is involved here in some way, and lipids are involved in a way that goes beyond what we knew about before. And the cells in the brain that are sort of the support cells, the so-called microglia, are at least as important as the neurons, which have always gotten all the attention.

All of that has led to in a partnership with industry, the Accelerating Medicine Partnership, the identification in just the last year of 52 new drug targets, which are of great interest to academics and drug companies, and which will lead us down a whole bunch of new directions in terms of therapeutics.

But I have to say the amyloid hypothesis is still very much on many people's minds, even though we have had all of these failed trials and we don't understand why they have failed. Please keep in mind, Biogen is still taking the position that their most recent trial, when they reanalyzed the data, did look as if it provided benefit to people who got the highest dose of this antibody against amyloid for the longest period of time. And they have gone back to FDA, and FDA has been willing to look at the data again. And watch this space closely. If FDA decides there is something there, we might actually finally be in a place where we have a signal of some benefit, and then, of course, the whole game changes. There is a huge difference between having everything fail and have something work a little bit because then you can build on that, and we are all watching that closely. So it is really all hands on deck.

NIH is running now over 200 clinical trials, not just about drugs, but also about preventive interventions. The SPRINT MIND study, which Gary Gibbons could tell you more about, has definitely

shown that reducing blood pressure seems to be a good way to prevent the onset of dementia in susceptible individuals. Vascular contributions are really important here. We are pretty sure that physical exercise helps. We are pretty sure that cognitive exercises are also of benefit. I wish I was able to say that with absolute certainty. So we are making progress, but let's make no mistake, this is a really hard problem.

The CHAIRWOMAN. Okay. I will ask you next year. I will write you a letter next year. [Laughter.]

Can I come as a guest? Okay. Dr. Sharpless, another one of my favorite issues because it has been so disappointing. Are there any advances that have been made in early detection and treatment for kidney cancer?

Dr. SHARPLESS. Yes. We think the incidence, in fact, of kidney cancer has gone up modestly related to improved detection, so finding smaller lesions earlier. This provides some challenges because when you start detecting very small cancers, we already worry about this issue overdiagnosis and overtreatment in detecting really, you know, dangerous cancers as opposed to the more indolent type.

But I think that kidney cancer is an important human cancer where we have made some progress, but there is more to be made. It is not one of our most outstanding successes in the cancer world. Immunotherapy has some role for these patients. In terms of early detection, we are still considering a number of approaches, including, I think perhaps the most promising right now in addition to imaging is, you know, the ability to detect nucleic acid in the blood, so blood tests for something like kidney cancer and other related cancers. So we have a number of approaches, but stay tuned. It is still early.

The CHAIRWOMAN. Well, my time is running out, so I am sure Dr. Gibbons and Dr. Volkow, you all know about the rising rates of e-cigarettes, particularly among young people, which is just startling. Okay. If you want to make a quick statement, and then we can go back and get into it because I am really concerned about the incredible rates.

Dr. VOLKOW. And I think we should be concerned. In 2018, we saw a doubling in 1 year of the number of kids that were vaping nicotine, and in 2019, we saw a doubling of the number of kids that were vaping THC. So the concern is, of course, that these kids are becoming addicted both to THC and nicotine, and we may lose the big battle that we have won over combustible tobacco with all of the adverse consequences. So, yes, we should be very concerned.

The CHAIRWOMAN. So we will save it for the next round. I don't want to overstay my welcome. Thank you.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you very much, Madam Chair. And, Dr. Fauci, I am surprised you have a voice left at all. [Laughter.]

You appear to have been everywhere. You must have, like, twins or something. You are everywhere. Let me ask you a question about, because you used the word "the sequence" for the coronavirus-19. And that is the one, I take it, that the Chinese have shared, that sequence. My understanding is that they have

also been unwilling to share other samples of the virus, that that sequence is just one place in time.

Dr. FAUCI. Right.

Mr. HARRIS. And that it would be useful to know to see other samples. Is that true? I mean, from a scientific point of view, is that something that would be useful?

Dr. FAUCI. It would be useful, but we are mitigating that problem, Dr. Harris, because we now have unfortunately enough cases of our own.

Mr. HARRIS. Correct, and that is of concern to me, you know, that the Chinese did not share that because, I don't know. Look, in this instance, days or weeks might be very important, and I am afraid that we might have lost days or weeks because of China's unwillingness to share those early case samples. Now, the fatality rate is, of course, controversial because who just announced that they think it is 3.4 percent. You have been, I think, quoted in the New England Journal of Medicine a few days ago that, well, it is probably less than 1 percent.

Dr. FAUCI. No.

Mr. HARRIS. Where do you think it is going to end up because we don't know the denominator.

Dr. FAUCI. You said it, sir. If you look at the cases that have come to the attention of the medical authorities in China and you just do the math, the math is about 2 percent. If you look at certain age groups, certain risk groups, the fatality is much higher. As a group, it is going to depend completely on what the figure of asymptomatic cases is. So if you have asymptomatic cases, it is going to come down.

What we are hearing right now on a recent call from the WHO this morning is that there aren't as many asymptomatic cases as we think, which may then elevate, I think, what their mortality is. You know as well anybody that the mortality for a seasonal flu is 0 percent. So even if it goes down to 1 percent, it is still 10 times more fatal.

Mr. HARRIS. When we will know with our own data, do you think?

Dr. FAUCI. We will know, I hope. I am torn, Dr. Harris, because if we get enough data to have a big "N," it is going to be bad news for us, but we are learning more and more. The thing that is encouraging is that as part of the WHO umbrella team that went to China finally after a long period of time, there were two U.S. individuals on there, one from the CDC and one from the National Institutes of Health. He has come back. He is now in self-isolation in his home, but he is going to be giving us a report pretty soon about that. You know him. Cliff Lane. He is the individual who is my deputy. And I think we are going to get the information you need.

Mr. HARRIS. Good. Well, thank you. Dr. Collins, a couple of questions about data and information sharing. In your budget justification, it said the NIH is in the process of updating its data sharing policy. I am curious if you have any information on the amount of data that is indeed shared by NIH grantees, and whether you believe mandatory sharing of data should be a requirement of all those receiving granting. And a related question. The Administra-

tion has suggested that, you know, if someone receives Federal funding, the published research should be available free upon publication, not a 1-year waiting period, but free upon publication. So could you comment on those two, what I would call, you know, just kind of transparency issues regarding Federal funding?

Dr. COLLINS. Those are very much on our mind, Dr. Harris. And certainly in terms of having our grantees share the data that they have generated with public funds, we feel very strongly that is part of their responsibility. And certainly the data sharing policies that we have been putting together make that increasingly clear. There are some legal limitations on our actually making that a mandate, but we can certainly put, in terms of a term and condition of the award, that that is the expectation, and we can monitor that to see if, in fact, it is happening.

With regard to publications, we also believe that if the public is paid for science, that science ought to be accessible to people who are interested in looking at it. As you know, this is a controversial topic because some of the journals would find this to be an existential moment for them if everything was free immediately. We are working in that direction. We have for a few projects, like the Cancer Moonshot, like the HEAL Initiative, required that everything that comes out of those projects has to be accessible at the very moment that is published without any charge or any firewall, and that is a signal of where we want to go eventually. But this is a complicated negotiation.

Mr. HARRIS. That is right, but is it your feeling that it would be an existential threat, or that the journals could probably find a way around it?

Dr. COLLINS. I think all the journals are looking at options that they might try to adopt as alternatives to those that require complicated and expensive journal subscriptions.

Mr. HARRIS. Thank you very much. I yield back.

Ms. DELAUBRO. Congresswoman Lee.

Ms. LEE. Thank you, Madam Chair, thank you, Ranking Member, for this hearing. Thank you, Dr. Collins. Thank you for your team. It is always good to see you. And I associate myself with the remarks of everyone who has talked about the importance of continuing with our bipartisan work because, really, you are in the business of life saving and life affirming, and just thank you for everything that you are doing.

Of course, you know I have focused a lot on the National Institute of Minority Health and Health Disparities, and unfortunately I see this \$30,000,000 cut. The request, \$305,000,000, and the enacted level was \$336,000,000, it is a \$30,000,000 cut. Now, we know there are many disparities as it relates to communities of color when you look at the disproportionate rates of lupus, and thank you very much for following up with our request on lupus in terms of an action plan, higher rates of Alzheimer's among older African Americans, sickle cell disease.

In many ways, I feel like I have received a medical education from all of you because so many of my family members, friends, and community suffer from multiple sclerosis, COPD, lupus, sickle cell, HIV and AIDS, the A1c test, diabetes and sickle-cell trait relationship. So I personally, like most members, have gotten into the

weeds on a lot of these diseases, and we have put in budget requests and language. And I want to thank you for being responsive and for bringing forth the plans that we have asked for.

So in terms of these cuts, I am curious with regard to what the \$326,000,000 cut to the National Heart, Lung, and Blood Institute would do in terms of our COPD action plan. Also the cut, again, in the National Institute for Minority Health and Disparities, the \$30,000,000 cut, and over and over. I could talk about these cuts as it relates to, you know, some of these diseases. Multiple sclerosis. The BRAIN Initiative, I believe there is a cut of about \$40,000,000. So can you just kind of tell me how you are going to deal with this if these cuts, in fact, go through?

And then my second is, and I want to thank you for the report as it relates to the "Growing Absence of Black Men in Medicine and Science." And we are working very closely now with partners in this. And I wanted to ask you with regard to the Common Fund, how can we support more comprehensive work because this is outrageous in terms of what is happening to black men in medicine and in the sciences. And how we can help fund the National Academy of Sciences based on their roundtable work that they want to continue, and can we look to the Common Fund? Unfortunately, I see a cut of under \$96,000,000 less. No, I am sorry, \$42,600,000 than 2020. So we can kind of talk about how we are going to address these issues within this budget?

Dr. COLLINS. There are so many important questions there. Let me just try, because I know time is short. With regard to what NIH does when we encounter a circumstance of really significant resource constraints, I think all of the people at the table would agree with me that we try to still identify what our priorities are and try to protect those as much as we can. We look around to see if there are things that could be slowed down without quite as much of a serious impact, but it is painful to try to do that. And every one of the areas you talked about, we would have to struggle with exactly that kind of priority setting.

I am really glad you raised the issue about our workforce and the need for more representation from underrepresented groups. Our workforce does not look like our country, and it should. I want to mention, and this is something that you brought up in terms of the Common Fund, the program called the BUILD Initiative, which is a way in which we are making it possible for people from traditionally underrepresented groups to have a real scientific experience as undergraduates, which is how you actually capture the attention and the imagination and the passion of young people.

And that program, which has now been going on for 4 or 5 years, is actually looking very promising. None of these programs we do would be done without really evidence-based analysis. We are not going to support things that don't work. We also have supported a National Mentoring Network for people who may not be, like me, a white male who would naturally have a network that they could depend on. That has also turned out to be quite positive.

You are right that maybe an area we are particularly worried about is African-American men. We have a recent initiative we are discussing with the NCAA about how to interest athletes in science and provide them with scientific opportunities, like summer intern-

ships in a research lab, so that that will be seen as a more attractive possible career path with mentors and role models that they can learn from. So we are all over this.

Ms. LEE. Dr. Collins, would it be possible to work with your team to present new strategies, new ideas, and see if we can develop some broader partnerships that would actually enhance what you are doing?

Dr. COLLINS. Absolutely. We are closely aligned with the National Academy on this topic, and they have been very much partners, and we would like to build on that and do even more.

Ms. LEE. Okay. Thank you very much. We will follow up.

Ms. DELAUBRE. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair, and thank you all for being here. Good to see you all again, and, Dr. Collins, I appreciate your many years of service. I wondered if you and also Dr. Sharpless could talk briefly about the President's Childhood Cancer Initiative. That is something that I know we funded, and I just wondered if you could give us an update on that.

Dr. COLLINS. Dr. Sharpless is ideally suited for that.

Dr. SHARPLESS. I would be happy to take that. You know, childhood cancer is an area where we have seen significant progress over the last few decades, but we still have a ways to go. There are still clearly too many kids dying of cancer in the United States, and even the kids we are able to cure are often left with lifelong survivorship challenges because of significant surgery, and radiation therapy, and chemotherapy. So it is an area where we need clear progress. And the Administration announced this is a top priority of theirs to make progress in childhood cancer, and the President announced this initiative at the State of the Union more than a year ago. And now Congress has appropriated the funds, and we are tremendously grateful for that important devotion of effort and resources to this topic.

So it is under way. We have sort of convened a lot of the thought leaders in the community about how to make progress most expeditiously in childhood cancer. We have charged the working group to come up with ideas, and we are well under way. The focus here is on sort of how to use data better for childhood cancer and sort of radical data aggregation. I suspect, for example, we would be able to create a registry that has data on every child with cancer in the United States, and in terms of outcome and follow up, that will be a significant improvement over what we have now. So it is a very exciting initiative that is really getting started.

Mr. MOOLENAAR. Okay. Thank you. And Dr. Volkow, I wonder, in the past, you have discussed efforts to develop non-opioid alternatives to help manage both acute and chronic pain. I wonder if you could give us an update on the status of that research and some of the innovative approaches that might be coming down the pipeline.

Dr. VOLKOW. Yeah, thanks for that question. And indeed the general support from Congress that gave us \$500,000,000 to our base to actually study and address interventions in science that can solve the opioid crisis has enabled us to advance enormously our investments in understanding pain, transition from acute and chronic, but also to develop new therapeutics, and to determine

what implementation we can currently do to help patients that are suffering from chronic pain.

As a result of that, there are several projects that have emerged, including the creation of two networks. One of them will enable the development of new molecules and testing, and the other one will enable the testing in patients with pain of the interventions. And this is done with industry, with partnerships with industry so that we can help accelerate, but also with academic centers.

And this has been an incredibly challenging area to develop treatments that are as effective for pain, but safe, and that is why it is so incredibly relevant that we create the partnerships with the pharmaceutical industry. I mean, Francis has taken a lead on this, and I don't know if there is anything else, Francis, that you think is worth mentioning.

Dr. COLLINS. No, I think you have said it well. I would like to emphasize, this is another all-hands-on-deck circumstance where 20 of the NIH institutes are getting together to work on this initiative we call HEAL, which stands for Helping End Addiction Long Term, and for that, we need to have non-addictive, but effective, pain medicines. And we are working quite quickly in that space, recognizing it is a really hard problem.

Mr. MOOLENAAR. Thank you. Dr. Fauci, we have been talking a little bit about the coronavirus, and I wondered if you could comment some of the partnering that NIAID has been doing with BARDA on the development of medical countermeasures for these threats in general, biological and pandemic threats.

Dr. FAUCI. Yes. Thank you very much for that question. It transcends the coronavirus certainly because, you know, the NIH's fundamental mandate and work is in fundamental basic research and its translation into translational research, which is then translated into a product for intervention. And if you look at the things that are now out from a number of diseases, from HIV, to Zika, and now to coronavirus, it is essentially a process where we do the initial fundamental research, bring it to its early stage of development, usually in a Phase 1, and hand it over to BARDA.

What BARDA does, they get their resources and partner predominantly with either biotech companies or larger pharmaceutical companies to make a product based almost invariably, in fact, if you look at some of the things that have now come out with products, almost every single one of them, with few exceptions, has NIH fingerprints on them from the very beginning. So I think it is really a nice marriage and part of the continuum from the fundamental research for the product, and it has worked very well.

Mr. MOOLENAAR. Thank you very much. Thank you, Madam Chair. I yield back.

Ms. DELAUBRO. Congressman Pocan.

Mr. POCAN. Thank you very much, Madam Chair, and thank you all for being here. Dr. Collins, thanks for having all your colleagues here. I think the single easiest thing to say is it, and it is totally a tribute to all your work when you see the bipartisanship when this comes forward. When our ranking member was the chair of the committee or Ms. DeLauro, we as Congress increased funding to NIH, and I think it just shows how much we all value everything you do. So thank you.

And I just want to say thank you so much for updating the statistic, and I will mention it because I think it is good for every to know. We used to have, how many drugs were approved, I think, in a 6-year period that had NIH support, and it was every single drug. You just did a 10-year period. We look back going through 19 of the 356 drugs approved by the FDA, each and every single one had support from the NIH, and that is our tax dollars. So thank you for updating that number, and I think it is something, as we talk about drug pricing and other issues, it is very, very helpful.

I feel like I would be doing legislative malpractice, however, if I didn't talk about the coronavirus, especially with Dr. Fauci here. I want you to know I follow you very closely. I have enormous respect for what you say. I have been following Scott Gottlieb and have enormous respect for him. I have been following the World Health Organization trying to get some various sources on this. And I have to be critical in one area, and I would love you to help maybe talk me off the ledge on this, but I don't know if you can, is the lack of how we are handling testing right now, the fact that all of a sudden, CDC has dropped keeping track of how many people we test.

We had someone this morning talk to us who was part of the Ebola response. Their comment, and I will paraphrase, is, you know, when you don't even know what you don't know, that is not a great place to be, and trying to figure out how to deal with things, and the fact that if we start not keeping track of this, the amount of tests and who we are testing. We should be much more aggressive, I believe, in my opinion. We should be in the hospitals. Anyone who has got a pneumonia that we can't necessarily identify, we should be testing, because otherwise medical professionals need to know. I just feel like this is one area. You gave me great response on where we are on finding something to help, whether it be treatments or otherwise, a vaccine. I feel like this is one where we are dropping the ball, and I do want to get to another question, but let me ask you on this particular one, talk me off the ledge. I am nervous that we are not keeping track of who we are actually testing and the fact that we are not more aggressively testing.

Dr. FAUCI. Well, I am not going to try and talk you off the ledge because you are making a good point.

Mr. POCAN. Okay.

Dr. FAUCI. Push him off. [Laughter.]

No, it is less the keeping the track of the test, sir, than it is making the tests available and withdrawing the restrictions on who can be tested. So let me explain because this is really an important issue.

Mr. POCAN. I just want to leave a minute for the other question.

Dr. FAUCI. Okay. So the issue is the tests from the CDC were for public health components, State and public health groups. They would have to give it to them. The test result comes back from the CDC. That started off with some technical problems which delayed the test going out. The major issue that I find, and many of my colleagues find, problematic is that if you are looking for people in the community who don't have a recognized link to a case, we call

it community transmission, then you have got to withdraw the restrictions that in order to get a test, you have to have a link to something. It is almost inherently contradictory. Those have been lifted. The FDA has taken the constraints off, and now we finally have companies that are going to be making many, many more tests.

Mr. POCAN. But should we be proactive in testing, especially in hospitals and places like that, rather than waiting for people to come and be tested?

Dr. FAUCI. Yes.

Mr. POCAN. Okay, because I just feel like that is one of the components—

Dr. FAUCI. The answer is yes.

Mr. POCAN. Okay.

Dr. FAUCI. And I feel strongly about that.

Mr. POCAN. Thank you. I love when I get a one-word answer. Maybe you could meet with Secretary DeVos and explain to her yes or no questions. The second area, I am worried about supply chain. You know, I just read China Rx because Rosa told me, and now I have got Mike Gallagher, one of my colleagues on the Republican side from Wisconsin, you know, I think is going to read the book next. I am concerned about, you know, the fact that, as we have had the conversation previously about this, the number of either drugs that are made, active ingredients that are made, I would add medical devices that are made in places like China, and I don't know. Do we really know what that supply chain is with the various companies?

We did a letter this morning, Pramila Jayapal and I, to, I think, the top 20 or so prescription drug companies and are asking this very question. But do we keep track of this anywhere to know how many of the drugs are made in places like China, and where we could be for potential shortages in a case like this?

Dr. FAUCI. I believe that the FDA does, and, in fact, your concern is one that we have been talking about as part of pandemic preparedness for years. When we put together the plan back in 2005, we said one of the real problems is supply chain. I was somewhat, I would say, impressed/shocked that something like 90 percent of the fundamental ingredients that go into many of the drugs, not the actual drug itself, comes from China. So that is a real problem, and I don't have any answer for you. It is not anything that we do at NIH, but it is something that impacts us.

Mr. POCAN. Can I ask one really, really quick follow-up? Should we be tracking active ingredients in medical devices as well, supply chains?

Dr. FAUCI. I would imagine yes, but, again, that is out of our purview.

Mr. POCAN. Thank you.

Dr. FAUCI. Thank you.

Ms. DELAUBRE. We will do a hearing or a briefing with Rosemary Gibson, China Rx, so that we can talk about that. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair, and I am glad Mr. Pocan asked about this. This is one yesterday when I was at the White House I asked Vice President Pence about, the supply

chain issue. And I know in the last number of months we have heard "we're fine," "we're fine," "we're fine," "we're fine," or weeks, and then this last week, we started to hear, well, there are some concerns. I think February 27th was the first time that a prescription manufacturer noted that there is a supply chain issue with regard to the coronavirus, and we have already seen shortages for unknown reasons, of things like immunosuppressive drugs.

And this is an area that I am very focused on seeing what the solutions can be in the short term, because people say go get 3 weeks of your prescription. Well, if your prescription is being rationed, you can't do that. So there is now in the, you know, year that we are going to be dealing with maintenance and treatment of this virus. What should we be doing? What can you see? And then obviously there is the big picture. You talked about needing to fix the supply chain overall for preparedness. Could you speak to that?

Dr. FAUCI. Well, the supply chain problem is, as you know very well, a long-term problem that has been brought to our attention multiple times. And then when you have something like this, you realize you have a supply chain problem which you cannot fix immediately, and there is no real easy fix for it. I don't have an answer for you, but maybe this would be a lesson as we go forward that, as I have said to this committee many times, this isn't the first nor the last emerging microbe that we are going to be confronted with. And one of the issues that is vulnerable when you have an emerging infection is getting cut off from things that we depend on from other nations. I'm sorry, I can't tell you what to do tomorrow or next month, but maybe we could talk about the future and how we might turn the knob a little bit.

Ms. HERRERA BEUTLER. I am interested in that. I want to hear about the future and how we can change the big picture. I do think there are some immediate solutions that I am going to be asking the Administration to be considering and the different task forces to make it easier for people to access their prescriptions. Maybe it is even accessing a brand that is available over a generic that is not available, and how can we help make that cost effective for patients and hold them harmless. That is an area that I am looking at for in the immediate short term because people need to have access, period.

You know, the other thing I wanted to ask about is, and I don't know if you can speak to this. So being from Washington State, in my districts on the coast, I am in between Seattle and Lake Oswego. Obviously people at home are very attuned to what is happening. The State has requested, and, you know, there has been a lot of coordination. I have been on the phone. The governor is talking to the Vice President, is talking to the task force, talking to our senator. Like, everybody is mobilizing, and I am very proud of our public health response. I am grateful for the CDC, and even FDA folks were on the plane immediately, so we are moving forward.

One of the things that was asked, and it is kind of around the strategic national stockpile, which is not necessarily under your jurisdiction, but perhaps you could speak to. We have made a request for personal protective equipment. I think only about half of that has been let to us as a State. And then also what is your opinion

about expanding CDC testing criteria, because I agree. I actually think, so the State can only test certain amount of folks. We needed it in the commercial labs available for people to go in and test. Would you support expanding that criteria so we could get more people access? Your thoughts.

Dr. FAUCI. Yes, I would support it. Expanding criteria means withdrawing restrictions. That is the point—

Ms. HERRERA BEUTLER. I just want to hear it another way.

[Laughter.]

Dr. FAUCI. Okay.

Ms. HERRERA BEUTLER. I think we can't say it enough.

Dr. FAUCI. Yeah, right, and I feel very strongly about that. Washington has a very good public health group.

Ms. HERRERA BEUTLER. Mm-hmm, we do.

Dr. FAUCI. They have put together a test that they have done. They have been able to do it. They need help. They need support. I was on the phone late into the night last night with my colleagues from Washington, and we really do need to act aggressively there.

Ms. HERRERA BEUTLER. When you say "help" and "support," give me specifics.

Dr. FAUCI. For example, they are doing contact tracing on in the nursing home outbreak. Now if they find out that it is a community out there, they are going to have to do contact tracing on that. They are stretching their resources, and that is an issue.

Ms. HERRERA BEUTLER. So backfill support obviously—

Dr. FAUCI. They need some help.

Ms. HERRERA BEUTLER. And they need—

Dr. FAUCI. I think, in fact, I am certain. Not that I think, I am certain the CDC is right now as we speak helping them.

Ms. HERRERA BEUTLER. That is my understanding, but it is an evolving situation.

Dr. FAUCI. I was on the phone with them last night, so that is the reason why.

Ms. HERRERA BEUTLER. We appreciate that. Thank you, Madam Chair.

Ms. DELAUBRE. Thank you. On the supply chain issue, I would hope on a bipartisan basis that we could take a look, which is not the subject of this committee, but advanced manufacturing and what we can do in the long term on manufacturing those ingredients here rather than in China. And I think that is well worth our time and effort to take a look at. Congresswoman Frankel.

Ms. FRANKEL. Thank you very much for being here. All right. So I just have to ask you some supermarket questions. So people think, like, when I go to the supermarket, people think that members of Congress should know everything, all right? So these are very simple. So one of the questions I get is if the coronavirus is just cold symptoms, well, that is what we hear on the news.

VOICE. No, flu.

Ms. FRANKEL. Okay. More like the flu. Okay. I guess the question I have is how long does it last, and what makes it so serious?

Dr. FAUCI. It isn't a common cold. The confusion is that about 10 to 30 percent of the common colds that you and I and everyone else get during a season happen to be a coronavirus, but a certain sub-

set of coronaviruses can cause extremely serious disease. They did it with SARS, they did it with MERS, and now they are doing it here with the novel coronavirus. The reason it is serious is that, a question that was asked by Dr. Harris, is that the mortality of this is multiple times what seasonal flu is. So seasonal flu spreads widely. The mortality is 0.1 percent. Right now in China, the mortality for this particular infection, the latest report, was 3 to 4 percent. It might be a little bit less.

It isn't a cold. It is very interesting that most of the common colds are upper respiratory infections. This virus, not to get too technical, the component of the virus that binds to a receptor in the body to allow it to infect, those receptors are rich in the lung. That is the problem. It binds to it, so a person can present no sneezing, no sinusitis. Fever, shortness of breath, you do a chest X-ray, and you have pulmonary infiltrates. That is not the common cold.

Ms. FRANKEL. Okay. Well, thank you for that. Now I will have a better answer for people. Next question, if you are able to comment on this. In terms of your research, is there anything that you think the FDA can do to speed up your research? I see a shaking of the head by Dr. Collins.

Dr. COLLINS. You are referring to coronavirus specifically?

Ms. FRANKEL. Or any drug that you have been researching.

Dr. COLLINS. So we work very closely with the FDA. We actually have a Joint Leadership Council.

Ms. FRANKEL. Maybe this a better question. Is there anything that we can do to speed up the FDA? Yeah.

Dr. COLLINS. Well, Tony, maybe you should say specifically with coronavirus because FDA has been all-hands-on-deck in that space and has been very recently pretty actively enhancing the ability to do laboratory tests.

Dr. FAUCI. I don't think there is anything that you could do to speed up the FDA. Quite, frankly, they may need more resources to do the kinds of things they are doing. That is right, Madam Chair. But we have very good relationships with them. They have been very, very cooperative and collaborative with us in trying to get these countermeasures out as quickly as possible without cutting corners that would impact safety and our ability to evaluate efficacy.

Dr. COLLINS. Maybe the former acting commissioner of the FDA might want to answer this question as well since he is now the head of the Cancer Institute. So, yeah, what could the Congress do to help the FDA there, Ned?

Dr. SHARPLESS. Yes. To answer your question, I am here as NCI today. I don't really want to speak on behalf of the FDA, a different Federal agency. But I think, you know, a challenge like this is really trying for the Food Drug Administration because it is so sudden, and this sort of machinery is built to be deliberative. I think probably, you know, the device centers, decision-making about making these LDTs, the lab-developed test, more widely available and releasing those restrictions is a really important development that I think the academic labs will be able to bring these tests up to speed very quickly. I think they are definitely going to need more funding.

I think they have some significant hiring challenges in the FDA that I worked on a lot. 21st Century Cures gave them a new hiring authority that was much appreciated, and I suspect they will be using robustly. But they are really great people, and I am sure they are up to the task.

Ms. FRANKEL. I think I am running out of time. So one more question on Alzheimer's. Is private industry doing any research because I have always heard that because it is so expensive, that they really are cutting back on that.

Dr. COLLINS. They are, but it is not all companies. Again, I have the privilege of serving as the co-chair of the executive committee of what is called the Accelerating Medicines Partnership, which is focused on Alzheimer's as well as rheumatoid arthritis, lupus, and diabetes. And there are five companies there that are invested in this in a big way, and they have been willing to put their funds as well as ours together into a partnership where all the results are open access. But it has been concerning that a number of other companies have ceased working on Alzheimer's disease because of so many clinical trial failures. We need them to come back. I mentioned earlier we have more than 50 new drug targets. We are trying to encourage them to get interested again.

Ms. FRANKEL. Okay. Thank you. I yield back.

Ms. DELAUBRO. Congresswoman Bustos.

Mrs. BUSTOS. Thank you, Madam Chair. Well, first of all, thank you for answering so many of the questions that we have around coronavirus, but I am going to actually switch topics. Is that okay? [Laughter.]

So I am from Illinois. The congressional district I serve is 14 counties, goes up to the Wisconsin State Line. The Mississippi River is on the western part of my district and then goes into central Illinois. Eleven of the 14 counties are rural, and then we have the population centers of what we call the Quad Cities, Peoria and Rockford. So each of these counties and communities face the unfortunate circumstances that can lead to negative health outcomes, probably like almost every congressional district in the country. And, as you know, these are called social determinants of health, and I am just going to give you a few examples.

In Peoria, Illinois, we have got a problem with food deserts. And I heard a story from a person in my district, it takes them 16 bus stops to be able to access fresh fruit and vegetables. Sixteen bus stops. And then in Rockford, Illinois, Congresswoman Lauren Underwood just came to my district. She is the co-chair of the Black Maternal Health task force, and we brought her in so we could bring health professionals together and find out why in the State of Illinois black women are 6 times more likely to die as a result of pregnancy-related conditions than white women. So it is something that, again social determinants of health. How do we get to this?

We have a hospital in my district that took them 7 years to hire a primary care physician. Seven years. And then we have just closed within the last year the obstetric services out of Pekin, Illinois and Galesburg, Illinois. So those are some of the examples that were facing. So along with Congressman Cole, we introduced

the Social Determinants Accelerator act. I am very proud that we have gotten that out there.

But here is what I had like to ask you, and maybe, Dr. Collins, you can start, but I would love to hear from the rest of you on this. The National Institute on Minority Health and Health Disparities has a strong focus on social determinants of health, but each of your institutes obviously has skin in the game on this. So I am wondering if you can talk about how you are together addressing this, what I can take away from this. I love the powerhouse that we have sitting in front of us, and that is what I would like you to focus on for the couple minutes that we have here.

Dr. COLLINS. And it is a wonderful topic, and, in fact, every one of the NIH institutes, as you say, has skin in the game in various ways, and I could give you many examples. Because of the time, maybe I will first ask Dr. Bianchi to say what we are doing in terms of this very thorny and difficult and important issue of maternal mortality, which is particularly a problem of health disparities.

Mrs. BUSTOS. Thank you, Doctor.

Dr. BIANCHI. Thank you. NIH really shares your concern. The problem that we have is, although maternal mortality is rising, it is still a relatively rare event, so it is very difficult to study it. There are only about 700 women. That is too many, but it is hard to study 700 hundred a year. We are focusing on the so-called near misses. In addition, there are 50,000 more women who are near misses, and these women can help us to identify differences in survival. Why do these women survive whereas there are others who do not?

We also really need to understand why is there a difference in African-American women, as you mentioned, but also American Indian women as well as Alaska Native women, who all have higher risks of mortality, as well as all women over age 40. It is also important to recognize that maternal death doesn't just encompass pregnancy, labor, and delivery, but it encompasses the full year after delivery.

Mrs. BUSTOS. Right.

Dr. BIANCHI. And so we have to connect obstetrics with internal medicine. Pregnancy puts a stress on a woman's body, as you know. It unmasks comorbid conditions, such as diabetes, depression, and heart disease, so it is really an opportunity to intervene. Dr. Collins has put up the slide because we are now developing a trans-NIH initiative that is going to be known as IMPROVE. This is the first time you have heard about this. It is implementing a maternal health and pregnancy outcomes vision for everyone.

It has two components. One side on the right is the foundational biology part, which is really aimed at determining predictive biomarkers as well as novel technology, and on the left, there is a social and biobehavioral aim. It is very important to connect the communities not only to hear from them what they need, but then to be able to implement some of these changes.

Dr. COLLINS. Everybody could tell you more about it, and I am sorry because of the time I can't call on the other folks at the table, but we would love to talk to you more about this. This is a very high priority for us.

Mrs. BUSTOS. Okay. We will set aside some time where we can talk outside of this hearing, but thank you very much. I appreciate your perspective on that. I yield back.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. I yield to Congresswoman—

Ms. DELAURO. She wants to yield to you. Go for it.

Mrs. WATSON COLEMAN. Can you take that 33 seconds off my time?

Ms. DELAURO. Go for it.

Mrs. WATSON COLEMAN. Good morning, everyone. Thank you for being here, and I am so sorry that I missed a lot of the testimony. I think that you do important work, and I thank you for the service that you provide. Dr. Fauci, you said that do support proactive testing.

Dr. FAUCI. Mm-hmm.

Mrs. WATSON COLEMAN. True? Right.

Dr. FAUCI. Yes.

Mrs. WATSON COLEMAN. So what does that mean? Why are we not doing it, and what does it mean, and who would be tested, and under what circumstances?

Dr. FAUCI. We are beginning to do it now. It was not implemented earlier, and—

Mrs. WATSON COLEMAN. What does that mean, though?

Dr. FAUCI. Proactive testing means when you have community spread where you do not have a known index case. So let me give you an example of what non-proactive is, and then it will be easy to show what proactive is. So you bring in someone, as we did when we flew many of our diplomats and others from Wuhan, we brought them back to the United States. And the thing you needed to do was to test their obvious contact, like their wives or their husbands or what have you, and you wind up seeing that they are infected or not. Proactive means I don't know what is in the community, so I am going to go to a bunch of emergency rooms, and when people present with symptoms that look like they might be coronavirus, even though they have no connection with anybody who has coronavirus, they didn't travel anywhere, and test them to see if they are infected.

Mrs. WATSON COLEMAN. That is even in communities that have absolutely no knowledge of having being there.

Dr. FAUCI. Absolutely. Absolutely.

Mrs. WATSON COLEMAN. If I go to the emergency room in New Jersey where there are no confirmed cases or anything, but I have got some symptoms—

Dr. FAUCI. Right.

Mrs. WATSON COLEMAN [continuing]. Flu-like symptoms, right?

Dr. FAUCI. Right. Right.

Mrs. WATSON COLEMAN [continuing]. They would test and make sure that it is not the corona.

Dr. FAUCI. There aren't enough resources to do it in every single emergency room and every single center. So what the CDC has done, they started by taking six sentinel cities, and now they are expanding that to many more cities, essentially doing sentinel surveillance in different places. And that will give us a good idea, or

at least a partially good idea, of what is under the radar screen that we are missing.

Mrs. WATSON COLEMAN. So are these cities clustered only near like the State of Washington?

Dr. FAUCI. No. No. The cities are Seattle, Los Angeles, San Francisco, Honolulu, New York, and Chicago, and there will be more.

Mrs. WATSON COLEMAN. My understanding is that the CDC is managing diagnostic tests sent to State public health labs, while FDA is managing tests at private labs. How does it get determined who does what?

Dr. FAUCI. It is not a question of managing. It is a question of the CDC's fundamental mandate is to develop the test and provide it for public health purposes to individual State and local public health authorities. The issue with the FDA came in when the FDA can give permission for a medical center—you pick it, University of Washington in Seattle, Cornell in New York City—to develop their own test or to partner with a biotech or diagnostic production line, and do their own tests on their own without needing the very intensive quality control that the FDA generally gives to a test. So that gives much more flexibility to have many, many, many more centers do their own tests.

Mrs. WATSON COLEMAN. Okay. My husband had pneumonia in December, and he is still coughing. I am like, I want to send him. I want to send him to have him checked out. I am very interested in research into health disparities among minorities and non-minorities and minority children, and what is happening with the suicide rates, how it seems to be growing exponentially or just disparately in the African-American community. And I am wondering, the budget as proposed, what is the impact on the Institute that would do that kind of research and be able to support those kinds of services?

Dr. COLLINS. So as we mentioned earlier, when NIH is faced with resource constraints, we try to identify what are the most high-priority issues and try to protect those, even if it means that we have to cut back in other places. I totally agree with you. The question of health disparities, and especially something as heartbreaking as suicide, has to be a very high priority. And the National Institute of Mental Health, who is not represented at this table, has a big investment in that space, and particularly trying to understand are there ways of identifying who is at risk and making an intervention before it is too late.

And we are getting closer to that and even using things like machine learning, taking advantage of what happens because everybody is carrying around a cell phone. There are indicators in terms of people's reduced social interactions that they are perhaps in a depressed state that you would not have otherwise known. A lot of that research is now going on, and it is very appropriate to focus particularly on the health disparity part of it.

Mrs. WATSON COLEMAN. I am sorry. Is that my 33 seconds?

Ms. DELAURO. Fifty-two and now a minute.

Mrs. WATSON COLEMAN. I yield back. I have other questions regarding this issue. Thank you.

Ms. DELAURO. We are hoping for a third round. Congresswoman Clark.

Ms. CLARK. Thank you so much, Madam Chairwoman, and thank you all, this incredibly esteemed panel. Dr. Fauci, I am hearing a lot from hospitals in my State of Massachusetts who are feeling under resourced and unprepared for the coronavirus. Can you tell us a little bit about, as we are anticipating moving from containment to mitigation, how we are going to help with the hospitals around the country? Uh-oh. [Laughter.]

Dr. COLLINS. Was that a response?

Dr. FAUCI. Yeah, that was a response. [Laughter.]

So when you say "we," are you talking about the United States government? So, I mean, I can't—

Ms. CLARK. NIH and CDC.

Dr. FAUCI. Well, the NIH is not going to be able to do anything there except make, as quickly as possible, the results of the research we do to be able to be deployable in places like Massachusetts.

Ms. CLARK. Right.

Dr. FAUCI. The CDC works very closely with State and local health authorities, and that is one of the reasons why I think you are going to see, and I don't know what it is going to be, is that there are going to be resources that are going to have to be forthcoming to go. And I understand there is a supplemental package being run through. I don't want to address that, but that is one of the ways to answer the question, is that the States, Massachusetts included, are going to need some help to be able to implement the kinds of things that I think are going to be needed.

Ms. CLARK. Looking at Massachusetts and this entire health crisis, one of the things I am glad about is that Massachusetts has a very high number of insured people.

Dr. FAUCI. Right.

Ms. CLARK. That does not hold true across the country, and I am concerned about how our health insurance policy plays out in something like this. Can you tell me where you see the gaps, and what is most immediately obvious to you about what we can do to redress it?

Dr. FAUCI. That is a very good question. And because of that, most recently, it must have been in the last couple days, they all seem to mesh these days. But it has been a couple of days, that the director of the CMS has now been made a member of the President's task force, so that person is there. Those questions came up. Exactly the question you are asking came up at the task force meeting last evening, and that is going to be addressed.

I don't know what the answer to it is because that is not my area, but it clearly came up, just like you said, that some States, some territories, some regions have good insurance, good care, and others don't. So how are we going to get the tests equitably distributed, not based on whether somebody can pay for them or not.

Ms. CLARK. Yeah, you know, it pulls in our paid family leave policies, all these different things, and we don't expect the CDC to take on that whole policy agenda, but they are so intertwined. And I hope that the task force will also look at immigrant communities. If we cannot get immigrants to fill out a Census because of fear, how are we going to get them to access healthcare for their children and themselves?

Dr. FAUCI. Again, a very good question because that also came up at the task force, and from what I am hearing, that is not going to be an impediment. Right.

Ms. CLARK. Excellent. We will wait and see. Dr. Volkov, good to see you. I was also very concerned that the Trump Administration had proposed transferring \$5,000,000 from substance use and mental health services, nearly \$63,000,000 from NIH to fight the coronavirus. I don't think we make tradeoffs between public health emergencies. But I wonder if you can tell me what progress has been made and what steps are NIDA taking to work on the youth-focused interventions and recovery support services.

Dr. VOLKOW. Well, again, one of the things that has helped us enormously has been the \$500,000,000 that came to address the opioid crisis, because one of the projects that has been prioritized is prevention interventions. And when you address prevention interventions to help to avoid kids start taking drugs, you don't do it specifically for opioids. You do it in a general sense. And this is also important because we are seeing now that the opioid crisis is shifting not just from opioids, to getting into psychostimulants, so it is not like we are going to have to address prevention for one drug. We need to address the question what is making us vulnerable as a country, and youth are the most vulnerable of all of them.

So we have several initiatives that are on that are going to be expanded, for example, prevention to rural communities that are at very, very high risk for drugs, to the criminal justice setting. How do we intervene in schools? And another project that we have been able to hopefully launch, as you know, we have done a 10-year follow-up for children from 9 to 10 upward to understand what are the factors in the brain that makes you vulnerable to drugs, but how does the environment influence them? We want to start in infancy to look forward. So these are just some of the examples that we are targeting to try to develop knowledge and implementation methods to prevent youth from taking drugs.

Ms. CLARK. Great. I am out of time. I would love to follow up with you in another way on medically-assisted therapies treatment for younger people as well. Thank you.

Ms. DELAURO. Thank you. What I am going to try to do is to ask three or four questions and get quick answers to them, so, and let me just start with this. Dr. Bianchi, endometriosis, a disease that impacts 1 in 10 women, leading cause of hysterectomy. Can you describe NICHD's research related to endometriosis? Tell us what your top priorities for the research would be if provided with additional resources. And I am asking this question, and where is my colleague, Congresswoman Finkenauer, who has a very serious interest in this area, and thank you for being here, Congresswoman Finkenauer. So hold on to that.

Dr. Collins, we gave you \$12,500,000 for gun violence prevention research. I want to have you tell us what do you expect to do with that. Also with the Office of Research on Women's Health, the NIH budget has grown by 39 percent. Office of Research on Women's Health has increased only 8 percent. Anyway, they have a critical role in doing what we need to do across all of the institutes. How would additional resources for the Office of Research on Women's

Health enable the office to better advance and coordinate women's health research?

And, Dr. Gibbons, cardiovascular disease and women. You know, stroke, heart disease leading cause of death for women in the United States. What research is NHLBI supporting to improve diagnosis and treatment of women with heart disease? Dr. Bianchi.

Dr. BIANCHI. Thank you, Madam Chair. As you said, 1 in 10 women have endometriosis. These are women of reproductive age. It is associated with chronic pain, has enormous economic impacts because women do not go to work. It is a leading cause of infertility, and it is also associated with an increased incidence of cancer. NICHD has a Gynecologic and Health Disease Branch where we are funding research on the diagnosis, prevention, and treatment of endometriosis. We have made it one of our 10 aspirational goals in our strategic plan, and I am very proud of the fact that NICHD's research, we are talking about drugs that were developed as a result of NIH support, the drug Orlissa, which is the newest drug to treat pain in women with endometriosis, came out of an NICHD SBIR grant. Thank you.

Ms. DELAURO. And I will just say this to Congresswoman Finkenauer, that you ought to be in touch with Dr. Bianchi to get all the information that you need to move forward. Dr. Collins, prevention research.

Dr. COLLINS. Very quickly to preserve time for Dr. Gibbon. Firearms. We have invested in firearms research all along, and having these additional funds from the Congress in the current fiscal year is something that we welcome. We are invested in a full set of threat research to Americans' well-being, and we will continue to do so, and are certainly committed to executing any funding directives from the Congress.

We have already written up various funding opportunity announcements, are waiting momentarily for them to be cleared. We will look at such things as the role of videogames, the role of trying to keep firearms out of the hands of adolescents, such things as the violence interrupter schemes that are carried out in some cities, do they actually work. We need data here, and we are the data people.

Ms. DELAURO. That is right.

Dr. COLLINS. So you can count on us. You asked about ORWH, the Office of Research on Women's Health. A very important part of what we do, Janine Clayton, who is the director of that, is a wonderful catalyst. But let me emphasize that while the funding of ORWH is modest, it is about \$43,000,000—

Ms. DELAURO. Right.

Dr. COLLINS [continuing]. The overall funding for women's health research is about \$4,400,000,000, so it is reflective of the way in which this, in fact, involves all of the institutes.

Ms. DELAURO. I am very, very concerned about the amount of funding to the Office of Women's Health Research. I understand it is being done. It is cross cutting, but this is something that many, many years ago we identified as something critically important, and I want to make sure they are getting the resources that they need. Go ahead, Dr. Gibbons on NHLBI.

Dr. GIBBONS. Well, maybe I will take off on that point. A key part of the initiative for the NHLBI to address women's health and

cardiovascular disease is actually to take more of a focus in their reproductive years. And to do that, we recognize that a leading cause of maternal morbidity and mortality actually relates to cardiovascular disease, typically women over the age of 30 in their reproductive and child-bearing years.

So we have a number of initiatives that are targeting that. So, for example, pregnancy is often a stress test for the cardiovascular system. Peri-cardiomyopathy is a major cause of maternal morbidity and mortality. So we are really striking up an initiative to better understand what are the drivers and biomarkers and actually genetic factors that may be predisposing to that. Similarly, we recognize that women who have adverse pregnancy outcomes often have a long-term trajectory of increased cardiovascular risk. So we have the nuMoM2b Healthy Heart Study that is following up over time and recognizing that there may be interventions we can do to change the whole trajectory of those women.

Ms. DELAUBRO. Mm-hmm. [Audio malfunction in the hearing room], and really these things playing together. They are not in isolation. They are not in silos.

Dr. GIBBONS. That is correct.

Ms. DELAUBRO. And they work together on this. Let me yield to my colleague, Ranking Member Cole.

Mr. COLE. Thank you very much, Madam Chair. When I think about the appropriations, you know, it is too easy sometimes get caught up in a what are we doing this year kind of mentality. Really the way this process works is everything is cumulative and incremental in appropriations. And so under that philosophy, we have adopted over the last 5 years a cumulative and incremental increase for NIH funding. And so, Dr. Collins, I want to ask you two of my favorite questions because you always take me in interesting directions.

First is, one of the things we have been able to do that we would not have been able to do had we not made these kind of consistent investments and looking forward, what are the things that you think we might be able to do if we were to continue down the path that we have been on; that is, sustained inflation plus increases for the NIH over the next 5 years?

Dr. COLLINS. I love being asked these questions. Thank you, Mr. Cole. The way in which these 5 years of steady increases influence things is perhaps most dramatically visible in what we have been able to do for early-stage investigators. Back in 2015, we funded 600 of those grants in 1 year, and that was not nearly enough, and people were getting pretty concerned whether they had a career path. This past year, we funded over 1,300 of those, more than doubled this investment in the next generation of talent. And morale has just dramatically changed. I will be in Alabama tomorrow and Friday meeting with investigators, and I can tell you they are going to be really excited about science because now the environment makes it possible for them to take risks. Similarly, we have been able to increase the number of just overall grants and the number of principal investigators. We have enriched the breadth and depth of the entire workforce that we depend on.

In terms of specific things, we have been able to put forward projects that are truly bold improving our understanding of life to

single cells, the single cell biology effort, being able to go after things, like the influenza vaccine, at an even higher rate, the universal flu vaccine, than we would have otherwise, and develop platforms like what we are now using for coronavirus. We couldn't have done that if we hadn't had the support.

Initiating this dramatically bold program called All of Us that aims to enroll 1 million Americans in a long-term prospective study of health, and that is going to be a platform for so many other things that we will want to learn about, and that takes resources. The BRAIN Initiative, really trying to figure out how what is between your ears does what it does. Again, now spending \$500,000,000 on that. And it is remarkable what kind of technologies have been invented and what impact that will have on brain diseases. Cancer immunotherapy, making great advances we would not have been able to do as quickly without your help. And the whole focus on opioids and finding alternatives to opioids through the HEAL Initiative. Those are just a few of the things that we would not have been able to do had it not been for your strong support and seeing this predictable upward trajectory.

What we could do going forward? Well, gosh, the sky is kind of the limit here. I mentioned in my opening statement about gene therapy, that we are at this cusp where we can begin to take what has now been done curing sickle cell disease with gene therapy. Let's start curing a lot of other of these conditions as well. You can see the path forward to do that. New opportunities in terms of artificial intelligence machine learning applied. We are going to have a big investment there coming in the next year or two because we can see ways this could play out in multiple different applications.

A new focus maybe on nutrition. We are talking seriously about that. It is an area that we know is critical for health, and yet the science hasn't necessarily quite gelled around the new opportunities. It is time to do that, and, again, that is going to take resources. And all the things we talked about in terms of health disparities, ending HIV in the U.S., dealing with the new difficulties with methamphetamine and cocaine, not just about opioids. Those are all in our minds as visionary things that we can accomplish with this kind of path being continued. So I really love the question, and everybody at the table would have their own answers, but I guess I kind of gave you a bunch of mine.

Mr. COLE. Well, Mr. Sharpless, on cancer, what would your answer be?

Dr. SHARPLESS. Yeah, you know, I think you mentioned Jim Allison earlier, the Nobel Laureate who won the Nobel Prize for figuring out kind of using the immune system to cure cancer, right? I think what is maybe not known about Jim's story is that he started out in a small institution in Texas. That is where the first paradigm change in research was done. It was not a glamorous institution. It was before he went to Berkeley. It was before MD Anderson. It was before he went to Sloan Kettering.

And I think that I am obsessed with the fear that there are these great scientists with terrific ideas who are working out there sending us their grants. We have had an explosion of grant submissions, a 50 percent increase over since 2013, and that we are not able to get to their great idea because our paylines just aren't high

enough. So with the generous appropriation that Congress has been giving us, we have been trying to get those numbers up so that we can get to the really innovative cutting-edge science that make a difference for patients, like Dr. Allison's work.

Mr. COLE. I just would say, Madam Chairman, I hope we look at this this way. We ought to be thinking about this because, as Dr. Collins said, every person here could give us a different answer if we could tell them some certainty. We are going to stay on the track that we have been on, and we want you to think that way and present those kind of possibilities. I think this committee has done that, and, you know, frankly done a good job at it.

Ms. DELAURO. Congresswoman Lowey.

The CHAIRWOMAN. Thank you very much, and I want to take this opportunity again to thank you all for your extraordinary work. I came back because I wanted to get back to the whole issue of e-cigarettes with Dr. Gibbons and Dr. Volker. With all the information out there, it is not penetrating the kids, and the rising rate of e-cigarettes among young people, as you know, is startling. When I look at the numbers, 64 people died. Nearly 3,000 were hospitalized last year with vaping respiratory-related illnesses.

Now, as I understand it, many, but not all, of these cases were attributed to vitamin E acetate, long-term impacts of vaping, but concern is growing that there could be long-term health consequences: heart disease, stroke, cancer. In the couple of minutes we have, I would like to hear from both of you. What can we do about it? And if you have any ideas, it would be welcomed. I just see these numbers increasing on college campuses exponentially.

Dr. VOLKOW. Yeah, one of the things that we don't necessarily recognize is that these vaping devices are very high technology for delivering drugs in ways that make them very, very rewarding and addictive. So you can actually deliver huge quantities of nicotine in much higher concentration than what you normally do with combustible tobacco. As a result of that, what we are observing is in the past where a kid will take several months to escalate, now we are seeing this escalate in a couple of weeks, and that is also associated with toxicity with higher risk of addiction, and that is what we are now facing.

And the numbers speak for themselves. One of the main reasons, which was not even recorded in the past, why teenagers are saying that they are vaping nicotine is because they say they are hooked to it. So they have done that transition very, very rapidly, and I think the message is that it is urgent that we do interventions to prevent that. We need to stop it because, otherwise, we will go into tobacco smoking again. But also all of the points that you are saying that I will let my colleague, Dr. Gibbons, address, we don't really know what are the consequences of delivering this vaping into your lungs as well as other organs.

Dr. GIBBONS. So you clearly raised an important area of concern. Just last summer, obviously you are describing the cases of e-cigarette and vaping associated lung injury that really started to explode as sort of a new epidemic and mysterious illness. We didn't know why people were presenting with shortness of breath, and other symptoms requiring hospitalization, until we got this history of vaping. This was an area where close collaboration, between

NIH, FDA, and CDC in response to this public health threat was pretty immediate and collaborative. Within weeks, we were convening subject matter experts from around the country, and, again, leveraging prior investments this committee has made because we were able to leverage centers of excellence in tobacco regulatory science, bring and convene people who have already been studying e-cigarettes together, and say what can we do, what is going on about this new vaping epidemic related to lung injury.

That mobilized a research agenda. And so, again, within weeks we put out a notice to engage our research community to start studying what is driving this EVALI. And the CDC, with its case definition and surveillance apparatus, was able to start to make these links to THC and substances that might be combined with THC that might be driving it. By December, we clearly had a sense that vitamin E acetate from samples from the lung may be a key associated element of this phenomenon.

And, again, related to the researcher community we established, investigators were already beginning to study and get the causal link between vitamin E acetate and study it in animal models. And, in fact, in just the past few days, it was published in the New England Journal of Medicine, by NHLBI-funded investigators in Roswell Park, that indeed just giving vitamin E acetate through a vaping device, at least in this mouse model was, was they could recapitulate a lot of the lesions seen in patients with EVALI.

So literally, within 8 months, we been able to close the loop from a mysterious disease involving a collaborative effort between NIH, CDC, and FDA, to address that public health threat, and with that awareness, we are starting to see the cases come down. But, as Dr. Volkow mentioned, we still don't know the long-term effects. In fact, we have now funded a cohort to follow and trace all those patients with EVALI, and we recognize that EVALI is probably just the tip of the iceberg. What is happening to subclinical injury to the lung in the long term of these young people? That is still an unknown.

The CHAIRWOMAN. Well, my time is up, but I would just hope that we could work together. I think it is pretty conclusive this just isn't good for kids, adults, or anybody.

Dr. GIBBONS. Absolutely.

The CHAIRWOMAN. What are we doing about it? The kids don't believe it, and working with CDC, perhaps—

Ms. DELAURO. Ban it.

The CHAIRWOMAN. I am with you. I would ban it completely. But I would like to follow up with you because it seems to me the science is conclusive, and what are we going to do to get these kids to understand, cut it out. Thank you very much.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you very much, and thank you all for being here. It makes me nostalgic for the days I used to do research. [Laughter.]

How exciting it is, especially when we have discoveries. Dr. Collins, just briefly, you know, a group of us are going to send a letter to the President asking him to look again at human embryonic stem cell research, which we understand still continues at the pace of about a \$25,000,000 a year at the NIH. As you know, I mean,

the future really is pluripotency, you know, inducing pluripotency of regular cells into stem cells states. And the idea that we are continuing to destroy human embryos and funding it or funding the destruction basically through the NIH, I think is a mistake because, you know, human embryos are, in fact, the youngest humans. And I think many believe correctly that human life should never be used as a mere means for achieving the benefit of another human being. That is not the purpose of human life.

So I would hope that if the President responds positively to our letter, that you could come up with a way to phase out that, you know, to just phase out the use of a \$25,000,000 on something that really has yielded no direct clinical benefit yet. And I understand there are basic science reasons to pursue it, but these are humans. These are the youngest humans. We should move away from that as soon as practical.

Dr. Volkow, it is good to see you again. You probably know what I am going to ask about. It has been a year, and I want you to update us on, you know, the marijuana research that is done, looking at its effect on the brain because, you know, as more States attempt to move to recreational use of marijuana. Fortunately in the last omnibus bill, you know, an attempt was turned back to make the recreational marijuana industry much more profitable and widespread through, you know, removing banking restrictions. I mean those restrictions are still in place, so it buys us some time to actually educate the American public, I think, about how dangerous it can be. So if you could just talk about that.

And just as an aside, I do believe our colleagues in Energy and Commerce are going to move finally a medical marijuana research bill that makes it easier to do research and to truly discover what is merely a pie-in-the-sky promise with regards to what marijuana can do and those diseases where it really will be of help. But if you could just update us about some of the research that indicates just about the dangerous expansion of marijuana, especially with the bleed down to younger individuals that we see. I mean, whether it is e-cigarettes or marijuana, you can make it illegal, but young people are going to use it. So if you could just briefly in the last 2 minutes discuss what is—

Dr. VOLKOW. You know, and thanks for asking that question because it is an area where there has been major changes in the perception of the American public that we have a drug that is benign. And as a result of that, we are seeing a very dramatic increase in the number of people that are consuming marijuana, 44,500,000 million in 2018.

Of greatest concern, of course, relates to children because the brain is developing until we are in the mid-20s, and the endogenous cannabinoids system, which is the one that is basically stimulated by marijuana, is crucial in enabling that development, including migrations of cells, how cells communicate with one another. So what the research has shown that kids, adolescents, consuming marijuana, and there is a dose effect, are much more likely to show disruptions in terms of structure and function of the brain. That appears to be associated with cognitive impairments. The criticism that has been done of those studies is that they have to look at it retrospectively, which is the reason why we are currently doing the

ABCD Study that is looking prospectively to address specifically that question objectively in ways that cannot be challenged.

What also has merit very clearly, and this is from stories that have come across all over the world by independent nations, is that the use of marijuana with high-content THC is associated with a greater risk of having psychosis. Now, the big question is, is this acute or chronic psychosis, and there is now data to show unequivocally that high doses of THC can make psychotic any one of us. Chronically, now, the data indicates that it does increase the risk, that you could develop a chronic psychosis, whether you have the genetic vulnerabilities as we would recognize it now or not. So and this, again, highlights why we need to provide information to the public so that they go in with their eyes wide open when they make decisions of taking drugs, but, importantly, when we make policy decisions.

Mr. HARRIS. Thank you very much. I yield back.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Thank you very much. Dr. Fauci, of course have worked together for many years on HIV and AIDS, on the epidemic. I co-chair the bipartisan Congressional HIV/AIDS Caucus, and we are still working together in a bipartisan way to make sure that we have the resources to address this epidemic. We are at the tipping point now in the field of HIV research, including vaccine development. So I would just like to ask you if you have kind of an update on the future progress in these areas in terms of vaccine for HIV and AIDS.

Secondly, I would like to ask you, just in terms of the coronavirus, has it hit a pandemic level or not, and how do we explain to our constituents the difference between an epidemic and a pandemic? And I want to find out, as serious as this is, well, I think we are doing a good job in explaining how to prevent the transmission of the virus. But given that there is a 2 percent fatality rate for this virus and it is impacting people who are elderly, I wanted to find out, do you think, from your perspective, that that 2 percent is accurate right now in terms of fatality rates?

And then to Dr. Collins if we have time, just on sickle cell, how close are we now? I mean you have done some remarkable work on sickle cell disease, and we are waiting, and I know we are close. Of course, you know, 1 in 10 African Americans in the U.S. have sickle cell, well, at least the trait, and so I wanted to just see how close we are, and how we are doing as it relates to identifying the trait early enough where those who have diabetes recognize that the A1c test is not accurate or could provide false results.

Dr. FAUCI. Okay. I will be really quick because you had a lot of questions. So the vaccine, as you know, we had a disappointing situation with the vaccine trial that was finally looked at by the Data and Monitoring Safety Board in South Africa, which was called HVTN 702, which was using the model that we used in the Thai trial, and that showed, safety, no deleterious effect, but no efficacy. There are two other major trials that are going on, one in southern Africa, one in the Americas and Europe. Those trials, we won't have the data on them probably for at least another couple of years. They are using a different concept. They are using a different vector. They are using a different protein, and they are

using a different adjuvant. So I can't give any prediction of what the result is going to be.

Simultaneous with that, there is another whole effort on HIV vaccines using a structural biological approach to get the right confirmation of an immunogen to induce broadly-neutralizing antibodies, which are the gold standard of protection against viral infections. So there is still a lot of good work going on, but we did have a disappointment.

Number two, the word "pandemic," there are many, many people who have different descriptions and definitions of "pandemic." "Pan" being all, means widely distributed. The WHO has not declared this a pandemic yet because they haven't had very sustained transmission throughout the world, so, technically, it is not a pandemic. It will be up to them to make that declaration.

Next, the 2 percent mortality. A report just came out today that when they looked at the totality of the data, in China mostly because 90-plus percent of the infections are in China, it was somewhere around 3 percent, up from the 2. The percent mortality will depend on the denominator of number of cases. So if you are not counting every case, then the mortality would look high. If you are counting a lot of cases that are subclinical, the mortality will become lower. But no matter how you slice, it is many, many, many more times lethal than the influenza that we get in the season, particularly for the elderly and those who have underlying conditions, because most of the deaths and the hospitalization, the mean age is about 70.

Ms. LEE. Dr. Collins, quickly.

Dr. COLLINS. Very quickly, and my colleague, Gary Gibbons, is very much in the lead of this effort. We have a whole Cure Sickle Cell Initiative that NHLBI is leading. And the good news is here, we now have at least three clinical trials that are using gene therapy for sickle cell disease that appear to be working and working dramatically. They are very high tech. They require very specialized technology and hospital services. So it is not quite ready for broad extrapolation, but we are going to see, I think, in the next few years sickle cell disease becoming one of those conditions that we can actually cure.

In fact, we have started a new initiative with the Gates Foundation to figure out how we might extrapolate that to Sub-Saharan Africa, which is where most people with sickle cell disease live. And it would be unethical, I think, at this point to say we are fine because we figured out how to do this in a high-tech environment. We have to figure out how to do it in a low-resource setting as well. The interaction with A1c and sickle trait is now well recognized, I think, by many physicians. It was a very significant JAMA publication that laid out exactly the data about this about a year ago, so I think there has been a recognition that this has to be paid attention to in managing diabetes with somebody who has sickle cell trait.

Ms. LEE. Thank you very much.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you so much. I was delighted to hear this morning the story on NPR about the incredible advances, and you did a very good job, Dr. Collins, on, you know, injecting a virus into

the retina and potentially restoring vision. It is unbelievable. But I know that there are many concerns also with CRISPR and these technologies after the Chinese scientists edited genes of babies last year. So I know there is great work going on about putting up the sort of ethical guardrails that we need. I wonder if you can tell me what steps NIH is taking to protect patients and mitigate wrongdoing as we continue to push the boundaries of science and medicine for amazing cures.

Dr. COLLINS. Well, this is an area of intense interest of for all of us, and it is this remarkable circumstance of the application of CRISPR-Cas, so-called gene editing, for many different genetic diseases. And you mentioned the one that was just reported about this morning, which is a cause of blindness, is one of the most exciting things that is happening right now in terms of research. Let me make it clear. Those approaches basically approach a way to fix the spelling of a misspelled gene somewhere in the body, but it doesn't get passed on to the next generation. It is non-hereditary.

What happened in China was an intent to actually make this kind of change in an embryo, which would be what you call the germline, the hereditary changes, and we all agree that that is utterly inappropriate at the present time. There is so much we don't know about that, so many risks, so many theological and philosophical consequences to beginning to change our own instruction book. We at the NIH would not support that. In fact, that would be illegal in the United States, that kind of embryo manipulation. The World Health Organization has a high-level panel that is looking at this, and we wait for their recommendations. And so far, they have also come down quite strong on this. Our National Academy—

Ms. CLARK. Do you know when you expect that recommendation?

Dr. COLLINS. The WHO recommendation? I think probably in the next few months, sometime during this calendar year, from what I hear. They are beginning to close in on some sort of conclusions. Again, WHO has a challenge because they have got to get all those countries to sign on to it, so there will be a draft and then we will sort of see what happens. Certainly in this country, that would not be something we would do, but at the same time, there is all this promise if you don't deal with the hereditary applications. But what we call the somatic cell part, you are dealing with the eye, or amygdala, liver, or maybe the brain for a child who has otherwise an untreatable genetic disorder. This is potentially enormously exciting. We have a whole program at NIH and our Common Fund trying to develop the ways to deliver that gene editing apparatus safely to the tissue where you want it to go, because it is one thing to know how to do it in the cell culture, but in a person, how do you actually send it to the right zip code and have that result happen safely and effectively. There is a lot going on in that space, and we have made a pretty big investment.

For me, who is a geneticist, you know, these 7,000 genetic diseases waiting for some kind of solution, this is a scalable approach that might actually work, not in the next 100 years, but maybe in the next decade. But we have to work really hard to knock down all the barriers.

Ms. CLARK. Thank you. Dr. Sharpless, it came to my attention recently through crackerjack staff that 20 percent of cancer trials failed due to insufficient patient enrollments because there are barriers, restrictions on eligibility, access to transportation, et cetera, ability to take time off work. What efforts are NCI undertaking to enhance clinical trial recruitment and operations at smaller community sites that may not traditionally be engaged in clinical research?

Dr. SHARPLESS. Yeah, I think it is a really important topic. Clinical trials accrual, the whole foundation rests on being able to recruit patients. And we have so many trials and so many great ideas in cancer, but if we can't test them, then we really can't make progress. So fixing this problem is an intense focus for the National Cancer Institute.

I think one big issue is, you know, basket trials in the prior era were designed poorly. They were designed to be done in, you know, tertiary care centers only and not to be done in sort of the other sorts of environments, and required, you know, just a process that was bad. And so one of the things that has happened in the last few years is a real focus on these sort of basket trials that can be done in the community. So the NCI Match trial accrued 6,000 patients at 11,000 sites, for example. We have this in-core network that has these sites that allow people to get to accrued trials in the community. We know that being on a trial provides better care, and it also provides a more diverse population on the trial, so it is really important.

And lastly, I should mention, we have made it a crusade to get rid of these arbitrary and somewhat silly eligibility enrollment criteria that keep people off trials, like HIV positive or treated brain metastases, or things like that. So we, working with others in the oncology community, have tried to make trials simpler and more doable in the community, but it is still an area where we need some improvement.

Ms. CLARK. Great. Thank you so much.

Ms. DELAURO. Congresswoman Frankel.

Ms. FRANKEL. Thank you again for being here. This has been terrific. And so I have three questions. Okay. Number one is, I had read a report or a study that women are feeling like doctors are dismissing their complaints, so, number one, I am curious whether or not there is any research on sex discrimination in medicine. Number two is, where I live in West Palm Beach, it seems like in the entertainment district, every other storefront is selling CBD. Florida has also legalized marijuana. So I am just curious whether or not there is any research to show that either CBD or the marijuana is medically effective. And then my third is back to my grocery store questions on coronavirus, is I know you are not supposed to touch your face, but is it any part of your face? Where are the germs going? And if someone is gets quarantined, how long do they have to be quarantined for, and can there be repeated quarantines? I mean, I guess the better question is, do you think this is going to be a widespread issue in our country? Sex discrimination first, yeah.

Dr. COLLINS. Sex discrimination first. Dr. Bianchi.

Dr. BIANCHI. Certainly with regard to maternal mortality, there is definitely discrimination and that women's voices are not being heard, and that is one of the aspects of the IMPROVE Initiative that we want to address. That is the community-based initiative. We know that there is not only a dismissal of women's voices, but also there is infrastructural racism, and we are definitely including that as part of this overall initiative.

Ms. FRANKEL. The CBD and marijuana.

Dr. COLLINS. Nora.

Dr. VOLKOW. We know there is evidence from CBD to be effective for helping to treat seizure disorders in children, Dravet syndrome, and that has led to a medication. Otherwise, there are no other FDA products approved for CBD, but there is interest with respect to its analgesic effects. There is interest with respect to its anti-inflammatory effects. And we also definitely are interested and are evaluating its potential therapeutic value to help treat different types of addiction, including opioid addiction. With—respect

Ms. FRANKEL. When you say "interest," does that mean there is research being done or—

Dr. VOLKOW. Research is being done.

Ms. FRANKEL. Okay.

Dr. VOLKOW. We are funding researchers to do this both in animals and in humans. And with respect to the THC, the information is more limited. There is some evidence that it could be beneficial for multiple sclerosis, for spasticity from multiple sclerosis, also for pain indications, and otherwise, the evidence is not very good in terms of its potential benefits. But researchers are doing studies, and we are funding researchers to do studies on PTSD, for example, could it have a value.

Ms. FRANKEL. All right. Back to the coronavirus.

Dr. COLLINS. Yeah, touching your face.

Dr. FAUCI. So—

Ms. FRANKEL. First of all, to have the germs get in you.

Dr. FAUCI. Okay. So, first of all, you asked a question about touching your face.

Ms. FRANKEL. Yeah.

Dr. FAUCI. So the public health ways to avoid getting coronavirus are very similar to those to avoid influenza, and that is particularly as simplistic as it sounds: washing your hands as frequently as you can. One of the problems with respiratory-borne diseases is that they are spread either by droplets, gross droplets—someone coughs or sneezes on you—or even a bit of aerosolized where you can be sitting next to someone very closely, and you don't cough and sneeze, but the virus can aerosolize—

Ms. FRANKEL. So, I mean, does it go into you through your nose, your mouth?

Dr. FAUCI. That is what I will get to.

Ms. FRANKEL. Okay.

Dr. FAUCI. All right. So what it is, it will get in through a mucosal surface. That could either be your nose, your mouth, or even your eye. The reason for washing your hands is that people often do the wrong thing. That is why you hear us say cough into the crook of your elbow because people sometimes go like this, to blow their nose. They will shake hands with you, touch a doorknob.

Fifteen minutes later, you come by and do that, then you touch your face, and that is how you get it. So that is the way. That is the first thing.

Secondly, incubation period quarantine. The incubation period, the median time from when you get exposed to when you get clinical symptoms, is about 5.2 days. That is the median. The range is somewhere between 2 and 14. Fourteen is much, much more the outer limit. So when someone is suspected of being exposed, they either self-isolate or they get actual institutional quarantine for 14 days.

Ms. FRANKEL. But you could have—

Dr. FAUCI. Fourteen days. Fourteen.

Ms. FRANKEL. You could have multiple self-quarantines. I mean, what if you get exposed and then you stay home, and then you get exposed again and you stay home? Do you have to stay home every time you get exposed?

Dr. FAUCI. Well, it depends on what you mean by “exposed.” I mean, if you are exposed to someone who has documented infection, and then you are tested and you go into voluntary isolation, not necessarily quarantine. The only time you get quarantined is if it is very, very clear that you have direct contact with someone.

Ms. FRANKEL. But it could be multiple times.

Dr. FAUCI. Well, it could be if you are in a situation where you are in an outbreak. Well, that is very interesting because when you go from containment, which means to prevent the spread, to mitigation, which means in the community, distancing yourself socially. If, I don’t want to say “when” because every time I say “when,” it is a headline. If. [Laughter.]

Dr. FAUCI. Okay. If it gets to the point where there is really widespread infection, if that ever happens or—

Ms. FRANKEL. Do you expect that to happen in our country?

Dr. FAUCI. I can’t predict that. I cannot—

Ms. FRANKEL. Are you worried about it?

Dr. FAUCI. I don’t worry. I try and just do things that can prevent it.

Ms. FRANKEL. Thank you very much. I yield back.

Ms. DELAUBRE. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. When there is a vaccine available, who gets it first besides my colleague to my left? [Laughter.]

Dr. Fauci, who gets it first, and how do we go about distributing it?

Dr. FAUCI. Well, the standard approach when you have a vaccine, for example, for influenza, when you have limited vaccines, you give it to the most vulnerable. And the most vulnerable clearly are the elderly and those with underlying conditions, and those generally are heart disease, chronic lung disease, kidney, diabetes, and obesity, or those who are using immunosuppressive drugs who might have an underlying cancer.

Mrs. WATSON COLEMAN. And so we are 18 months or so away from that. Probably?

Dr. FAUCI. At least. The other thing that is important is the healthcare workers and those who are the frontline responders because those are the ones in every disease we know that are the most vulnerable. In fact, if you look in China, the people who were

most vulnerable before they had good PPEs were the healthcare providers.

Mrs. WATSON COLEMAN. Mm-hmm. Thank you. Dr. Collins, following up on my interest in the whole issue of health issues and the disparate impact on minorities, one of the things that I learned from the emergency task force that we had on mental health and black youth suicide was that researchers, black researchers in particular, have not been having their research requests considered, and they have been denied these requests for reasons having to do with not communicating clearly what it is that you are looking at. The implications of community outcomes or collaborations not necessarily recognizing the significance in our space, with regard to issues of that nature.

One of the things that one of the Institute directors talked about was having more workshops, having more input from black researchers into what would be considered and whose grants and stuff will be considered. What are the things that we can do to ensure that researchers of this nature are getting an equal opportunity to do the research that is important for the disparities that exist in the minority communities?

Dr. COLLINS. This is an issue that we are looking at with great seriousness since it was documented a few years ago that, in fact, an African-American investigator, who comes to NIH with their best and brightest ideas, has a lower chance of getting funded than other groups. And that is very disturbing to look at, and there were many hypotheses about what might be involved. I think we have not completely sorted out all the reasons, but we have discovered a number of them, and certainly part of this issue does relate to, I think, the fact that oftentimes investigators may not have been in as strong a position to be able to put forward a grant application because of the lack of mentoring, the lack of opportunities to sort of be involved in networks, which may be a natural thing for others, but for minorities not so much. And we are working very hard on ways to do a better job of mentoring with something like the National Mentoring Research Network.

We also identified the fact that there are different areas of research where minorities tend to migrate, and health disparities research is one of those, and you can see why that is. That is some oftentimes a passion for somebody who gets into research who comes from an underrepresented group. They want to work on understanding why their communities are not being as well served. And yet it is clear that some of the research that goes on in that space doesn't fare as well in our peer review system, regardless of whether the applicant happens to be a minority or not. So there is some action there that we need to take.

We are still trying to sort this out. There was a paper we published a few months ago about this which got a fair amount of attention. We are continuing to do the analysis to see what else we are missing here. We are determined to sort this one out.

Mrs. WATSON COLEMAN. Well, I am glad. I am both a co-founder of the Congressional Caucus on Black Women and Girls, and we are interested in those things that impact individuals, particularly because of the intersection of their gender and their race, and as well as the interest in what is happening with our children and

mental health disparities, things of that nature, big issues in my community. So I thank you for the work that you are doing, and I look forward to the work that you will be doing in the future. Thank you. I yield back.

Ms. DELAURO. Thank you. We are going to do a kind of a third round here with 3 minutes each. But I wanted to let you know I have just been informed, I do not know what the dollar amounts are, but it would appear that the House and the Senate, Congressman Cole, have come to an agreement on the supplemental. [Laughter.]

God is in His Heaven. All is right with the world.

Dr. COLLINS. Yes.

Ms. DELAURO. And so actually we just got that that notice, and so that word will be getting out about dollar amounts, et cetera, et cetera, et cetera. So, again, yes, wonderful. This is where we need to go.

I am going to do my rapid fire piece here again. Dr. Gibbon, status update on NIH's efforts on a commission on lymphatic diseases. Okay. NCI. You talked about lots of activity in the area, Dr. Sharpless. Tell us a little bit about what is driving the interest in cancer research because you have so many more. I would love to know at some point, and maybe I will just sit and talk with you about where we stand with ovarian cancer and finding a marker for ovarian cancer.

Universal flu vaccine update, Dr. Fauci. If we could provide additional resources in 2021, how quickly might we move to some success there? And, Dr. Collins, the NIEHS. In past emergencies, they supported training for workers, for healthcare workers, airports, correctional institutions, et cetera. Just a quick overview of their work or training activities in recent public health emergencies, H1N1 flu pandemic, Ebola, and could they support what we need to do for this current COVID-19 outbreak. So status of the commission on lymphatic disease.

Dr. COLLINS. Sure.

Dr. COLLINS. A lightening round.

Ms. DELAURO. A lightening round.

Dr. GIBBONS. Exactly. So you hit on the important issue that of lymphedema is often debilitating and disproportionately affecting women. We have established a task force that is trans-NIH that is focused on lymphatic research, this issue. The NHLBI alone spends \$20,000,000 a year on this issue along with many other ICs contributing even more to that collective effort.

One of the key activities of interest is part of the human cell atlas that Dr. Francis Collins described in which we were able to get single cell resolution characterization of many cells in the body. One of the key organs, if you will, is the lymphatic system, and so understanding that system both in normal human health and development, as well as in response to injury and disease is fundamental to really getting to better treatments for the disease.

Ms. DELAURO. We will have further conversations on this, but we did encourage in the omnibus a national commission on lymphatic disease, so we are going to pursue that with you. NCI. What is driving this interest?

Dr. SHARPLESS. First of all, I would say it is a really good problem.

Ms. DELAURO. Yes. Amen.

Dr. SHARPLESS. I mean, you think of all these people coming with good ideas. That is that is what drives science.

Ms. DELAURO. We got to be able to fund them, too.

Dr. SHARPLESS. It is probably a lot of things. I think the National Cancer Center Program plays some role. I think our low paylines, frankly, people just write more grants. But the main one, I think the really inherent one is the exciting time in cancer research, the scientific progress. I saw this at the FDA when, like, 30 percent of the business in terms of new approvals and devices and drugs were cancer-related products. I see this in Big Pharma. I see this in basic science. There are just a lot of people who think they have good ideas for cancer, so I think that is the main one. And I would be happy to follow up with you on ovarian cancer.

Ms. DELAURO. Yes, on ovarian cancer. Still after all these years, we don't seem to have a marker.

Dr. SHARPLESS. Agreed.

Ms. DELAURO. And we know how many thousands of women die every year from ovarian cancer. Dr. Fauci, universal flu vaccine.

Dr. FAUCI. Thank you very much to the committee for the plus-up on the universal flu vaccine. We are making significant progress. As I mentioned last time, the first in human Phase 1 trial for a universal flu vaccine for the Group 1 influenzas, which is a whole cluster of influenzas went into clinical trial. It was successful. It showed to be safe, and it showed to be immunogenic. We will start very soon a Phase 1 trial for the Group 2, which is the other whole group of influenzas.

So we are really moving along very, very quickly. By the end of the summer, we will be able to go into a Phase 2 trial. That is going to be important because that is going to involve hundreds, if not a couple of thousand, of people, and we will need the resources that you gave us to be able to do that Phase 2 trial. Thank you.

Ms. DELAURO. And I would assume additional resources.

Dr. FAUCI. Yes, indeed. No, I mean, well, that you are going to give us. [Laughter.]

Ms. DELAURO. Amen. Amen.

Dr. COLLINS. Very quickly, NIEHS has played a critical role in training people who can deal with outbreaks. They previously worked on Ebola. They are totally prepared to step in on this Phase 2, need some support for that. And basically, it is airports, as you said. It is correctional facilities. It is hospitals. They both do train the trainer efforts, they do face-to-face, they run courses.

Ms. DELAURO. You mentioned that you need some help with that. Can we be instrumental in pushing for NIEHS to be engaged and involved in the training, which is—

Dr. COLLINS. I am curious in looking in the supplemental and see whether there is a way that this can be factored into that—

Ms. DELAURO. Okay.

Dr. COLLINS [continuing]. Because we are going to need a lot of training for people who aren't quite prepared for this yet.

Ms. DELAURO. Okay. Thank you. Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair. I want to follow up quickly actually on the point you raised with Dr. Sharpless because I want to have a little more information. We have got obviously explosion, as you pointed out, going on for a variety of reasons. Are there some things we should do so that we don't leave good science on the table just because right now cancer seems to be a lane where there is a lot more happening than maybe some other areas?

Dr. SHARPLESS. Yeah, I think there are. You know, probably the main thing to realize about this problem is that it is not a 1-year problem. You know, it is like a mortgage. We pay these grants. They have 4- and 5 and, in some cases, even 6-year budget tails. And so when we invest in the RPG pool and this pool of grants today, which, you know, goes up 3, 5, 8 percent every year at the NCI over the last, you know, 5 to 10 years, then that has outyear costs for us that are quite significant. And so, you know that provides some hesitation on the part of the NCI to be good stewards.

You know, if we over invest today, we could have a real problem 3 years from now if we are not smart about it. So, you know, there is a realization that this problem is not going to be fixed this year or next year, that we expect that we are going to get these increased number of grants for a while because there are people which have a lot of really great ideas. So I think this, you know, sustained commitment that you have provided for so many years is really what the doctor ordered for the NCI RPG problem.

Mr. COLE. Yeah, I think that is important. I couldn't agree more. Dr. Collins, the Attorney General has raised some awareness of threats posed by foreign governments that obviously, particularly the People's Republic of China, you know, frankly raiding our science or interfering with our research. Can you tell us what your level of concern is on that, some of the measures you might be taking to respond?

Dr. COLLINS. We are quite concerned. Dr. Mike Lauer, who is the head of our Extramural Research Division, has spent probably two-thirds of his time now on this over the course of the past many months. First, let me say that we greatly depend upon and value foreign investigators, foreign-born investigators, who are part of our workforce, the vast majority of whom are honorable, hard-working, incredible contributors. And one thing we have to be careful of is that even as we have identified this as a serious issue, that we don't extrapolate into anything that would look like sort of racial profiling, which would be a really unfortunate, unmerited, and unforgivable kind of approach.

At the same time, we have identified numerous examples, I am sorry to say, of individuals who have been receiving substantial financial benefits from relationships with foreign countries—yes, often China—without disclosing that, and it is a requirement that they do so. Likewise, we have instances where individuals have shared grant applications that were not even yet reviewed with colleagues in other countries to give them some kind of an edge on developing some new invention. Obviously that has consequences for intellectual property.

We are very serious about identifying those circumstances. You have probably seen in the press some dramatic examples of individ-

uals who have been found to be egregiously against the way that scientists should behave, and have, as a consequence, lost jobs and, in some instances, been brought forward for various kinds of criminal prosecution. Again, I think most of the people that you might see in our workforce or honorable, but we are determined. We are stewards of the public trust. If there are instances that are not going the way they should, we will be following up on them.

At the moment, we have dozens of these investigations that are currently under way. We are working with the FBI on this, and they have been good partners with us, and we will keep our eye on this and continue to see where the trouble is and then act upon it.

Mr. COLE. I just want to commend you for your vigilance here, and, frankly, also for the even-handed attitude. There is a danger here that this could degenerate into a place where none of us would ever want it to go. And so thanks for having the focus on the problem, but also thanks for remembering, as you say, most of the folks that are involved in these endeavors are honorable, able, and are serving humanity. So it is a tough problem, and I think you have struck the right balance. Thank you, Madam Chair.

Ms. DELAUBRO. Congresswoman Frankel.

Ms. FRANKEL. Well, first I just want to say, I want to thank our chair, and our ranking member, and all our panelists. It is so refreshing, and I think we are blessed to be able to have a bipartisan discussion on health research, and very fortunate to have people of your caliber leading the way. I am not going to ask you more supermarket questions. I would just note that I have touched my face so many times today—

[Laughter.]

Ms. FRANKEL. Seriously, I am very worried about the social and economic impacts of the potential of this virus. That is really very frightening, and I am not going to get into it with you guys. So I am going to ask you some different questions. Specifically, in Florida, and I also know in the Nation, that suicides are a big issue, and also I saw something that that it is a leading cause of maternal death. Is that right? That is suicide.

Dr. COLLINS. [Nonverbal response.]

Dr. BIANCHI. [Nonverbal response.]

Ms. FRANKEL. No? Okay. I am glad you are saying no. But I want to just combine these questions because I am curious not only about suicide research, but also postpartum depression research.

Dr. COLLINS. I will quickly start with suicide and then ask Dr. Bianchi about postpartum because that fits in with our maternal mortality topic. Certainly suicides increasing in many different communities and demographic areas are of deep concern, and there are many diagnostics about why that might be going on that relate to people's sense of isolation, which is clearly a growing problem in this Nation. We at NIH are aiming to do everything we can to identify the factors and, particularly, the predictors of who is at risk and what the interventions might be. And there are certainly some of those, such as trying to make sure that people don't have access to lethal force for that moment where somebody makes a sudden decision to end their life. And it is often a rather sudden decision.

I will say also in terms of treating the clinical depression that often undergirds this, there is a major development that has happened, which is the development of this drug called ketamine, which has this remarkable phenomenon in many people who have had chronic clinical depression and not responded to anything else, of after an intravenous infusion, having an almost, within an hour, lifting of the clouds. That is now being tried in people who are acutely suicidal and starting to look pretty promising in that space if you can catch somebody before they take the drastic action, and lift them out of what seems to be a hopeless circumstance. So that is one bright spot in what is clearly a very tough problem.

Dr. BIANCHI. Yeah. So NICHD is funding research that currently is looking at postpartum women who potentially are at risk for suicide. So the difficulty with the postpartum situation is some of these women have no prior history of mental health problems. So, again, it is this rare issue where how do you know if someone is going to be at risk. So we are funding an investigator who is actually looking and taking a machine learning approach through the electronic health record to begin to identify certain clues in the record.

But the other issue is a lot of pregnant women are depressed, and they are taking antidepressants during pregnancy. So we need to know are these drugs safe to take during pregnancy and lactation. And there is an area where I am concerned because women who are at risk are not taking their medicines because they think it is better for the baby, and so we are doing research to show what is safe and what isn't safe. And we have a study called the CUD-DLE Study where women taking these medicines are donating their breast milk so that we can see what is actually in the breast milk.

Ms. FRANKEL. Thank you very much.

Ms. DELAURO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chairman. Dr. Sharpless, I would like to talk to you about endometrial cancer. I know that their cancers have shown a lot of improvements in the number of deaths over the time. The National Cancer Institute surveillance epidemiology and End Results Program shows a worsening survival rate from endometrial cancer from 1996 to 2016, and the incidence rate for black women surpassed that of white women in 2007 and continues to increase to this day. The incidence of the more aggressive Type 2 cancers is dramatically higher for black women than for white women.

I am wondering what your plan is. What is happening in that field, and what are you planning in terms of funding clinical trials and trying to come up with specific therapies that address these disparities?

Dr. SHARPLESS. Sure. Thank you for the question. I think we are equally concerned by the statistics you mentioned. This is a cancer which is increasing in mortality in the United States. As I mentioned, most cancers are actually declining in mortality. The few that are actually showing an increased mortality are particularly of concern, and why is that happening? We think endometrial cancer and a few other cancers, it may be partially related to obesity,

you know, the obesity epidemic. Obesity is associated with endometrial cancer. We don't think that is the entire explanation.

The basis for the disparity is an area of active research between African-American women and other populations. You know, this is a problem across many cancers, including endometrial cancer. Generally, our findings have been that they are, in part, these, you know, social determinants of health, access to care, these sorts of things, and partly often driven by biology and some combination thereof. And so we have funded efforts in endometrial cancer and other gynecological cancers to see specifically address that question.

We have SPOREs in endometrial cancer of gynecologic malignancies, which the Center of Research Excellence is funding, but, you know, an area where we are devoting a lot of focus because of the worrisome statistics you mentioned.

Mrs. WATSON COLEMAN. Thank you. I yield back.

Ms. DELAUBO. Thank you. I will just yield to the ranking member for any final comments before we conclude.

Mr. COLE. Thank you very much, Madam Chairman. I think like many members, this is always my favorite hearing of the year, and I think because we all marvel at your abilities and the work that you are doing and you are about, and what your colleagues are doing. And we all see the good in these investments, and we all feel as if you have been really good stewards of money that the Congress has chosen to put at your disposal. And we all think the American people and, frankly, all of humanity have benefited enormously as a result of those investments.

I am proud of this subcommittee. I am proud of my chairman who has been my partner in this for years, and I am proud of our colleagues on the other side of the Rotunda who have worked with this for years, and I think it is absolutely critical, Madam Chairwoman, that that continue. Now, I would be the first to say, and I know my chairman knows this better than I do, this is going to be a very tough year. We have a 2-year budget agreement. It is essentially flat funding if you look at some of the requirements in a couple of the other departments that are going to take money, we know. Veterans I am thinking of in particular. My friend, the chairman, and her counterpart, my friend Chairman Blunt, are going to be confronted with really tough decisions. I have had this discussion over many years with Dr. Collins. I usually use the phrase, you know, we are in another one of those years where we are robbing Peter to pay Paul. Fortunately, you are Paul, and somebody else is going to have to be the Peter, and that it is not your job to make those decisions. It is the job of this committee.

And my friend, the chairman, and I have commiserated with this over this many years because there are lots of wonderful things in this bill, lots of things we agree on, lots of things that are national priorities. But I think this committee has made the right decision over the last 5 years in a bipartisan sense by probably making you the top priority in the bill every single year. And I don't think that is ever been more dramatically demonstrated than right now.

You know, how many questions did we have on coronavirus, and yet there will be another coronavirus out there. And I thought one of the most telling answers of the hearing, you know, when Dr. Col-

lins made the point that these past investments have put us in a stronger position to deal with these current challenges. And I thought Mr. Sharpless made an excellent point, Dr. Sharpless, as well when he talked about the extraordinary opportunities we have in a particular area right now. And those opportunities come and you have to use the resources you have to take advantage of those openings, and you also have to make commitments that sustain themselves over years. I mean, the committee has to think in terms, again, always of cumulative and incremental, whether it is investment in your physical infrastructure, or it is just thoughts about projects that clearly take multi years to come to fruition, and we have got to make sure the revenue stream is there and available.

So, again, I thank all of you for the work. I thank this committee, you know, on a bipartisan basis for its sustained commitment here. And I think, Madam Chairwoman, the wisdom of that has been borne out, and I hope we can continue that. I know if it was up to you and me, I know it would be continued, and, you know, we are pretty persuasive with our colleagues sometimes, too. [Laughter.]

We really make a pretty good team here and in dealing with our friends across the Rotunda, who fortunately have approached this with the same mindset that we have for many, many years to come. So hopefully we can continue this because I think it will, frankly, render enormous benefits to the American people, and that is what all of us came here to do. With that, I yield back, Madam Chair.

Ms. DELAURO. Thank you, very, very much to my dear friend and colleague, and, if I might add, co-conspirator in what we do in this subcommittee. And indeed, this is always an extraordinary hearing, and it is a revelation. You know, we have a doctor on our committee in Dr. Harris, but as far as I know, the rest of us are not scientists. We are not doctors.

Mr. COLE. Wait a minute. I am a doctor. [Laughter.]

Ms. DELAURO. Well, yes, right. You are a political science doctor here. But what we are about is trying to grapple with issues about which we spend time studying and learning so that we can try to do the right thing. You do every day in your life focus on a mission of which there is no nobler cause or highest commitment, which is to save lives. And we get to work in cooperation with you to make sure that we push the edge of that envelope. You do. We need to do that with the resources that we provide you to do your work.

I will just say this to my colleague that, yes, you are Paul, but I always have, and you have heard me say this before, I have to worry about Peter as well—

[Laughter.]

Ms. DELAURO [continuing]. And looking at that, but I think you know where our hearts and our commitments are to make sure we go down the road. I would just say one other thing. You know, this is a committee in working together, which does not deal with “gotcha.” We are not sitting here to try to stump you to make a political comment. We are here to try to get the best information and the best advice so that we can respond. And when some of the questions are hard and they are tough, it is not for political pur-

poses, but it is to look at our stewardship of public dollars and where those public dollars are going. And we are so trustful of you with being good stewards of the public dollar, and we can sell that, both my colleague and I, to other members of this subcommittee as well as the committees across the aisle with our Senate colleagues.

I am going to end on a humorous note that I am going to have to stop hugging people, Tom. [Laughter.]

And I just want to make sure, Dr. Collins, that people can afford ketamine, okay? That is another issue that we could——

[Laughter.]

Ms. DELAURO. Thank you. The hearing is concluded. Thank you all very much.

[The following questions and answers were submitted for the record:]

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
National Institutes of Health Budget Request for FY 2021
(3.4.20)

Questions for the Record

Submitted by Congresswoman Roybal-Allard

Antibiotic Resistance Research at NIH
Question for Dr. Anthony Fauci

NIAID is currently engaged in research to address the threat of antibiotic resistance, and this research is poised to yield new ways to treat, detect and prevent antibiotic-resistant infections. The president's FY 2021 budget proposes cuts of \$3 billion from NIH's overall budget, and \$440 million from the NIAID.

Question: How would these proposed reductions impact the administration's efforts to combat antibiotic resistance, including the development of a new generation of vaccines aimed at drug-resistant microbes, new ways to treat and prevent resistant infections, and new diagnostics to rapidly identify highly resistant bacterial infections?

NIH Response:

On March 17, 2020, the Office of Management and Budget released an amendment to the FY 2021 President's Budget request for the National Institute of Allergy and Infectious Diseases (NIAID), setting the NIAID request level to \$5,885 million and thereby eliminating the originally proposed reduction of \$440 million.

The emergence of antimicrobial resistance (AMR) in a range of bacterial and fungal pathogens is a public health threat of significant concern and a major area of research for NIAID. According to the Centers for Disease Control and Prevention, there are at least 2.8 million antibiotic-resistant infections each year in the United States, and more than 35,000 people die as a result.¹ NIAID is the lead institute for AMR research at the National Institutes of Health (NIH). In December 2019, NIAID released its *Antibiotic Resistance Research Framework: Current Status and Future Directions*. This framework describes NIAID's AMR research portfolio and outlines innovative approaches and research opportunities to address this urgent public health priority.

¹ www.cdc.gov/media/releases/2019/p1113-antibiotic-resistant.html

Strategic approaches to AMR supported by NIAID include the development of rapid point-of-need diagnostics, improved therapeutics, alternatives to traditional antimicrobial drugs, and vaccines. These efforts are a critical component of the *National Action Plan for Combating Antibiotic-Resistant Bacteria 2020-2025*, which was released in October 2020. A reduction in funding for AMR research could slow progress in this area; however, AMR research will remain a priority for NIAID. NIAID is committed to supporting ongoing investments to address AMR and will continue to build upon the NIAID-supported advances outlined below.

NIAID has invested in research to develop rapid point-of-need diagnostics to help identify drug-resistant infections, inform appropriate treatment strategies, and improve antibiotic stewardship. NIAID-supported research has led to the development of six novel diagnostics capable of distinguishing between multiple infectious agents: a sepsis diagnostic that simultaneously tests for 24 bacterial and fungal species; a urinary tract infection diagnostic capable of detecting bacteria in urine within three hours; a pneumonia diagnostic that can detect a number of different bacterial and viral species as well as identify seven genetic markers of AMR; and three devices capable of quickly diagnosing both chlamydia and gonorrhea infections. All six diagnostics have received U.S. Food and Drug Administration (FDA) clearance. NIH also partnered with the Biomedical Advanced Research and Development Authority (BARDA) to support the Antimicrobial Resistance Diagnostic Challenge competition to identify innovative and rapid point-of-need diagnostic tests that inform appropriate antibiotic treatment and facilitate antimicrobial stewardship. On August 5, 2020, Visby Medical, Inc., was awarded \$19 million in prize funding for its novel, point-of-need diagnostic test that accurately detects the bacterium that causes gonorrhea, *Neisseria gonorrhoea*, and assesses drug susceptibility. Following further development, the hope is that this diagnostic could be used to rapidly diagnose patients with gonorrhea and identify the appropriate antibiotic treatment for the infection.

NIAID is actively pursuing improved therapeutics for AMR pathogens and is supporting the development of many novel antimicrobial agents, including new forms of existing antibacterial drugs that are not susceptible to known bacterial resistance mechanisms. One of these therapeutics, XERAVALTM, is a novel tetracycline that has been approved by the FDA for the treatment of complicated intra-abdominal bacterial infections. In addition, NIAID has supported the development of novel therapeutics that are currently in late-stage clinical trials to treat complicated urinary tract infections, uncomplicated gonorrhea, multidrug-resistant tuberculosis, and other infections. NIAID also provides in-kind and technical support for the Combating Antibiotic-Resistant Bacteria Biopharmaceutical Accelerator (CARB-X), a public-private partnership led by BARDA that invests in the development of new antibiotics, diagnostics, vaccines, and other products to combat drug-resistant bacteria. CARB-X has funded 71 innovative projects, with 45 projects currently ongoing. Eighteen projects funded by CARB-X have focused on the development of new antibiotic classes. CARB-X also supports the

development of novel approaches to combating AMR, including vaccines against drug-resistant bacterial infections and products designed to modulate the gut microbiome.

NIAID is exploring several alternatives to traditional antimicrobials that leverage advances in basic research on pathogenesis, drug resistance, immune system function, and the microbiome. NIAID-supported researchers are investigating the use of beneficial bacterial strains and fecal microbiota transplants to prevent and treat bacterial infections. NIAID also is pursuing strategies using bacteriophage therapy to treat bacterial infections and has recently issued a funding opportunity announcement to bolster research in this field. NIAID scientists and grantees also are studying the use of antibodies to help boost the human immune response to *Klebsiella pneumoniae* and other pathogens.

In 2019, NIAID renewed and expanded funding for the Antibacterial Resistance Leadership Group (ARLG), which oversees clinical research on AMR, including optimization and development of traditional and non-traditional therapeutics, treatment strategies, and diagnostics for identifying antibiotic-resistant microbes. The ARLG also supports efforts to optimize the use of existing antibiotics and develop non-traditional AMR countermeasures such as bacteriophage therapy.

Vaccines that confer protection against bacterial and fungal pathogens also can help reduce the use of antibiotic drugs and may limit the spread of AMR pathogens. NIAID-funded scientists are using novel approaches to develop investigational vaccine and immune therapeutics against multi-drug resistant Gram-negative bacterial infections and advancing the development of candidate vaccines to protect against bacterial and fungal pathogens that can become drug-resistant, including *Staphylococcus aureus* (*S. aureus*). NIAID also has supported basic research, discovery, and development of the NDV-3 vaccine candidate, which has demonstrated clinical efficacy in preventing recurrent vaginal yeast infections. NDV-3 also has been shown to protect against infections caused by *S. aureus* and *Candida auris* in animal models. In addition, NIAID is planning to conduct a Phase 2 clinical trial to test whether Bexsero, a vaccine licensed to prevent meningitis, also can protect against gonorrhea.

NIAID recognizes that a comprehensive, multi-pronged, multi-disciplinary approach is necessary to address the serious threat posed by drug-resistant microbes. NIAID will continue to use the resources provided by Congress to prioritize the development and evaluation of improved strategies to identify, prevent, and treat AMR infections.

Maternal Health Disparities

Question for Dr. Diana Bianchi

Given the growing disparities in maternal health – specifically related to maternal mortality – in this country, the NIH houses several research networks that have been highly efficient and successful in conducting clinical research that has changed the practice of medicine, like the Maternal Fetal Medicine Units Network (MFMU) at the NICHD.

Question: How is NIH leveraging these types of networks and other existing mechanisms to tackle this public health crisis from a research perspective, especially in light of the NICHD's new strategic plan?

NIH Response:

In the United States, women who are members of some racial or ethnic minorities, such as non-Hispanic Black women, face higher rates of maternal morbidity and mortality compared to White women. NIH is continuing its longstanding research efforts to improve maternal health and prevent maternal mortality and morbidity, with 22 Institutes, Centers, and Offices supporting over \$334 million in research projects in FY 2019; over 50 percent of the projects were funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD).²

As highlighted in the strategic plan, NICHD is committed to setting the foundation for healthy pregnancies and lifelong wellness. NICHD is supporting research to understand the causes of and potential interventions for preventing maternal mortality and treating maternal morbidity. NICHD-supported investigators have shown that pregnancy-related health outcomes are influenced by a woman's underlying health and other factors such as race, ethnicity, geography, age, income, and potential complications of co-occurring conditions such as obesity. For example, one NICHD-funded study indicated that differences in hospital quality can significantly contribute to racial and ethnic disparities in health outcomes.³ Another study found a reduction in the risk of severe maternal morbidity from obstetric hemorrhage when hospitals implemented evidence-based recommendations to improve clinical practice; the reduction was more dramatic for Black women than for White women.

As requested by Congress, NICHD contracted with the National Academies of Sciences, Engineering and Medicine to conduct a study on the choice of birth setting, including risk factors, social determinants that influence risk, and maternal health outcomes. The report,⁴ released in 2020, concluded that improvements to the maternity workforce, such as involvement of a wider range of health care professionals and better insurance coverage for non-hospital

² https://www.report.nih.gov/categorical_spending.aspx

³ Howell EA, Janevic T, Blum J, Zeitlin J, Egorova NN, Balbierz A, Hebert PL. "Double Disadvantage in Delivery Hospital for Black and Hispanic Women and High-Risk Infants." *Maternal and Child Health Journal*, 2020, 24(6), 687–693.

⁴ <https://www.nationalacademies.org/our-work/assessing-health-outcomes-by-birth-settings>

births, could help minimize risks regardless of the birth setting. It also suggested ways to improve childbirth services in hospital settings, birthing centers, and home births.

NICHD regularly collaborates with other NIH Institutes and Centers that support research on maternal mortality and morbidity. The National Institute on Minority Health and Health Disparities (NIMHD) recently launched *Addressing Racial Disparities in Maternal Mortality and Morbidity* (RFA MD-20-008)⁵, an initiative designed to support multidisciplinary research examining the efficacy and/or effectiveness of multi-level interventions to reduce health and health care disparities in maternal morbidity and mortality experienced by racial and ethnic minority women. In collaboration with the NIH Office of the Director, the National Heart, Lung, and Blood Institute, and the National Institute of Nursing Research, NIMHD supported five grants through this initiative, covering topics such as hospital quality, participation of doulas throughout the continuum of care, and research with a specific focus on postpartum health. NIMHD is also supporting research to test the effectiveness and cost-effectiveness of an intervention that expands access to enhanced prenatal and postnatal services to address maternal morbidity and mortality in Black women.

Understanding the underlying social, economic, and structural factors are critical if we are to improve maternal health and prevent maternal mortality and severe morbidity. NIH recently launched its new *Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone* (IMPROVE) initiative by awarding over \$7 million in grants through a Notice of Special Interest on Maternal Mortality.^{6,7} This initiative is supported by multiple NIH Institutes, Centers, and Offices and is co-led by NICHD, the NIH Office of the Director, and the NIH Office of Research on Women's Health. The goal of the IMPROVE initiative is to address the health disparities in women disproportionately affected by maternal mortality and morbidity, including geographic disparities and social determinants of health. The COVID-19 pandemic has added even more urgency to this work, as researchers move quickly to recognize how this disease affects maternal, fetal, and newborn health outcomes. NICHD's *Gestational Research Assessments of COVID-19 (GRAVID)* study is leveraging its Maternal Fetal Medicine Units Network to analyze the medical records of a diverse group of 24,500 women to evaluate whether changes to healthcare delivery implemented as a result of the pandemic have led to maternal mortality, maternal morbidity, pregnancy-related complications, and cesarean delivery. Through these efforts and the IMPROVE initiative, NIH is working to improve health outcomes for pregnant women across the country.

⁵ <https://grants.nih.gov/grants/guide/rfa-files/RFA-MD-20-008.html>

⁶ <https://grants.nih.gov/grants/guide/notice-files/NOT-OD-20-104.html>

⁷ <https://www.nih.gov/improve-initiative>

Maternal Mortality***Questions for Dr. Francis Collins***

This country faces a maternal health crisis. We have worked to support public health programs that address maternal mortality nationally and at the state level through the work of this committee, however, it seems that research into the causes and prevention of maternal mortality, including death by suicide, is lagging behind.

Questions:

1. How much funding is being utilized to address maternal health at the NIH?
2. How does that compare to research into other specific disease states?
3. What NIH-wide activities are occurring that will address the causes and prevention of maternal mortality?

NIH Response:

The Centers for Disease Control and Prevention estimates that approximately 700 women die each year in the United States from pregnancy-related complications. Disparities exist among Black/African American and American Indian/Alaska Native women, who are about three times as likely to die from a pregnancy-related cause compared to White women. Over 50,000 women in the United States experience severe maternal morbidity (SMM). In response to this crisis, NIH recently launched its new *Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone* (IMPROVE) initiative by awarding over \$7 million in grants through a Notice of Special Interest on Maternal Mortality (MM).^{8,9} This initiative is supported by multiple NIH Institutes, Centers, and Offices (ICOs), and is co-led by the *Eunice Kennedy Shriver National Institute of Child Health and Human Development* (NICHD), the NIH Office of the Director, including the NIH Office of Research on Women's Health. The goal of the IMPROVE initiative is to address the health disparities in women disproportionately affected by MM/SMM, including geographic disparities and social determinants of health. Specific conditions to be addressed by these grants include leading causes of maternal deaths in the U.S., heart disease, hemorrhage or bleeding, and infection, research on contributing conditions, such as diabetes,

⁸ grants.nih.gov/grants/guide/notice-files/NOT-OD-20-104.html

⁹ www.nih.gov/improve-initiative

obesity, mental health disorders, and substance use disorders, as well as structural factors that may contribute to delays or disruptions in maternal care.

NIH lists funding information for a wide range of research categories on its website, including Maternal Health.¹⁰ NIH is continuing its longstanding research efforts to improve maternal health and prevent maternal mortality and morbidity, with 22 ICOS supporting over \$334 million in research projects in FY 2019. Recent findings from NICHD-funded grants demonstrate that a hospital quality improvement effort can reduce racial disparities in severe maternal morbidity¹¹, and that adverse pregnancy outcomes are more common among women who are deaf or hard of hearing.¹² A new public-private partnership through the Foundation for the National Institutes of Health with support from the Bill & Melinda Gates Foundation is supporting a large clinical trial conducted by investigators in NICHD's Global Network. The trial will assess whether a single oral dose of the antibiotic azithromycin during labor reduces the risk of maternal and infant bacterial infection and death in seven low- and middle-income countries. This intervention was shown to be effective in a smaller study and, if successful, would be a low-cost intervention.

The COVID-19 pandemic adds even more urgency to NIH's work on maternal mortality and morbidity, as researchers try to quickly recognize how this disease affects maternal, fetal, and newborn health outcomes. NIH's Rapid Acceleration of Diagnostics – Underserved Populations (RADx-UP) initiative leverages existing community partnerships to develop, validate, improve, and implement testing for COVID-19, including approaches for pregnant and postpartum women and their infants.¹³ NICHD's *Gestational Research Assessments of COVID-19 (GRAVID)* study is leveraging its Maternal Fetal Medicine Units Network to analyze the medical records of a diverse group of 24,500 women to evaluate whether changes to healthcare delivery implemented as a result of the pandemic have led to higher rates of maternal mortality, maternal morbidity, pregnancy-related complications, and cesarean delivery. Through these efforts and the

¹⁰ https://www.report.nih.gov/categorical_spending.aspx

¹¹ Howell EA, Janevic T, Blum J, Zeitlin J, Egorova NN, Balbierz A, Hebert PL. "Double Disadvantage in Delivery Hospital for Black and Hispanic Women and High-Risk Infants." *Maternal and Child Health Journal*, 2020, 24(6), 687–693.

¹² Mitra, M, et al. Pregnancy, birth, and infant outcomes among women who are deaf or hard of hearing. *American Journal of Preventive Medicine*. 2020.

¹³ <https://www.nih.gov/research-training/medical-research-initiatives/radx>

IMPROVE initiative, NIH is working to improve health outcomes for pregnant women across the country.

Older Adult Nutrition

Question for Dr. Francis Collins

A recent GAO report classified federal research on older adult nutrition as “limited.”

Question: How will HHS achieve an increased focus on this topic despite the cuts to NIH and the National Institute on Aging proposed by the President’s FY21 budget?

NIH Response:

Research on older adult nutrition is conducted across the National Institutes of Health (NIH), with foci in the National Institute on Aging (NIA); the National Institute of Diabetes and Digestive and Kidney Diseases; the National Heart, Lung, and Blood Institute; and the National Cancer Institute, among others. Notably, the *2020-2030 Strategic Plan for NIH Nutrition Research*,¹⁴ developed by the NIH Nutrition Research Task Force, includes a strategic goal on defining the role of nutrition across the lifespan, with a research objective to assess the role of nutrition in older adults to promote healthy aging. A related strategic goal aims to reduce the burden of disease in clinical settings by improving the use of food as medicine.

NIA-supported investigators are testing the effectiveness of dietary supplementation with a wide variety of nutrients in different contexts, including brain health and cognition. NIA also supports research exploring the role of the gut microbiome—the trillions of microbes that reside in the intestine—on a wide variety of health parameters. Because the composition of the microbiome is heavily influenced by the foods we eat, the results of these studies may further elucidate the mechanisms linking nutrition and health and even suggest avenues for potential intervention.

In addition, NIA incorporates questions about diet and nutrition into a number of cohort studies, including the Health and Retirement Study (HRS), the Healthy Aging in Neighborhoods of Diversity across the Lifespan study, the Baltimore Longitudinal Study of Aging, and others. This enables researchers to identify and follow trends in diet and nutrition and to identify potential correlates to and long-term outcomes of dietary choice, food insecurity, and nutritional status. For example, investigators used data from the HRS¹⁵ to explore the potential associations between home and social networks and fruit and vegetable consumption among adults over age

¹⁴ <https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/strategic-plan-nih-nutrition-research>

¹⁵ Choi, Alshire, and Crimmins, 2020: <https://pubmed.ncbi.nlm.nih.gov/32792025/>

53. They found that older adults who lived alone with no children or friends nearby had the lowest fruit and vegetable consumption. However, the consumption of fruits and vegetables did not significantly differ among participants who lived with someone; lived alone but had children or friends nearby; or lived with someone and had children or friends nearby. These results support previous findings that living alone is associated with lower fruit and vegetable consumption, but also suggest that having a robust network, whether within or outside the home, may attenuate this association.

A particularly active area of research is on the effects of diet and nutrition on cognition. Studies have shown that malnourished adults with dementia show a more rapid cognitive and functional decline than their better-nourished counterparts. NIA-supported investigators are currently developing and testing interventions to address both insufficient nutrient intake¹⁶ and dysphagia¹⁷, or difficulty swallowing, among individuals with dementia. Researchers are also studying the association between certain diets, including the Mediterranean¹⁸, Mediterranean-DASH Intervention for Neurodegenerative Delay (MIND)¹⁹, Multicultural Healthy Diet²⁰, and modified ketogenic diets²¹, and development and spread of brain pathology. These and other studies are beginning to suggest that better diet quality may be neuroprotective.

Enhanced focus on each of these topics can be achieved through the planned coordination of research activities across the NIH and Federal government through the continued work of the

¹⁶https://projectreporter.nih.gov/project_info_description.cfm?aid=9951623&icde=52475231&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

¹⁷https://projectreporter.nih.gov/project_info_description.cfm?aid=10045900&icde=52475329&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

¹⁸https://projectreporter.nih.gov/project_info_description.cfm?aid=9936132&icde=52475437&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

¹⁹https://projectreporter.nih.gov/project_info_description.cfm?aid=9887889&icde=52475372&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

²⁰https://projectreporter.nih.gov/project_info_description.cfm?aid=9925720&icde=52476758&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

²¹https://projectreporter.nih.gov/project_info_description.cfm?aid=9695920&icde=52475419&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

Nutrition Research Task Force²² and by groups such as the NIH Nutrition Research Coordinating Committee²³ and Interagency Committee on Human Nutrition Research.²⁴

Cardiovascular Disease Burden vs. Funding

Questions for Dr. Francis Collins

Over the past half-century, we have witnessed unprecedented progress in addressing cardiovascular disease, yet recent trends show that declines in heart disease and stroke death rates have slowed for all races and are increasing substantially among certain population

groups such as rural Americans. In the NIH-Wide Strategic Plan, it is stated that disease burden “will serve as a crucial, but not only, consideration in aligning NIH’s research priorities with public health needs.” Placing the highest burden on our nation’s health and economy, heart disease and stroke stubbornly remain the leading cause of death and disability in the United States, affecting 121 million Americans and accounting for 1 in every 6 healthcare dollars spent or \$1 billion a day.

Questions

1. Despite this significant burden, the NIH only invests 5% of its budget on heart disease research and a mere 1% on stroke. What level of funding is needed to advance new science to combat these deadly diseases?

NIH Response:

The majority of NIH’s budget is not set aside for specific diseases or conditions. Instead, most NIH funding is awarded based on peer review of investigator-initiated research proposals. This long-standing policy and practice ensure that NIH funding is driven primarily by scientific need and opportunity, as assessed by scientific experts working in their respective fields. Moreover, the majority of NIH grants involve basic research, which seeks to understand the fundamental

²² www.niddk.nih.gov/about-niddk/advisory-coordinating-committees/nih-nutrition-research-task-force

²³ www.niddk.nih.gov/about-niddk/advisory-coordinating-committees/nutrition-research-coordinating-committee

²⁴ www.nal.usda.gov/fnic/interagency-committee-human-nutrition-research

biological processes involved in both health and disease. Basic research is the bedrock for disease-focused research and has yielded breakthroughs—often wholly unexpected—into the causes and treatment of a variety of diseases, including heart disease and stroke.

For more than 70 years, the National Heart, Lung, and Blood Institute (NHLBI) has led the fight against heart and vascular diseases. Though the NIH investment in heart disease and stroke represents a small investment of its overall budget, more than half of the NHLBI's \$3.5 billion budget in fiscal year 2019 was used to fund research on cardiovascular and heart diseases, with about half a billion of that overall budget going toward investigator-initiated research. Almost 10 percent of the National Institute of Neurological Disorders and Stroke (NINDS)'s \$2.2 billion budget for fiscal year 2019 was used to fund research on stroke.

The NIH frequently seeks individual input from stakeholders—including researchers, clinicians, patients, professional societies, and voluntary health organizations—to identify scientific gaps and opportunities and to help set priorities. For example, more than 4,450 stakeholders from all 50 states and 42 countries provided input into the NHLBI Strategic Plan, which lays the foundation for the NHLBI research agenda.¹ Thanks in part to NIH-funded research, over the past 50 years, the age-adjusted death rate for heart disease and stroke in the United States has declined by more than 70 percent. Yet challenges remain, including the continuing high prevalence and mortality of heart disease and stroke in underserved groups, including racial and ethnic minorities and rural populations.

NHLBI's budget is enabling implementation of its Division of Cardiovascular Sciences Strategic Vision that identifies key areas of future research, including addressing health inequities and improving cardiovascular health across the lifespan.²

NHLBI also continues to invest in improving public awareness of heart disease through the Institute's long-standing, evidence-based health education program, The Heart Truth®. This program has recently enhanced its focus on women who are especially vulnerable and harder to reach through traditional public health programs, including African American, Hispanic/Latina, and Native American women, and those living in rural areas. In addition, NINDS continues to support its Mind Your Risks program, launched in 2015 to boost public awareness about the link between high blood pressure and the risk of stroke and dementia, and the importance of controlling hypertension.³ NINDS is now in the process of updating the campaign with new messaging and outreach efforts aimed at populations that experience health disparities in blood pressure control, especially Black men between the ages of 35-50.

2.What are you doing to address the high rates of cardiovascular mortality, especially in rural America?

NIH Response:

Nearly 46 million people, or one in six Americans, live in rural communities, where they face a higher rate of disability and mortality from cardiovascular disease. NHLBI is supporting a spectrum of research to better understand and reduce this disparity. For example, in 2019, NHLBI launched a new epidemiological study to identify risk factors and prevention strategies for cardiovascular disease and other chronic diseases in rural America. The Risk Underlying Rural Areas Longitudinal (RURAL) Cohort Study will follow 4,000 people living in 10 low-income counties in Alabama, Kentucky, Louisiana, and Mississippi.⁴ The researchers will use a mobile clinic equipped with an exam unit, including a CT scanner, to assess cardiac and pulmonary health in these communities. They will examine differences between higher and lower risk counties that could offer insights into practical risk reduction strategies and will evaluate the use of mobile health (mHealth) tools such as smartphone apps and wearable activity monitors.

Additionally, NHLBI's Cardiothoracic Surgical Trials Network, which conducts trials to evaluate cardiac surgeries and procedures, has increased its research capacity to address cardiovascular disease in rural communities. The network recently added two larger medical centers in New Hampshire and Maine to expand its reach in rural New England, and to help implement trial findings in rural communities.⁵

Finally, the Institute launched another new program in 2019, to help bring proven disease interventions to high-burden communities, called Disparities Elimination through Coordinated Interventions to Prevent and Control Heart and Lung Disease Risk (DECIPHeR). The program will support researchers to partner with local healthcare systems, government agencies, and community organizations, to work together to design, test, and sustain effective approaches to deliver successful treatments. NHLBI anticipates that some of the funded projects will address the high burden of disease in rural areas, as well as in low-income and minority or underserved populations.

Health Disparities in Cardiovascular Disease

Questions for Dr. Gary Gibbons

Cardiovascular disease exacts a disproportionate toll on racial and ethnic minorities especially African Americans. For example, according to the American Heart Association, cardiovascular disease mortality rates are nearly 34% higher for blacks than the overall U.S. population. The incidence of high blood pressure - a leading risk factor for heart disease and stroke, is also among the highest in the world for African Americans. The prevalence of hypertension among black men is 57.6% and 53.2% among black women.

Curiously, the incidence of cardiovascular disease and mortality of Hispanics is lower compared to non-Hispanics despite the presence of substantial cardiovascular disease risk factors among

the population. These risk factors include a higher prevalence of hypercholesterolemia or high cholesterol, obesity, and diabetes.

Questions:

1. In your FY 2021 budget, the NHLBI has committed to strengthening its investment in population studies including the Jackson Heart Study, the nation's largest study of cardiovascular disease in African Americans. With the planned extension of this study until 2024, what has this research already uncovered about the disproportionate burden of cardiovascular disease on African Americans since this study was first initiated in 1998 and what do investigators hope to discover in the future?

NIH response:

The National Heart, Lung, and Blood Institute (NHLBI) continues its long-standing support of the Jackson Heart Study, which began as a collaborative effort among three Jackson Mississippi-area academic institutions to investigate the disproportionate burden of cardiovascular disease (CVD) in African Americans, potential causes for this disparity, and preventive strategies. Since the enrollment of the first participant in September 2000, the study has grown to include 5,300 adult African American women and men and has generated new findings on the prevalence of risk factors and subclinical disease associated with CVD in African Americans. For example, a new analysis found that among African Americans, smoking is a significant risk factor for peripheral artery disease (PAD), in which arteries in the leg become clogged with fatty deposits. Study participants who were current smokers were twice as likely as non-smokers to have subclinical PAD in their legs.¹ These findings highlight the need for smoking cessation and prevention efforts to reduce PAD in this population.

NHLBI has renewed funding for the study to support a fourth cohort clinical exam which will include new assessments of cognitive function to investigate the links between cardiovascular health and brain health. Additionally, new ancillary studies of the cohort are addressing a wide range of topics, including: the roles of hypertension, arterial stiffness, atrial fibrillation, and physical activity levels in cognitive function and dementia; factors that affect blood pressure, such as whether or not a clinician is present; assessment of immune cell properties and their role in atherosclerosis; and whether people living in neighborhoods that provide safe, affordable places for physical activity have lower levels of CVD risk. A revitalized Community Engagement Center is using innovative approaches to translate 20 years of the study's findings into improved community health by supporting health education and screenings at traditional gathering places like barbershops and churches. For example, through the Brothers Reaching Out to Help Educate on Routine Screenings (BROTHERS) program, barbers in African American-owned barbershops have been trained to conduct blood pressure screenings and to talk to their customers about blood pressure control.

2. African Americans represent 14% of the U.S. population but account for 44% of HIV diagnoses. As more people are living longer with HIV, what research is being done on the cardiovascular comorbidities of HIV?

NIH Response:

The emergence of effective antiretroviral therapy (ART) for human immunodeficiency virus (HIV) has led to a decline in deaths from acquired immunodeficiency syndrome (AIDS) worldwide, but as people with HIV age, they are at higher risk than their peers for CVD, as well as chronic lung, blood, and sleep disorders. In 2019, NHLBI became the primary steward of a long-term observational study that aims to understand and reduce the impact of co-occurring health conditions (comorbidities) that affect people living with HIV.² This new effort combines the Multicenter AIDS Cohort Study (MACS), a study of gay and bisexual men who have HIV, and the Women's Interagency Health Study (WIHS), a study of women who have HIV or at high risk for it. Through this MACS/WIHS Combined Cohort Study, researchers are following the current participants at 13 MACS/WIHS sites and recruiting about 1,500 new participants to increase the representation of African American and Hispanic/Latino men and women. Through a new program, NHLBI also will support the development of new approaches to deliver proven prevention and treatments for HIV comorbidities among patients in low-resource regions of the world, including sub-Saharan Africa. In addition to reducing HIV comorbidities in global regions with a high burden, these efforts could yield model programs that will benefit people with HIV in low-resource areas of the United States.

The National Institute on Minority Health and Health Disparities (NIMHD) also supports research to reduce cardiovascular health disparities associated with HIV. One study will examine that relationship. The study will retrospectively analyze patient-level data from electronic health records from institutions in the Southeast United States, where HIV and CVD are highly prevalent. Data from this study will help to inform clinical care guidelines and health system interventions to improve health for people of color living with HIV.

3. Considering that Hispanics/Latinos are the largest and fastest growing racial or ethnic population in the United States, does the NHLBI plan to study more closely what has been termed the “Hispanic mortality paradox?”

NIH Response:

The Hispanic mortality paradox refers to the finding that Hispanic Americans tend to have health outcomes that are comparable to, or better than, those of non-Hispanic white Americans, even

though Hispanics as a group have lower average income and education levels than whites. Indeed, a recent study found that premature mortality rates are lower for U.S. Latino populations and several Latin American countries than for U.S. white populations, suggesting that there may be a broader Latin American paradox.³ NHLBI is committed to understanding factors - including genetics, lifestyle, and social determinants of health - that contribute to Hispanic and Latino health. One of NHLBI's largest cohort studies, the Hispanic Community Health Study/Study of Latinos (HCHS/SOL), is following more than 16,000 Hispanic/Latino American men and women ages 18-74. The study has found a higher prevalence of CVD risk factors among Hispanics/Latinos who were U.S.-born or lived in the United States for more than 10 years, and those who preferred English over Spanish.⁴ A more recent study from HSCS/SOL found higher species diversity in the gut microbiome, which is considered beneficial for digestive health, in Hispanics/Latinos who immigrated to the United States in middle age compared to those who immigrated as children.⁵ Together, such findings suggest that aspects of Hispanic/Latino culture and diet may help protect against CVD.

4. Considering the broad diversity within the Hispanic population does the NHLBI also plan to examine the prevalence of cardiovascular disease among all Hispanic subgroups to gain a more complete understanding of health disparities among this population?

NIH Response:

NHLBI's HCHS/SOL study was designed to assess the prevalence of CVD, other chronic diseases, and their risk factors among Hispanic/Latino Americans, with an accounting of the vast diversity within this population. HCHS/SOL has sites in four geographically diverse U.S. communities (San Diego, Chicago, Miami, and the Bronx), and its participants identify as Mexican, Puerto Rican, Cuban, Dominican, and Central or South American. The study is now in its third renewal with additional support from the National Institute on Minority Health and Health Disparities (NIMHD). The study has found a comparable or higher burden of CVD risk factors among all major Hispanic and Latino groups in the United States, compared to non-Hispanic whites. However, it has also established that Hispanic/Latino Americans are not a homogeneous group when it comes to health. For example, the prevalence of three or more risk factors for CVD was higher among Puerto Rican-born men and women than in other Hispanic/Latino groups.

NHLBI also continues to support research on interventions to reduce the burden of CVD in Hispanic communities. For example, a trial in South Carolina tested the use of a smartphone-based approach to control blood pressure (BP) among Hispanic adults.⁶ Participants were given a smartphone app with a Bluetooth-enabled BP monitor and an electronic medication tray that provides a series of reminder signals to take medications (blinking light, intermittent chime,

automated phone call). After nine months, BP averages were significantly lower for this approach versus standard care.

NIMHD also has a study to understand CVD disparities among Hispanic/Latino immigrants. The FOCUS: Foreign-Born Latinos Cardiovascular Screening study will examine electronic health records data from a large national network of community health centers and link it with community-level social determinants of health data to identify which groups are at highest risk for the under-utilization of CVD prevention.⁷ Another NIMHD study will examine whether social and economic stressors in childhood and adulthood are associated with chemical modifications to DNA, and whether these changes impact cardiometabolic health across the life course.⁸

Cardiovascular Disease in Women
Questions for Dr. Gary Gibbons

Cardiovascular disease, including heart disease and stroke, is the leading cause of death of women in the United States, accounting for 1 of every 3 deaths. Researchers have learned that gender differences play an important role in the prevention, diagnosis, and treatment of cardiovascular disease. For instance, heart attack symptoms are often different in women and men and responses to cardiac medications vary. This can lead to misdiagnosis and delays in treatment for women.

Additionally, the U.S. maternal mortality rate is the worst among industrialized nations, and heart disease is the number one medical reason for maternal mortality. Further, many women who experience conditions like preeclampsia or gestational diabetes are at greater risk for heart disease later in life.

Questions

1. What research is NHLBI supporting to improve diagnosis and treatment of women with heart disease?

NIH Response:

Heart disease is the leading cause of death for both men and women in the United States. However, women have distinct risk factor profiles from men and tend to experience signs and symptoms that are uncommon in men. To improve women's heart health across the lifespan, the National Heart, Lung, and Blood Institute (NHLBI) supports a robust research portfolio, including cohort studies, clinical trials, behavioral and lifestyle interventions, and implementation science.

NHLBI-funded research shows that women's unique experience with heart disease, unfortunately, includes disparities in healthcare and outcomes. An analysis from NHLBI's Atherosclerosis Risk in Communities Surveillance study, a long-term study of heart health in communities in four states, found that young women hospitalized for heart attack were less likely to receive guideline-based therapies such as statins and non-aspirin antiplatelet drugs (blood thinners) compared to men.²⁵ NHLBI's Women's Ischemia Syndrome Evaluation (WISE) study found that heart failure is more likely to lead to hospitalization and death in women than in men.²⁶ NHLBI is building on these observations and using them to inform more effective interventions for heart disease in women, for example, by supporting sex-specific analyses of clinical trial data. One such analysis suggests that while the diuretic spironolactone does not improve outcomes for men with heart failure, it is associated with reduced all-cause mortality in women with heart failure.²⁷

The landmark Women's Health Initiative (WHI), launched in 1991, has fostered numerous studies on heart disease prevention and management in women. For example, an observational study completed in 2018 found that among older women aged 50-79 years, higher levels of physical activity and walking were associated with lower risk of developing heart failure over a decade later.²⁸ Building on those findings, the WHI Strong and Healthy (WHISH) is a pragmatic trial of over 50,000 women evaluating whether physical activity can prevent cardiovascular events in older women.²⁹ An ancillary study, WHISH-2 Prevent Heart Failure, is evaluating the effect of physical activity and strength training to prevent heart failure in women over 65.³⁰

An ongoing study to understand the impact of sleep-disordered breathing on cardiovascular events and cognition in older women, WHI Sleep Hypoxia Effects on Resilience (WHISPER), is testing a simple, home-based approach for identifying modifiable sleep characteristics for women at highest risk for cardiovascular disease that may help transform routine clinical care.³¹

²⁵ pubmed.ncbi.nlm.nih.gov/30586725/

²⁶ www.sciencedirect.com/science/article/pii/S0735109705025076

²⁷ www.jacc.org/doi/full/10.1016/j.jchf.2019.01.003

²⁸ www.sciencedirect.com/science/article/pii/S2213177918305341

²⁹ projectreporter.nih.gov/project_info_description.cfm?aid=9636598&icde=52371242

³⁰ www.clinicaltrials.gov/ct2/show/NCT03099889

³¹ projectreporter.nih.gov/project_info_description.cfm?aid=9983816&icde=52390999

WHI data is also being leveraged through NHLBI's TransOmics for Precision Medicine (TOPMed) initiative, which is supporting the collection and analysis of clinical, imaging, genetic, and environmental data from participants in NHLBI's diverse population studies to explore complex risk factors for chronic disease. One TOPMed study of approximately 11,000 WHI participants is exploring genes that contribute to stroke, hypertension, and deep vein thrombosis in women.

To empower women to improve their heart health, NHLBI's national health education program, *The Heart Truth®*, promotes heart disease awareness and prevention among women, especially minority women who may be at greater risk. The program evolves with the science and includes education about risk factors for heart disease and the latest knowledge about evidence-based interventions to reduce risk.

2. How is the NHBLI addressing maternal health in its research to protect women's heart health before, during, and after pregnancy?

NIH Response:

1. As the rates of obesity, diabetes, and hypertension rise among young Americans, many young women are at higher risk for cardiovascular disease, a leading cause of maternal morbidity and mortality. NHLBI supports research to understand and reduce women's risk of cardiovascular disease before, during, and after pregnancy.

Along with the *Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)*, NHLBI supports the nuMoM2b study, which is following a diverse population of over 10,000 women in their first pregnancies to learn more about risk factors for adverse pregnancy outcomes. A recent analysis of this cohort found that for women from the Caribbean, Central and South America, and South and East Asia, greater acculturation (defined by birthplace and English proficiency) was associated with greater risk of preterm birth, preeclampsia, and gestational hypertension.³²

The ancillary nuMoM2b Sleep-Disordered Breathing Study found that nearly 10 percent of women develop sleep apnea by mid-pregnancy, and that such women are at higher risk of gestational hypertension, preeclampsia, and diabetes.³³ An ongoing Phase 3 clinical trial is now

³² journals.lww.com/greenjournal/FullText/2020/02000/Association_of_Acculturation_With_Adverse.9.aspx

³³ pubmed.ncbi.nlm.nih.gov/27926645/

investigating whether treating sleep apnea with continuous positive airway pressure can reduce the risk of these cardiovascular conditions.³⁴

Other NHLBI-funded studies are focused on reducing hypertension during pregnancy, which increases a woman's risk of potentially fatal complications, including stroke and acute kidney failure. An NHLBI-funded multi-center clinical trial is investigating whether blood pressure-lowering drugs can safely treat pregnant women who have mild chronic hypertension; such treatment is typically avoided unless the hypertension becomes severe.³⁵

NHLBI also supports research into heart-healthy behavioral interventions for mothers-to-be. Lifestyle Interventions for Expectant Moms (LIFE-Moms), a consortium of seven clinical centers supported by NHLBI and the National Institute of Diabetes and Digestive and Kidney Diseases, compared standard prenatal care to lifestyle interventions, such as a healthy eating plan and physical activity routine, and found that the interventions helped women avoid weight gain at 12 months postpartum.³⁶

To better understand and improve maternal health, NHLBI is joining NICHD and the NIH Office of Research on Women's Health to hold a workshop in spring 2020, titled "Pregnancy and Maternal Conditions That Increase Risk of Morbidity and Mortality." An interdisciplinary team of experts will explore the risk of hypertension and cardiovascular disease among reproductive age, what can be done to identify women at highest risk, and what interventions could reduce morbidity and mortality.

Vascular dementia

Question for Dr. Gary Gibbons

Vascular dementia is the second most common form of dementia, after Alzheimer's disease, affecting almost a third of people over age 70. The NIH just completed the first randomized

³⁴ clinicaltrials.gov/ct2/show/NCT03487185

³⁵ clinicaltrials.gov/ct2/show/NCT02299414

³⁶ pubmed.ncbi.nlm.nih.gov/31292531/

clinical trial demonstrating that lowering of systolic blood pressure significantly reduces the occurrence of mild cognitive impairment, which is an established risk factor and often a precursor for dementia.

Question: As the incidence of dementia continues to rise, what is NHLBI doing to understand the connection between heart health and brain health – e.g. vascular dementia?

NIH Response:

The National Heart, Lung, and Blood Institute (NHLBI) continues to study the heart-brain connection, including cardiovascular risk factors for dementia, by leveraging its longstanding cohort studies on cardiovascular disease (CVD). For example, the Framingham Heart Study—first established in 1948—conducts ongoing surveillance of cognitive impairment and dementia among its participants, including second and third-generation descendants of the original cohort. These studies are helping investigators probe early signs and risk factors for cognitive decline. In early 2020, for example, a study of the second-generation cohort found that novel blood-based biomarkers called ceramides may predict the risk of vascular dementia at a preclinical stage, potentially allowing for early diagnosis and disease intervention.³⁷

Also, in 2020, the NHLBI is expanding its investment in the Jackson Heart Study, the largest longitudinal study of heart disease in African Americans, to include detailed assessments of cognitive function. In addition, the Atherosclerosis Risk in Communities Study (ARIC) has been expanded to learn more about vascular dementia and other cognitive issues through the ARIC Neurocognitive Study (NCS), which is co-funded by NHLBI, the National Institute on Aging (NIA), the National Institute of Neurological Diseases and Stroke (NINDS), and the National Institute on Deafness and Other Communication Disorders (NIDCR). Recently reported results from ARIC NCS showed that sustained hypertension in midlife was associated with increased risk for dementia.³⁸ NHLBI's Hispanic Community Health Study/Study of Latinos (HCHS/SOL) and the Multi-Ethnic Study of Atherosclerosis (MESA) have incorporated cognitive testing, brain magnetic resonance imaging (MRI), and positron emission tomography (PET) imaging to detect the brain amyloid deposits that occur in Alzheimer's disease. Among

³⁷ www.ncbi.nlm.nih.gov/pubmed/31950603

³⁸ pubmed.ncbi.nlm.nih.gov/31408138/

the HCHS/SOL cohort, researchers found that high cardiovascular risk is associated with low cognitive function scores.³⁹

Later this year, the Women's Health Initiative (WHI) will launch the Cocoa Supplement and Multivitamin Outcomes Study (COSMOS), which will evaluate a high-quality cocoa extract supplement and a multivitamin, alone and in combination, for their potential to improve cognitive function and to reduce the risk of CVD and cancer in older men and women (age 60 and over). In addition, the WHI Sleep Hypoxia Effects on Resilience study (WHISPER) is examining the potential impact of sleep-disordered breathing on long-term cognition. Specifically, the study will examine whether older women, with intermittent reduced hypoxia (low oxygen levels) during sleep, are at higher risk of cognitive decline. Also, in 2020, NHLBI is providing support to NIA's Pragmatic Evaluation of Events and Benefits of Lipid-Lowering in Older Adults (PREVENTABLE) trial⁴⁰ which will test whether statins can prevent disability, dementia, mild cognitive impairment, and CVD in older adults who do not currently have CVD or dementia.

NINDS is supporting a variety of other studies to investigate the links between heart and brain health. For example, the ongoing NINDS-supported MarkVCID consortium has developed and preliminarily validated several kits with fluid- and image-based biomarkers that could identify small vessel disease in the brain that could lead to vascular dementia. Soon these biomarkers will move into Phase 2 testing for use as outcome measures in clinical trials. MarkVCID kits will also be used in a newly launched NINDS initiative supporting researchers at 12 institutions to conduct in-depth MRI characterization of brain white matter lesions (WMLs), which are associated with cognitive decline but are also commonly seen in cognitively healthy people. This project aims to identify the specific characteristics of WMLs that can predict future cognitive decline and dementia. NINDS is also broadening the scope of the large, prospective Reasons for Geographic and Racial Differences in Stroke (REGARDS) study, which is examining vascular risk factors and health disparities in stroke incidence and outcomes, especially within rural areas and in African American and Hispanic populations as they age.

Finally, NHLBI, NINDS, and NIA held a workshop in November 2019 to discuss future clinical studies that will test approaches for reducing vascular contributions to cognitive impairment and

³⁹ pubmed.ncbi.nlm.nih.gov/31771064/

⁴⁰ projectreporter.nih.gov/project_info_description.cfm?aid=9860448&jcde=47929223&ddparam&ddvalue&ddsub&cr=3&csb=default&cs=ASC&pball

dementia. The workshop identified gaps and opportunities for trials that may deliver more potent pharmacological and lifestyle interventions that target vascular and other risk factors.⁴¹

Diversity in Human Tissue Research

Questions for Dr. Francis Collins

Relying on purpose-bred animals to study human diseases does not accurately capture the many genetic and lifestyle risk factors that contribute to disease, leading to failures in translation to the clinic and wasted resources. In order to realize the goal of personalized medicine, preclinical research must utilize diverse human-based samples to form the basis of our understanding of disease.

Minority groups are harder hit by many diseases but are often underrepresented in NIH-funded tissue biobanks, just as they are in clinical trials. For example, African Americans are twice as likely to have Alzheimer's or other dementias than Caucasians and Hispanic Americans are one-half times more likely, but only represent 4% and 3% of samples in NIH Neurobiobank, respectively. A lack of diversity in human tissue research can exacerbate health disparities when addressing serious health issues.

Questions:

1. How do you ensure that human tissues for research are collected from demographically diverse individuals so that this research is representative of all Americans, especially minority populations experiencing health disparities?

NIH Response:

⁴¹ www.nihbi.nih.gov/events/2019/future-clinical-trials-test-promising-approaches-reducing-vascular-contributions

NIH has taken critical steps to ensure that the scientifically appropriate enrollment of women and underrepresented and underserved groups in clinical research occurs and is engaged in efforts to increase inclusion of children, older adults, pregnant and lactating women, and individuals with disabilities where appropriate. The long-standing NIH inclusion policies aim to ensure that the knowledge gained from research is applicable to everyone affected by the disease or condition under study.⁴² Additionally, NIH requires researchers who propose research involving participants to include plans for how these groups will be enrolled, unless there is a scientific or ethical justification for their exclusion.

Repositories and biobanks typically are associated with pre-clinical research efforts; however, some may not be subject to NIH inclusion policies. These resources support the collection, analyses, storage, and distribution of biospecimens, which can include DNA, cell lines, or model organisms for research use. That said, NIH supports diversity wherever possible in all of its funded research and related resources, such as biobanks. The National Institute of General Medical Sciences (NIGMS) Human Genetic Cell Repository, for instance, contains more than 11,300 cell lines and 5,700 DNA samples derived from a diverse collection of healthy individuals and individuals with various inherited diseases.⁴³ The NIH *All of Us* Research Program (*All of Us*) biobank, moreover, supports the collection, analysis, storage, and distribution of the biosamples that the program collects for research purposes which currently includes blood, urine, and saliva.⁴⁴ As diversity is one of its core values,⁴⁵ *All of Us* participants come from different races, ethnicities, age groups, and regions of the country as well as are diverse in gender identity, sexual orientation, socioeconomic status, education, disability, and health status.⁴⁶

Biobanks that store information of biospecimens that use or generate identifiable, private information are monitored under NIH inclusion policies. However, NIH does not systematically collect race/ethnicity data on human material from biobanks that do not use or generate identifiable, private information.

In addition to consideration of inclusion policies, the NIH policy on Sex as a Biological Variable seeks to balance sex in preclinical studies.⁴⁷ The policy raises the expectation that

⁴² grants.nih.gov/policy/inclusion.htm

⁴³ www.nigms.nih.gov/Research/specificareas/hgrc/Pages/default.aspx

⁴⁴ allofus.nih.gov/funding-and-program-partners/biobank

⁴⁵ allofus.nih.gov/about/core-values

⁴⁶ allofus.nih.gov/about/diversity-and-inclusion

⁴⁷ orwh.od.nih.gov/sex-gender/nih-policy-sex-biological-variable

sex as a biological variable be factored into research designs, analyses, and reporting in vertebrate animal and human studies. Finally, the impending publication of the NIH Minority Health and Health Disparities Strategic Plan will provide mechanisms for NIH Institutes and Centers to contribute or collaborate in ensuring that human tissues for research are collected from demographically diverse individuals.

2. How do you plan to increase resources allocated toward supporting human tissue research?

NIH Response:

NIH supports a broad range of investments that involve banking samples for analysis. As an example, *All of Us* has continued to ensure diverse participation in biomedical research, including the collection of biosamples from participants reflecting the diversity of the United States. As stated above, the program collects biosamples from many participants and supports the analysis, storage, and distribution of those for research purposes.⁴⁸ The program will collect data from one million or more participants living in the United States, with the goal of improving health for all of us. National enrollment began in 2018. Since launching in FY 2016 with an initial funding level of \$130 million, *All of Us* has grown to \$500 million in FY 2020. The program is actively recruiting participants from diverse populations, including those that have been historically underrepresented in biomedical research. As of the date of the hearing, over 270,000 participants have already enrolled and completed all initial steps of the program, including donating at least one biosample to the *All of Us* biobank.⁴⁹ Of current enrollees at that time, more than 80 percent are from groups that have been traditionally underrepresented in biomedical research and 50 percent are from racial and ethnic minorities. The program aims to collect data of one million or more people living in the United States. Efforts to increase engagement with and participation of individuals from underrepresented communities will inform similar activities across NIH further and is anticipated to improve access and availability of human tissues for research.

3. How will you improve availability and accessibility of human tissues for research?

NIH Response:

⁴⁸ allofus.nih.gov/funding-and-program-partners/biobank

⁴⁹ www.researchallofus.org/data-snapshots/

Through critical investments such as *All of Us*, NIH is improving the availability and accessibility of human tissues for research. *All of Us* is building a resource of biosamples from participants reflecting the diversity of the United States, and is dedicated to ensuring that a broad and diverse research community has access to the program's data and samples.

4. In order to ensure that these resources can meet the growing need for preclinical research to study diversity and disparity risk factors, annual tracking is needed. Approximately how much of NIH's budget is currently allocated for biospecimen collection, storage, and use, and approximately how much of this budget is allocated for collection from demographically diverse subjects?

NIH Response:

NIH is currently reviewing the accuracy and completeness of its FY 2020 grant award data as part of its annual quality control review process. NIH anticipates having appropriate data and analyses completed (for the past five years) by the end of calendar year 2020 to address this request. Please also note (as stated earlier) that NIH only has inclusion data for biobanks that include identifiable information. For those biobanks that do not use identifiable information, NIH cannot systematically identify participant diversity because such demographic data is not collected.

Stakeholder Input into NIH Strategic Plan

Question for Dr. Francis Collins

The NIH is currently putting together its agency-wide strategic plan, as mandated in 21st Century Cures. Many agencies and institutes solicit public input through in-person public meetings when assembling planning documents and determining priorities to provide full transparency and allow stakeholders to have the opportunity to voice input in a direct, public manner. However, the NIH has only solicited public input through an online Request for Information and webinars.

Question: Do you plan to gather public input on your NIH-wide strategic plan through an in-person public meeting?

NIH Response:

The NIH-Wide Strategic Plan outlines NIH's research priorities, and how these align with the agency's mission and goals in an evolving research landscape. It represents one facet of NIH's stewardship of federal dollars and contributes to maintaining transparency and accountability to its many stakeholders. NIH recognizes that input from the public—including members of the scientific and healthcare communities, professional societies, advocacy organizations, industry, other federal agencies, and the general public—provides valuable insight during its strategic planning process.

In order to solicit comments from the public on the proposed Framework for the Plan, NIH published a Request for Information (RFI) in February 2020.⁵⁰ To reach as many different stakeholder groups as possible, the RFI was posted in the NIH Guide for Grants and Contracts and the Federal Register and advertised broadly through the NIH website and social media accounts. The comment period was set purposefully long (six weeks), and further extended for one week as the COVID-19 pandemic hit, to encourage a robust response. In addition, NIH hosted two interactive public webinars in March 2020, to provide the opportunity for stakeholders to voice input in a direct manner by asking questions on the Strategic Plan development process and commenting on the Framework. The webinar format allowed for broader participation from members of the public around the country by eliminating the need for travel to attend. The Framework was also presented to two NIH advisory bodies for their consideration—the NIH Advisory Committee to the Director (ACD) in December 2019, and the NIH Council of Councils (CoC) in January 2020. These committees are comprised of public and scientific members, and meetings are open to the general public. The Strategic Plan Framework and content was adjusted considerably in response to public feedback gleaned from these varied forums. Moving forward, the draft Strategic Plan will be presented to and discussed by the CoC on November 13, 2020 and with the ACD during their December 2020 meeting—both of these meetings are public forums and are advertised in the Federal Register.

NIH strongly believes that sharing details of the development of the NIH-Wide Strategic Plan, in addition to gathering and incorporating public input is an integral part of the strategic planning process, ensuring transparency and providing the public with the opportunity to share their voice and help shape NIH's priorities moving forward.

⁵⁰ <https://grants.nih.gov/grants/guide/notice-files/NOT-OD-20-064.html>

NIMH primate research***Questions for Dr. Francis Collins***

In February 2020, troubling video was released of ongoing invasive psychological research on nonhuman primates at the National Institute of Mental Health's Laboratory of Neuropsychology. The disturbing footage released by NIH following a Freedom of Information Act lawsuit depicts monkeys chained up in tiny cages being intentionally frightened with mechanical snakes and rubber spiders, creatures that they instinctively fear. Documents show that prior to the tests, NIH researchers damage the monkeys' brains with injections of toxic acid, suction or burns to impair their ability to properly process emotions. Scientists, clinicians and other health professionals have criticized the research depicted in the videos as irrelevant to human health and a waste of NIH resources.

Questions:

1. How many different grants are currently supporting this research, and how much, by year and grant, have each of these projects cost taxpayers since their inception?
2. What clinical benefits have this research provided for human patients?

NIH Response:

The National Institutes of Health (NIH) encourages using the most appropriate models for scientific research and is committed to the highest standards of care for all research subjects. Accordingly, the procedures in the National Institute of Mental Health (NIMH) Intramural Research Program (IRP) Laboratory of Neuropsychology are used in a selective manner and conducted in a way that aims to minimize physical pain. The test cages are small, but temporary; the nonhuman primates spend approximately 10 minutes at a time in the test cages, and then are returned to their typical housing. The psychological stressor – exposure to (toy) snakes or spiders, for 30 seconds at a time – is not unlike a stressor that nonhuman primates would encounter in their natural environments. The scientific merit of this laboratory's work is regularly assessed by the NIMH Board of Scientific Counselors (BSC). The BSC consists of individuals from outside NIH who possess outstanding scientific credentials and are committed to providing rigorous, objective reviews. Furthermore, the laboratory's protocols and practices are regularly reviewed by the NIH Office of Animal Care and Use to ensure their compliance with the Animal Welfare Act and other federal regulatory standards.

Scientific advances from this laboratory have improved the understanding of how the brain responds to fear which will support future efforts to develop treatments for mental illnesses

including specific phobias and post-traumatic stress disorder (PTSD). For example, research from this laboratory suggests a potential strategy for treating phobias. Selectively manipulating the amygdala, a brain region involved in the response to fear, could reduce harmful phobic fear without affecting healthy, appropriate defensive responses to fear-provoking stimuli. The Laboratory of Neuropsychology has also pioneered the use of magnetic resonance imaging (MRI)-guided stereotaxic surgery, a method for making small, precise lesions to specific parts of the brain. Using such techniques, scientists have clarified the neural circuits underlying such important mental illnesses as PTSD, schizophrenia, and obsessive-compulsive disorder. Additionally, this laboratory has identified regions within the frontal cortex of the brain critical for regulating emotional expression and processing rewarding events, which are relevant to studies of anxiety disorders and depression respectively. Findings from studies conducted within the Laboratory of Neuropsychology have already significantly advanced our fundamental understanding of the neural circuitry of fear, anxiety, and emotion. Therefore, continued investment in these long-term research goals is vital for improving outcomes for people who suffer from mental illnesses.

NIMH has supported the research you described through one grant (referred to as a “project” in NIH intramural research), which has received a total of \$16,398,114 to date. The table below displays the detailed funding history of this project.

Fiscal Year (FY)	Project Cost (\$)
2007	613,030
2008	1,031,837
2009	1,485,711
2010	1,261,033
2011	1,505,964
2012	1,408,769
2013	998,893
2014	1,048,507
2015	1,213,924
2016	1,494,771
2017	1,218,093

2018	1,458,227
2019	1,659,355
Total To Date	16,398,114

Chimpanzee Retirement to Chimp Haven

Questions for Dr. Francis Collins

When Congress passed the CHIMP Act it intended for all NIH-owned chimpanzees to be retired to sanctuary. Despite this, four months ago NIH created an internal panel, developed outside the scope of Congress' mandate under the CHIMP Act, and determined that none of the chimpanzees warehoused at the Alamogordo Primate Facility (APF) were to be transferred to Chimp Haven, the national sanctuary.

NIH cited poor health reasons for keeping all the remaining chimpanzees at APF, including "poorly regulated insulin dependent diabetes." However, in recent congressional staff delegation visits to APF, the veterinarians at the facility stated that the chimpanzees appear healthy and many of their symptoms are controlled. Additionally, Congressional staff reported from their tour that the chimpanzees were housed in small social groups in an incredibly sterile environment and only one blanket was observed on the tour.

Keeping the chimpanzees at the APF requires significant taxpayer investment. According to the Charles River Laboratories contract with NIH and the per diem rate published for Chimp Haven on NIH's website, it would cost taxpayers approximately \$1.1 million more to keep the chimpanzees at Alamogordo instead of retiring them to Chimp Haven. And that is savings over just a 10-month period.

Questions:

1. Please provide a detailed budget estimate for the maintenance of all 41 chimpanzees were they to remain at APF for the next 5 years taking into account the expected mortality rate of the population, as well as a comparative cost estimate for that same period, of the cost to taxpayers were the chimpanzees to be transferred, as directed by Congress, to Chimp Haven.
2. Please provide a detailed breakdown of any health changes that have occurred in the 41 remaining chimpanzees since the NIH panel released its determination over 4 months ago and whether any external experts have assessed the chimpanzees in person. Additionally, provide detailed documentation of the composition of all social groups, and provision of any nesting materials.
3. Is NIH also planning to keep chimpanzees remaining at the Keeling Center for Comparative Medicine and Texas Biomedical Research Institute from being retired to Chimp Haven?

NIH Response

The National Institutes of Health (NIH) supports the goals of the CHIMP Act, which was enacted to provide a lifelong care system ensuring the welfare of these precious resources. NIH remains committed to retiring all eligible chimpanzees it owns or supports to the Chimp Haven federal sanctuary unless this move would significantly jeopardize the health of these animals.

Detailed Budget Estimate for Maintenance of Chimpanzees Remaining at Alamogordo Primate Facility (APF) for the Next 5 Years

Since the number of chimpanzees at any facility will change over time, the cost per day per animal at a facility will vary over the course of a year and from year to year. Costs vary between facilities due to the local economy, size of the chimpanzee population, and the presence of other nonhuman primates, where expertise may be shared. NIH conducts an annual census of its owned and supported chimpanzees after the end of each fiscal year (September 30) to provide the public with official figures on their numbers and cost of care.⁵¹ The total number of animals is expected to decrease annually as a result of normal mortality. The number of animals at different facilities may also increase or decrease as a result of relocation.

Table 1: APF Budget Estimate (100 percent of Costs Covered by NIH)

⁵¹ orip.nih.gov/comparative-medicine/programs/vertebrate-models/chimpanzee-management-reports

Year	Estimated Average Chimpanzee Census*	Estimated Per Diem (Cost/Animal/Day)**	Estimated Total Cost = Estimated Average Chimpanzee Census x Estimated Per Diem x 365 days
1	Year average: 37 (Start of year: 41; End of year: 33)	\$56	\$756,280 (37 x \$56 x 365)
2	Year average: 29 (Start of year: 33; End of year: 25)	\$130	\$1,376,050 (29 x \$130 x 365)
3	Year average: 21 (Start of year: 25; End of year: 17)	\$135	\$1,034,775 (21 x \$135 x 365)
4	Year average: 13 (Start of year: 17; End of year: 9)	\$165	\$782,925 (13 x \$165 x 365)
5	Year average: 5 (Start of year: 9; End of year: 1)	\$264	\$481,800 (5 x \$264 x 365)
Estimated 5 Year Total Cost			\$4,431,830

* As of March 4, 2020, 41 chimpanzees remain at APF.⁵² All 41 remaining APF animals are categorized as class V (animals with life-threatening, systemic disease that poses a constant threat and could result in abrupt death) per the Chimpanzee Health Categorization Framework,⁵³ which was harmonized across NIH-supported facilities including Chimp Haven. Based on historical actuals, Charles River Laboratories (contractor for APF) anticipates the animal census at APF to decrease on average by eight animals per 12-month period (expected mortality), but with an aging and frail population, this number could be significantly higher.

** The number of animals and thus the costs per animal per day (per diem) will vary throughout the year and from year to year at all facilities; projected costs are based on numbers and estimates provided in the contract with Charles River Laboratories for APF and are likely an overestimate as expected mortality could be significantly higher.

Comparative Cost Estimate for Chimp Haven for the Next 5 Years

NIH funding for the care of chimpanzees at the Federal Sanctuary is made through a contract with matching contributions as required by the CHIMP Act—the contractor (Chimp Haven, Inc.) must match \$1 for every \$3 for operating expenses. The provided comparative cost estimate

⁵² orip.nih.gov/comparative-medicine/programs/vertebrate-models/chimpanzee-management-reports

⁵³ orip.nih.gov/sites/default/files/ChimpanzeeHealthCategorizationFrameworkFinal_508.pdf

over a 5-year period if APF chimpanzees were to be transferred to Chimp Haven includes only the cost to NIH to transfer and then to care for the remaining APF animals to Chimp Haven.

Various assumptions were made in estimating a comparative cost estimate for Chimp Haven, including:

- Estimated transfer costs from APF to Chimp Haven using the current shipper and moving animals during a pandemic should travel restrictions be in place
- Expected mortality projections if the chimpanzees were moved (impact of transfer on the chimpanzees' lifespan once at Chimp Haven)
- Estimates of care costs at Chimp Haven based on recent yearly average per diem rates
- Space constraints at Chimp Haven
- Additional veterinary and animal care staff costs at Chimp Haven

Estimated Transfer Cost

Estimated transfer costs for each transfer from APF to Chimp Haven using the current shipper is approximately \$45,000 per transfer (NIH pays \$33,750 and Chimp Haven pays \$11,250). Approximately 5-6 animals can be consistently accommodated in the trailer for each transfer. Therefore, to relocate 41 animals from APF to Chimp Haven will require 8 transfers at an estimated total cost of \$270,000 to NIH.

Estimated Animal Care Costs at Chimp Haven

To account for the impact of stresses related to the transfer process, an expected mortality of 38 percent for the APF animals in the first year at Chimp Haven following transfer is based on the observed mortality of the transfer of chimpanzees from Keeling Center for Comparative Medicine and Research (KCCMR) to Chimp Haven on December 9, 2014, and April 8, 2015. This expected mortality is likely an underestimate as the proposed travel time is 4-5 times longer for APF transfers (26-28 hours) compared to KCCMR transfers (6-8 hours) to Chimp Haven, and the KCCMR animals were not all categorized as class V. The expected mortality for the remaining years is based on historical actuals from Charles River Laboratories (contractor for APF) for this group of animals. It is anticipated that the animal census for this group of animals will decrease on average by eight animals per 12-month period (expected mortality).

Table 2: NIH Portion of Estimated Animal Care Costs at Chimp Haven

Year	Estimated Average Chimpanzee Census*	Estimated Per Diem (Cost/Animal/Day)**	Estimated Total Cost = Estimated Average Chimpanzee Census x Estimated Per Diem x 365 days
1	Year average: 33 (Start of year: 41; End of year: 26)	\$47	\$566,115 (33 x \$47 x 365)
2	Year average: 22 (Start of year: 26; End of year: 18)	\$48	\$385,440 (22 x \$48 x 365)
3	Year average: 14 (Start of year: 18; End of year: 10)	\$49	\$250,390 (14 x \$49 x 365)
4	Year average: 6 (Start of year: 10; End of year: 2)	\$50	\$109,500 (6 x \$50 x 365)
5	Year average: 1 (Start of year: 2; End of year: 0)	\$51	\$18,615 (1 x \$51 x 365)
Estimated 5 Year Animal Care Cost			\$1,330,060

* As of March 4, 2020, 41 chimpanzees remain at APF.⁵⁴ All 41 remaining APF animals are categorized as class V (animals with life-threatening, systemic disease that poses a constant threat and could result in abrupt death) per the Chimpanzee Health Categorization Framework,⁵⁵ which was harmonized across NIH-supported facilities including Chimp Haven.

⁵⁴orip.nih.gov/comparative-medicine/programs/vertebrate-models/chimpanzee-management-reports

⁵⁵orip.nih.gov/sites/default/files/ChimpanzeeHealthCategorizationFrameworkFinal_508.pdf

** The number of animals and thus the costs per animal per day (per diem) will vary throughout the year and from year to year at all facilities. Per diem estimated for year 1 is equal to the average per diem cost from the past nine years (2012 – 2019).⁵⁶ Estimated per diems for years 2 through 5 are adjusted from year 1 based on a 2 percent inflation rate as provided in the current contract with Chimp Haven for the Federal Sanctuary. The estimated per diems are likely an underestimate as the overall number of animals at Chimp Haven will plateau once transfers of NIH-owned and supported animals are completed and then decline due to natural attrition, leading to increasing per diems over time.

The overall estimated 5-year total cost for 41 chimpanzees transferred from APF to Chimp Haven is \$1,600,060, which was calculated by adding the estimated transfer cost (\$270,000) to the estimated 5-year animal care cost (\$1,330,060).

Details of individual chimpanzee health status at APF

All details of individual chimpanzee health status at APF for October 2019 are included in the attached Excel spreadsheet. The data include: 1) the 44 animals that NIH decided not to transport to Chimp Haven, 2) health status with updates and health category,⁵⁷ and 3) composition of social groups.

The majority of these chimpanzees have cardiovascular disease; other animals have advanced renal disease or diabetes, and all are considered geriatric. The average age for the animals at APF is 43.5 years (males 44.6 years, females 42.3 years), which is well beyond the minimum accepted standard for defining chimpanzees as geriatric (35 years). Other co-morbidities, such as osteoarthritis and uterine masses, are present in these animals. These life-threatening, systemic diseases pose a constant threat and could result in abrupt death due to the stress of transportation and integration at a new facility. Since October 2019, evaluations of the animals by the two APF veterinarians and clinical staff have shown increased disease progression in the 41 animals that remain as of March 4, 2020.⁵⁸ Between October 1, 2019 and March 4, 2020, three animals have died or have been euthanized for medical reasons.

⁵⁶ orip.nih.gov/comparative-medicine/programs/vertebrate-models/chimpanzee-management-reports

⁵⁷ orip.nih.gov/sites/default/files/ChimpanzeeHealthCategorizationFrameworkFinal_508.pdf

⁵⁸ orip.nih.gov/comparative-medicine/programs/vertebrate-models/chimpanzee-management-reports

Social groups as of March 4, 2020 are indicated in the Excel spreadsheet (second tab). There were 11 social groups ranging in size from three chimpanzees to six chimpanzees. APF staff have been and continue to perform introductions to reduce the number of groups and increase the size of stable compatible groups. Due to the movement of animals to the Federal Sanctuary as well as attrition, social groups became inherently smaller but remained stable. Establishing larger groups provides a better management plan to reduce the need for resocialization as reduction due to attrition occurs. Plans to continue social introductions, particularly the groups currently containing three animals, are under consideration; successful introductions are a complex process.

The chimpanzees have daily access to materials to build nests. Various types of bedding are provided based on the time of year, such as straw, hay, bamboo fronds, shredded paper, cargo netting, half barrels of cut grass and blankets. This gives the animals the option to build nests if they desire. APF is the only chimpanzee center that has radiant heat on all its floors. This provides a comfortable sleeping environment in the cooler months and gives the animals a thermoregulation ability that is not necessarily available at other facilities. In warmer months, air-conditioning is provided.

In November 2018, NIH established a panel of NIH veterinarians with chimpanzee or other non-human primate expertise, independent from the NIH Chimpanzee Management Program, external stakeholder groups or organizations, and sites holding chimpanzees. The Panel was established to review the records of all chimpanzees that were deemed at-risk following the attending veterinarian's assessment that the chimpanzees should not move to the federal sanctuary, Chimp Haven, Inc., based on health or welfare related concerns. Currently, the Panel is in the process of reviewing NIH-owned animals at the Keeling Center for Comparative Medicine and Research (KCCMR) followed by NIH-supported animals from the Southwest National Primate Research Center (SNPRC).

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
National Institutes of Health Budget Request for FY 2021
(3.4.20)

Questions for the Record

Submitted by Congressman Pocan

Endometrial Cancer

I am concerned with the increased incidence and mortality rate of endometrial cancer and the lack of research on detecting and differentiating uterine sarcoma from benign fibroids. I understand that NICHD and NCI held a joint meeting on this topic in April 2019.

Question: Are there plans for a coordinated research effort between the NCI and NICHD in FY 2021 based on the outcomes from this meeting?

NIH Response:

The National Cancer Institute (NCI) recognizes the importance of research related to the determinants of gynecologic cancer progression from benign conditions. The workshop held in April 2019 was organized to help bridge the gap between research into benign gynecologic diseases that is funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) and research on malignant gynecologic disorders funded by the NCI. The intersection of these fields is critical to better understanding the development, progression, and treatment of endometrial cancer. A report from the meeting and a new funding opportunity are in development to help address this issue.

Critical research pursuits identified at the meeting related to benign fibroids and sarcoma include creating registries and cohorts to describe the natural history of these conditions and compiling biospecimen sets; studying the natural history of hormonal transitions such as perimenopause, pregnancy, and menopause and how these transitions affect fibroids; and innovating nonsurgical therapies. The research community is poised to address many of these questions given recent advances in genetics, imaging and model systems.

An NICHD-led funding opportunity currently in development will aim to support research through the development of Centers to Advance Research in Endometriosis (CARE). This program hopes to incorporate collaborative biologic and/or clinical studies to accelerate research into the causes and mechanisms of progression of endometriosis, and the development of more effective strategies for endometriosis diagnosis, treatment/management, and prevention. The NCI expects to sign on as a participating organization to potentially co-fund any cancer-related projects within a proposed grant.

This effort will provide an opportunity for both NCI and NICHD to fund research together that studies, in part, how endometriosis may progress to an associated cancer. The hope is that this collaborative research will help identify ways to prevent certain types of endometrial cancer in women who have these benign or pre-cancerous conditions.

I appreciate the National Cancer Institute sharing information with the patient and provider community bringing a greater focus to the increase in incidence and mortality rates for endometrial cancer. However, I am particularly concerned that black women are two times more likely to die from their endometrial cancer despite advances in care and improved survivorship. Given this significant disparity, I believe there is a need for a renewed emphasis on endometrial cancer research to facilitate optimal treatments and outcomes for minority populations.

Question: How does the NCI plan to increase research on endometrial cancer disparities associated with race, including biologic differences in tumor type, access to care, and diagnosis and mortality rates in FY 2021 and beyond?

NIH Response:

Endometrial cancer is the most common gynecologic cancer in the United States, with an estimated 65,620 new cases and 12,950 deaths in 2020.¹ There are increasing rates of endometrial cancer among racial and ethnic minority women, particularly women of African descent who have a higher rate of incidence for aggressive endometrial cancer and a significantly lower five-year survival rate than white women. Disparities in endometrial cancer may be linked to lack of access to care including quality surgical care, chemotherapy, or radiation treatment; genetic differences in tumors; and comorbid conditions among African American women.

Describing health disparities is a critical first step in developing interventions to address unequal outcomes. A recent study led by the National Cancer Institute (NCI) intramural researchers used population data from NCI's Surveillance, Epidemiology, and End Results (SEER) database to evaluate trends of hysterectomy-corrected uterine cancer incidence rates for women overall and by race and ethnicity, geographic region, and histologic subtype.² Correct estimation of these rates requires accounting for hysterectomy prevalence, which varies by race, ethnicity, and region. The researchers found that incidence rates of common subtypes of uterine cancer were stable in non-Hispanic white women over the study period and increased in women of other racial/ethnic groups. By contrast, incidence rates of aggressive subtypes have been increasing dramatically over time in all racial/ethnic groups; in particular, much higher rates of these aggressive subtypes were observed in Black women than in other racial/ethnic groups. The researchers also observed that the survival rate was lower among all women with aggressive subtypes than among women with common subtypes. Black women had the lowest survival rates, within each stage at diagnosis or histologic subtype.

¹ seer.cancer.gov/statfacts/html/corp.html

² pubmed.ncbi.nlm.nih.gov/31116674/

To begin to address these disparities, NCI is supporting several projects aimed at identifying molecular drivers that contribute to worse disease outcomes for Black women. For example, investigators at Wayne State University are examining genomic variation in high grade endometrial cancers from Black and white women. Much of the initial work was done by The Cancer Genome Atlas (TCGA), but this study will expand that initial work to be better representative of Black women in order to improve researchers' understanding of the spectrum of molecular variation among different racial groups.³ Another research project at Northwestern University seeks to understand the biological etiology of endometrial cancer through tumor genomics, and is investigating racial disparity for progestin response given that young Black women exhibit advanced disease with worse prognosis compared to young white women.⁴

NCI-supported investigators are now seeking to develop new therapies for uterine serous carcinoma (USC), a rare but aggressive type of endometrial cancer. In about one-third of women with USC, their tumor cells overproduce HER2, which is associated with poor prognosis in women with endometrial cancer. Black women with endometrial cancer are more likely than white women to be diagnosed with USC and are more likely than women of other races/ethnicities to have HER2-positive USC tumors. NCI clinical studies for patients that have HER2-positive USC and carcinosarcoma are currently in development.⁵

NCI also supports research addressing the socioeconomic drivers of cancer health disparities. The Gulf South Center for Research and Solutions in Cancer Health Disparities (Gulf South-CARES-CHD), brings together regional investigators conducting research in cancer health disparities to improve understanding of the biological and social determinants of health disparities and develop new interventions and clinical trials that address these inequalities.⁶ Another study at the University of Alabama tests a multi-level, interactive voice response system-supported physical activity intervention in populations at high risk for sedentary behavior (rural, mostly minority residents in the Deep South). This line of research will help extend the reach and sustainability of ongoing community health worker efforts by the Deep South Network for Cancer Control in rural Black Belt communities and thereby address related cancer disparities.⁷

Other research efforts are focused on understanding the underlying causes of endometrial cancer, in order to help better predict risk and work toward prevention and early detection of this cancer. For example, the Epidemiology of Endometrial Cancer Consortium (E2C2) is an NCI-supported consortium dedicated to studying the etiology of endometrial cancer through collaboration among investigators.⁸ E2C2 researchers recently showed that the use of aspirin, other nonsteroidal anti-inflammatory drugs, and acetaminophen may reduce risk of endometrial cancer among overweight and obese women.⁹ In a separate NCI-funded study, researchers have shown that an experimental screening test can detect some endometrial cancers at their early, more

³ projectreporter.nih.gov/project_info_description.cfm?aid=9916725&icde=52253999

⁴ projectreporter.nih.gov/project_info_description.cfm?aid=9961261&icde=52253999

⁵ www.cancer.gov/news-events/cancer-currents-blog/2020/endometrial-cancer-usc-her2-trastuzumab

⁶ projectreporter.nih.gov/project_info_description.cfm?aid=10005206&icde=52253999

⁷ projectreporter.nih.gov/project_info_description.cfm?aid=9929557&icde=52253999

⁸ epi.grants.cancer.gov/eccc/

⁹ pubmed.ncbi.nlm.nih.gov/30566587/

treatable stages.¹⁰ The test, called PapSEEK, is a type of liquid biopsy that identifies cancer-related alterations in DNA obtained from fluids collected during a routine Pap smear test. NCI also conducts numerous preclinical and clinical studies to identify more effective treatments for endometrial cancer progression and recurrence. The Endometrial Cancer Specialized Programs of Research Excellence (SPORE) grant at the University of Texas MD Anderson Cancer Center is conducting research that seeks to develop novel therapeutic strategies for advanced/recurrent endometrial cancer and aggressive subtypes.¹¹

NCI, along with the National Institute on Minority Health and Health Disparities (NIMHD), is dedicated to better understanding endometrial cancer disparities and to improving outcomes for all women with endometrial cancers. Both NCI and NIMHD will continue to address endometrial cancer health disparities at all stages of the research spectrum, from basic to translational and clinical studies, and survivorship research. More broadly, NIMHD is leading implementation of the NIH Minority Health and Health Disparities Research Strategic Plan (2020-2024), presenting opportunities for continued trans-NIH collaboration to address endometrial cancer disparities.

¹⁰ pubmed.ncbi.nlm.nih.gov/29563323/

¹¹ projectreporter.nih.gov/project_info_description.cfm?aid=10265734&icde=52278925

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Questions for the Record

Submitted by Congresswoman Barbara Lee

Question for Dr. Gary Gibbons, NHLBI Director

Question: I am pleased that NHLBI took the lead in establishing a National COPD Action Plan. Dr. Gibbons, can you provide an update on implementation of the plan?

NIH Response:

The chronic obstructive pulmonary disease (COPD) National Action Plan was launched in 2017, in collaboration with the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and other government and nongovernment partners. Since then, the National Heart, Lung, and Blood Institute (NHLBI) has initiated or supported many activities to fulfill the research goals of the plan. One major priority is to improve the health of rural and underserved communities who are most burdened by COPD, and several NHLBI research efforts are underway to address this disparity. In 2019, the Risk Underlying Rural Areas Longitudinal Cohort Study (RURAL) was established to address COPD and other diseases that disproportionately affect rural populations in four Southern states (Alabama, Kentucky, Louisiana, and Mississippi).¹

Another priority is to identify strategies to prevent the development of chronic lung diseases. In 2019, NHLBI began funding the American Lung Association to conduct the Lung Health Cohort study, which is recruiting young adults from 17 metropolitan regions across the United States to help identify risk factors and early signs of lung disease to support interventions before chronic disease such as COPD sets in.²

Efforts are also underway to improve the use of pulmonary rehabilitation (PR). Although PR has been shown to reduce hospitalizations and improve quality of life among people with COPD, it is estimated that only 4 percent of eligible patients use it.³ NHLBI-funded researchers are studying a variety of approaches to increase access and adherence to PR, including the use of home-based visits, coaching, and telehealth.

¹ https://projectreporter.nih.gov/project_info_details.cfm?aid=9710174&icde=47796914

² https://projectreporter.nih.gov/project_info_description.cfm?aid=9711058&icde=47796624

³ <https://pubmed.ncbi.nlm.nih.gov/32396181/>

In addition, NHLBI is continuing its support of the COPDGene Study, one of the largest COPD studies ever funded.⁴ The study is investigating genetic variation and clinical features, combined with lung imaging, to better understand individual differences in disease susceptibility (e.g., why some smokers develop COPD while others do not).

NHLBI's *Learn More Breathe Better* national awareness program continues to play a key role in supporting the goals of the COPD National Action Plan around the country by translating research for public and professional education programs. The Institute is currently planning to broaden its reach and fund community-serving organizations to implement innovative health education initiatives about COPD at the local level.⁵ The implementation of the action plan requires continued efforts from all partners. In November 2019, NHLBI convened a town-hall style meeting⁶ of the partners to discuss progress. In addition, NHLBI will launch a web-based platform in early 2021 that will allow partners to share their activities and collectively track their progress as they implement the goals of the plan.

⁴ <http://www.copdgene.org/>

⁵ <https://www.nhlbi.nih.gov/health-topics/education-and-awareness/copd-learn-more-breathe-better/community-subcontractor-program>

⁶ <https://www.nhlbi.nih.gov/news/2019/breathing-easier-meeting-addresses-implementation-tracking-copd-national-action-plan>

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Questions for the Record

Submitted by Congressman Moolenaar

Rare Cancer Research

Rare cancers make up almost one-third of cancer diagnoses yet 75% of clinical trials do not specifically include rare cancers or rare cancer patients. Additionally, there is significantly less publicly available information regarding rare cancer research.

Question: What is being done to increase the amount of rare cancer research and making the resulting data available to the public?

NIH Response:

Advances in research involving the specific genes, proteins, and other unique molecular characteristics driving cancer subtypes have led to the understanding that cancer is made up of a collection of hundreds, if not thousands, of rare subtypes as defined by these characteristics. The National Cancer Institute (NCI) remains committed to advancing progress against all cancers through funding for projects focused on rare cancers, and sustained support for the nation's cancer clinical trials infrastructure, and investments in databases, repositories, and other resources available to qualified researchers. Approximately half of NCI's budget consists of investments in basic research focused on understanding the molecular characteristics of cancers and elucidating the fundamental mechanisms and pathways that give rise to disease. This research is relevant to all cancer types, serving as foundational knowledge and allowing researchers to understand cancer biology and to identify potential targets for new therapies. Recognizing that incentives for research on rare cancers are limited in the private sector, NCI works to ensure the inclusion of rare cancer patients in NCI-supported clinical trials, in addition to supporting the broad spectrum of cancer research.

Data Sharing Policies and Resources

The NCI supports broad data-sharing policies and resources to maximize progress in cancer research. This begins with sharing results of research funded by the NIH. When a manuscript arising from research funded by NIH has been accepted for publication, investigators are required to submit the final article to PubMed Central immediately.¹ The final,

¹ <https://www.ncbi.nlm.nih.gov/pmc/>

peer-reviewed manuscript must be made publicly available no later than 12 months after the official date of publication, consistent with the NIH Public Access Policy.²

Through the Cancer MoonshotSM Public Access and Data Sharing Policy, NCI expands upon the NIH Data Sharing Policy to create an infrastructure that aims to accelerate the pace at which researchers, clinicians, and patients can collaborate in sharing data and knowledge to more rapidly advance progress.³ Additional efforts to enhance the research community's access to data on all cancers, including rare subtypes, include the NCI Cancer Research Data Commons and the Childhood Cancer Data Initiative (CCDI). The NCI Cancer Research Data Commons⁴, a unified, virtual platform for secure data storage and sharing, includes the Genomic Data Commons⁵ and the Proteomic Data Commons⁶; the Imaging Data Commons⁷ is anticipated to be available soon. For the first time, these datasets have been harmonized using a common set of bioinformatics pipelines.

Launched in FY 2020, the CCDI will connect data from basic research, clinical trials, population studies, individual patient data, pre-clinical models, and biospecimen repositories to ensure that data are accessible and easily sharable among qualified researchers in a secure manner. All childhood cancers are rare by definition, and going forward, NCI hopes to use the CCDI model to enhance data collection for other types of rare cancers. Recent CCDI awards focus on the submission of existing data to this NCI data resource, with an emphasis on data from ultra-rare pediatric tumors.

The Cancer Moonshot and Rare Cancers

Over the past several years, NCI's Center for Cancer Research (CCR) has taken a leadership role in rare cancer research, creating the Rare Tumor Patient Engagement Network, including MyPART (My Pediatric and Adult Rare Tumor network) and NCI CONNECT (Comprehensive Oncology Network Evaluating Rare CNS Tumors), in alignment with the goals outlined as part of the Cancer Moonshot. As of September 2020, more than 200 individuals have been enrolled in MyPART's Natural History Study of Rare Solid Tumors, with the goal of collecting information and biospecimens from people with rare tumors and their relatives and tracking their health history over a long period of time. MyPART's rare cancer clinics build upon the success of NCI's wild-type gastrointestinal stromal tumor (GIST), which was originally launched in 2008 and continues today. MyPART now also leads annual clinics for medullary thyroid cancer, launched in 2018, and pediatric chordoma, launched in 2019. NCI-CONNECT is

² <https://publicaccess.nih.gov/faq.htm>

³ www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/funding/public-access-policy

⁴ datascience.cancer.gov/data-commons

⁵ www.cancer.gov/about-nci/organization/ccg/research/computational-genomics/gdc

⁶ datacommons.cancer.gov/repository/proteomic-data-commons

⁷ datacommons.cancer.gov/repository/imaging-data-commons

studying 12 rare central nervous system (CNS) cancers in adults. Some of these 12 tumor types are diagnosed in only a few thousand people each year. Others are so rare that only a few dozen have ever been reported. NCI CONNECT conducts weekly tumor clinics for rare CNS cancer patients and also leads the Natural History of and Specimen Banking for People with Tumors of the CNS, with 830 patients enrolled as of September 2020.⁸

Similarly, the Cancer Moonshot-funded Cancer Immune Monitoring and Analysis Centers (CIMACs), led by researchers at the University of Texas M.D. Anderson Cancer Center, are spearheading the in-depth immune profiling necessary to advance the science of rare cancers, and are seeking to determine why some patients respond to immunotherapies and some do not. This can help empower research going forward by generating new avenues of discovery for rare cancers.

Clinical Research on Rare Cancers

In addition to the ability to access trials at over 2,200 sites supported through the National Clinical Trials Network (NCTN) and the NCI Community Oncology Research Program (NCORP), patients with rare cancers are also able to enroll in trials through NCI's Experimental Therapeutics Clinical Trials Network (ETCTN). The ETCTN was created by NCI to speed clinical trials of investigational drugs in rare cancer types. The network has investigators at more than 50 hospitals and treatment centers across the United States and Canada. This infrastructure helps with more rapid accrual for rare cancer trials and reduces travel for this patient population.

In partnership with SWOG (the SWOG Cancer Research Network, one of five NCTN groups), the DART (Dual Anti-CTLA-4 & anti-PD1 blockade in Rare Tumors) study focuses on extending the promise of innovative immunotherapy treatments to patients whose cancers are often so rare that a clinical trial is considered unfeasible due to small patient populations. Adult patients with certain types of rare tumors that no longer respond to standard treatment or experience reoccurrence are eligible to have a sample of their tumor sequenced and stored prior to enrollment. In addition, patients with extremely rare malignancies also have their normal genome sequenced and analyzed to determine if there are any hereditary or immune system factors associated with response to therapy, which can help clinicians in developing future trials for patients with these rare malignancies. Launched in 2017, the DART study⁹ is open at 942 hospitals across 49 states and the District of Columbia, allowing patients with rare cancer across the country to access this phase 2 trial. As of October 2020, 750 participants have enrolled, and investigators have already begun to publish trial results for completed cohorts,¹⁰ and present preliminary results at professional society meetings as additional cohorts are completed.¹¹

⁸ www.cancer.gov/rare-brain-spine-tumor/blog/2020/natural-history

⁹ clinicaltrials.gov/ct2/show/NCT02834013

¹⁰ pubmed.ncbi.nlm.nih.gov/31969335/

¹¹ meetinglibrary.asco.org/record/185172/abstract; www.abstractsonline.com/pp8/#!/9045/presentation/6909; www.abstractsonline.com/pp8/#!/9045/presentation/6908

Additional NCI-Supported Resources for Rare Cancer Researchers

In addition to working to ensure that genomic, translational, and clinical data on rare cancers is available to qualified investigators through the research efforts and data policies described above, NCI maintains a comprehensive portfolio of additional resources for researchers. For example, NCI is supporting ongoing efforts focused on drug repurposing, investigating natural products as anti-cancer drugs, and developing better animal models of rare and common cancers. The NCI Patient-Derived Model Repository (PDMR) is a national repository that serves as a resource for models for academic drug discovery efforts.¹² The repository currently has models available for approximately 20 rare cancers, with plans for additional cancer types.¹³ Other resources include the Developmental Therapeutics Program (DTP)¹⁴, NCTN Navigator¹⁵, the NCI Mouse Repository¹⁶, and PDX Finder¹⁷.

NCI remains committed to supporting research aimed to advance the understanding of all cancers, including rare cancers, and to inform the development of targeted cancer therapies for rare cancers and rare subtypes of cancers.

Rare Cancer Treatment

As our understanding of cancer has become more sophisticated, doctors have begun to develop treatments that are very patient specific. One way to do this is using molecular diagnostics to determine the molecular driver of a patient's cancer which can then help dictate what drugs to receive.

Question: Many rare cancer patients do not receive molecular diagnostic testing. What is being done to increase the number of patients receiving molecular diagnostics?

¹² pdmr.cancer.gov/

¹³ Rare cancer models in the NCI PDMR include Merkel Cell Carcinoma, Mesothelioma, Hurthle Cell Neoplasm of the Thyroid, Malignant Peripheral Nerve Sheath Tumor, Salivary Gland Squamous Cell Carcinoma (SCC), Pharyngeal SCC, Nasopharyngeal SCC, Laryngeal SCC, Carcinosarcoma of the Uterus, Vaginal Cancer, Cervical SCC, Synovial Sarcoma, Liposarcoma, Leiomyosarcoma – uterine and non-uterine, Rhabdomyosarcoma, Osteosarcoma, Chondrosarcoma, Malignant fibrous histiocytoma, Fibrosarcoma – not infantile, Ewing sarcoma/Peripheral PNET.

¹⁴ dtp.cancer.gov/

¹⁵ navigator.ctsu.org/navigator/login

¹⁶ frederick.cancer.gov/science/technology/mouserepository

¹⁷ www.pdxfinder.org/

NIH Response:

Decades of cancer genomics research supported by the National Cancer Institute (NCI) have transformed our understanding of cancer, advanced the conduct of clinical trials testing the efficacy of cancer therapies, and changed the way oncologists select treatments for patients. Oncologists are increasingly selecting therapies based on the specific genomic abnormalities identified in a patient's tumor through molecular diagnostic testing. This approach has revolutionized cancer diagnosis and treatment. However, researchers are still uncovering what each genetic alteration means from a clinical perspective, and only a minority of alterations are likely to be "targetable" with approved or experimental therapies.

While NCI does not play a role in determining whether individual patients receive molecular diagnostic testing after a cancer diagnosis, the Institute continues to support research that will advance the scientific understanding of tumor biology so that more patients can benefit from molecular diagnostics. This research includes studies to better describe the biology of tumors beyond their genomes. For example, while the presence of mutations can be determined from sequencing a tumor's genome, the effect of mutations on protein function cannot be fully understood without interrogating the proteome – the entire complement of proteins that is or can be expressed by a cell, tissue, or organisms. A better understanding of cancer at the protein level will enhance cancer diagnosis and treatment by providing more details about what is happening in tumors, as well as enable the development of new molecular diagnostic tests.

NCI supports several large initiatives across the research continuum to pave the way for the next generation of molecular diagnostics for cancer. The NCI-supported Clinical Proteomic Tumor Analysis Consortium (CPTAC)¹⁸ is a collaborative effort among academic institutions, industry, and several federal agencies to measure, in a rapid and large-scale manner, the entire complement of proteins in tumors and combine this information with genomic, imaging, and clinical data from patients. Efforts by the consortium have revealed new aspects of tumor biology that were not evident from genomic information alone, and identified additional targets for cancer treatment. All the information assembled by CPTAC is made publicly available so that others can use it to make their own discoveries. NCI is supporting research through CPTAC and other initiatives to advance the identification and use of protein molecular markers and proteogenomic information for clinical purposes.

These projects build upon pioneering, NCI-supported clinical trials that leverage molecular diagnostics, including the LUNG-MAP, NCI-MATCH, and Pediatric MATCH Trials. LUNG-MAP, or the Lung Cancer Master Protocol¹⁹, is a precision medicine clinical trial for people with advanced non-small cell lung cancer that has continued to grow after treatment. Patients' tumors are screened for the presence of certain genetic markers and assigned to a treatment arm based on these markers. Building upon this model, NCI launched the NCI-Molecular Analysis for Therapy Choice (MATCH) Trial²⁰ in 2015, which is open to patients with advanced solid

¹⁸ proteomics.cancer.gov/programs/cptac

¹⁹ www.cancer.gov/types/lung/research/lung-map

²⁰ www.cancer.gov/about-cancer/treatment/clinical-trials/nci-supported/nci-match

tumors, lymphomas, or myeloma, or if they have a rare cancer for which there is no standard treatment. In the study genomic sequencing of tumors is conducted to reveal genetic alterations, and eligible patients are matched to a therapeutic arm with a targeted drug that has shown success in other cancer types driven by the same molecular aberration. The trial seeks to determine whether treating cancer based on these specific genetic changes is effective, regardless of cancer type. The companion study for childhood and adolescent cancer patients, Pediatric MATCH, was launched in 2017.²¹

These innovative clinical trials would not be possible without the basic research conducted to understand the fundamental mechanisms that give rise to disease and enable researchers to identify molecular targets for therapies. The Neurotrophic tyrosine kinase (NTRK) family of genes is one such example. Describing the role of this family of genes was first made possible as a result of a basic science discovery in the 1980's at NCI's Frederick National Laboratory for Cancer Research. This discovery led to the development of an NTRK inhibitor, larotrectinib, which works against unique fusion oncoproteins that drive certain pediatric and adult cancers found in only about 1 percent of solid tumors, but commonly in rare cancer types. Larotrectinib was evaluated in both the NCI adult and pediatric MATCH phase II clinical trials, as well as in industry-supported trials. In May 2018, the U.S. Food and Drug Administration (FDA) issued larotrectinib an orphan drug status and Priority Review, and in November 2018, FDA granted accelerated approval. This is the second FDA approval for a precision cancer therapy that is based on a particular genetic alteration, rather than the site in the body in which a cancer occurs. The companion diagnostic FoundationOne CDx, which is approved as a companion diagnostic for more than 20 targeted therapies, is also seeking approval for use with larotrectinib. NCI's investment in basic science over decades has been critical to the development of targeted therapies and companion diagnostics, and has enabled the important role they play in helping to match these therapies to patients who are most likely to benefit.

Ongoing NCI-supported research on the molecular drivers of cancer will continue to enable the development of novel diagnostic tools, as well as expand the use of these tools so that they can be useful to more patients, including those with rare cancers.

²¹ www.cancer.gov/about-cancer/treatment/clinical-trials/nci-supported/pediatric-match

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Questions for the Record

Submitted by Congresswoman Herrera Beutler

Chronic Kidney Disease

Question: About 10% of the U.S. population has diabetes, an estimated 33.9% of adults have prediabetes, and about 15% of adults have Chronic Kidney Disease (CKD), many of which are undiagnosed. We need to be putting more money into researching diseases like diabetes and CKD and taking steps to reduce these numbers. How is NIH planning to effectively impact these rates when your budget decreases discretionary funding for the NIDDK by almost \$200 million?

NIH Response:

Diabetes and chronic kidney diseases (CKD) place an enormous personal and economic toll on the United States, including in minority populations that are disproportionately affected by these diseases. Rising rates of obesity—a key risk factor for type 2 diabetes and CKD—are further exacerbating this burden, which is why the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) integrates its support of obesity, diabetes, and CKD research to improve the overall health of the nation.

The NIDDK will continue to support research to relieve the public health burden of these diseases. We plan to continue ongoing research toward improving early diagnosis, prevention, and treatment. For example, the Rare and Atypical Diabetes Network (RADIANTE) seeks to understand how best to classify diabetes subtypes, which could bring more precision to diabetes treatment. The NIDDK is also supporting a research consortium to better define the development and impact of elevated maternal glucose levels and diabetes at early stages and longitudinally over the course of pregnancy, so that we might continue efforts to improve short- and long-term health outcomes in infants and mothers. The Kidney Precision Medicine Project is analyzing kidney biopsies from a broad range of people, using cutting-edge technologies to better understand kidney diseases and injury, identify new therapeutic targets, and stimulate development of personalized therapies. The (Re)Building a Kidney consortium is aimed at treating and preventing CKD by identifying ways to restore failing kidney function after injury

or disease. The NIDDK also chairs the statutory Diabetes Mellitus Interagency Coordinating Committee (DMICC) and Kidney Interagency Coordinating Committee (KICC), and will continue to use meetings not only for information sharing but also to find new ways to leverage research activities across the NIH and other relevant government agencies.

Heart Disease in Women

Reducing Maternal Mortality and Improving Women's Heart Health across the Lifespan. Maternal mortality and morbidity are rising in the United States even as they decrease globally. Each year, about 700 American women die from pregnancy or delivery complications. Cardiovascular conditions, including gestational hypertension and preeclampsia (which is marked by hypertension and elevated protein in urine), cardiomyopathy (heart muscle weakness), and venous thromboembolism (a clot that starts in a vein) are among the leading causes. Moreover, these conditions disproportionately affect women of color, and Black and American Indian/Alaska Native women aged 30 and over are four to five times more likely to die during childbirth than White women.

With rising rates of obesity, diabetes, and high blood pressure among young people, many women are coming into their pregnancies at higher risk for cardiovascular disease (CVD). Additionally, pregnancy is a risk factor for future CVD. There is an urgent need to improve women's heart health across the entire lifespan, and to use implementation science to bring proven interventions into practice to reduce racial/ethnic disparities in CVD. NHLBI supports research to understand and reduce women's risk of CVD, including during vulnerable windows of time before, during, and after pregnancy. For example, an ongoing trial is examining whether pregnant women with mild chronic hypertension, the most common medical disorder in pregnancy, will benefit from treatment to lower their blood pressure to a target often used for non-pregnant adults (<140/90 mmHg), without a harmful reduction in blood flow to the womb. In collaboration with the Eunice Kennedy Shriver National Institute of Child Health and Human Development, NHLBI is supporting research to better understand how sleep disturbance affects pregnancy outcomes. A recent analysis from the nuMoM2b Sleep-Disordered Breathing Study revealed that sleep apnea during pregnancy is associated with an increased risk of gestational hypertension and diabetes. The nuMoM2b Heart Health Study is now looking at how sleep apnea and other pregnancy complications, such as preeclampsia and hypertension, affect a woman's long-term health. Another NHLBI-funded study focuses on how to best manage blood clots in pregnant women. Researchers are also working to determine the most effective ways to improve pregnancy-related outcomes in obese and overweight pregnant women. A recent study found that lifestyle interventions can help.

Question: Heart disease is the number one killer of women in the United States. Myself and my colleague on this Committee and partner in the Maternity Care Caucus, Rep. Roybal-Allard, have a resolution recognizing the threat that heart disease presents to women and the need for us

to do more to address it. Dr. Gibbons, in the National Heart, Lung, and Blood Institute budget justification, you discuss the importance of addressing heart disease in women, particularly its impact on maternal health. How will you be able to prioritize finding solutions when the budget cuts funding by \$327 million?

NIH Response:

Since the establishment of the National Heart, Lung, and Blood Institute (NHLBI), originally the National Heart Institute, in 1948 and the creation of the Framingham Heart Study that same year, the Institute has strived for appropriate inclusion of women in clinical studies and will continue to make women's heart health a priority. NHLBI supports a robust research agenda to improve women's heart health across the lifespan, including cohort studies, clinical trials, behavioral and lifestyle interventions, and implementation science.

Landmark studies such as the Women's Health Initiative (WHI) continue to provide the foundation and infrastructure for additional studies such as the WHI Strong and Healthy (WHISH) pragmatic trial, which is evaluating physical activity to prevent cardiovascular events in older women.¹ NHLBI is also leveraging WHI to explore complex risk factors, including genetics, that can influence cardiovascular risk in women. Further, NHLBI invests in analyses of sex-specific data from large cohort studies to better understand the women's unique risks of heart disease. For example, a recent analysis of more than four decades of data from NHLBI's Framingham Heart Study, Multi-Ethnic Study of Atherosclerosis, and other studies found that in women, hypertension begins earlier in life and progresses faster, which indicates a need for early intervention to prevent heart disease.² Another analysis from the Atherosclerosis Risk in Communities study found that young women hospitalized for heart attack were less likely to receive certain guideline-based therapies compared to men.³ Finally, an analysis of sex differences in management and outcomes of suspected coronary artery disease in NHLBI's Prospective Multi-imaging Study for Evaluation of Chest Pain found that women with abnormalities on non-invasive testing were less likely than men to receive cardiac catheterization or statin therapy.⁴

These analyses, as well as the studies described in NHLBI's Fiscal Year 2021 Congressional Justification and noted in the question, confirm the need to keep women's heart health as a top priority in the NHLBI research portfolio.

In addition, NHLBI strives to translate research findings into public health practice through the Institute's long-standing, evidence-based health education program, The Heart Truth®. This program continues to collaborate with other federal agencies, such as the Centers for Disease Control and Prevention, and is expanding its network of non-governmental partners to broaden its reach and effectiveness. The program has enhanced its focus on women who are especially vulnerable and harder to reach through traditional public health programs, including African

¹ projectreporter.nih.gov/project_info_description.cfm?aid=9636598&icde=52371242

² jamanetwork.com/journals/jamacardiology/fullarticle/2758868

³ pubmed.ncbi.nlm.nih.gov/30586725/

⁴ www.sciencedirect.com/science/article/pii/S0002870318303090?via%3Dhub

American, Hispanic/Latina, and American Indian/Alaska Native women, and those living in rural areas.

Pediatric Research

Question: All of us recognize the unique needs of children across the healthcare spectrum, however these needs receive significantly less funding and research attention. Could you describe how you plan to include pediatric subjects in NIH-wide initiatives and how NIH plans to more evenly target funds for pediatric research as compared to adults?

NIH Response:

The National Institutes of Health (NIH) remains committed to understanding the healthy development of children, as well as the causes of and treatment for diseases, illnesses, and conditions affecting children. Funding for pediatric research has increased steadily over the past few years; in FY 2019, NIH spent over \$4.9 billion in this area.⁵ The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) provides approximately 18 percent of the total amount, joined by 24 other NIH Institutes and Centers (ICs).

NIH continues to prioritize pediatric research in NIH-wide activities and initiatives, leveraging these collaborations to effectively utilize resources and apply subject matter expertise to addressing critical scientific and biomedical needs. Each of these initiatives identifies the best research approaches to advance our understanding of a wide range of disease and health topics. When making decisions on how to appropriately steward funding, NIH applies careful analysis of existing research and unanswered scientific questions, consults scientific expertise, and utilizes peer review to make informed decisions. With input from national advisory councils, NIH leadership evaluates research proposals for scientific novelty and merit, potential impact, and existing representation across research portfolios. Several NIH-wide initiatives, such as the *All of Us* Working Group on Child Enrollment, are working to identify opportunities for the inclusion of pediatric participants in research while prioritizing the most promising science.

NIH will continue to support basic, translational, and clinical research studies on pediatric health and will aim to include pediatric participants in research as appropriate. In September 2020, NIH held an Inclusion Across the Lifespan Workshop, with a goal of examining the science of inclusion of relevant populations and sharing evidence-based, practical approaches to implementation of the NIH's inclusion policy. The workshop focused on phases of clinical study development and recruitment among pediatric, geriatric, and other special populations (e.g., racial/ethnic minorities, people with disabilities, rural/isolated populations, language-minority individuals, pregnant and lactating women, people with comorbidities, and sexual and gender minorities).

⁵ report.nih.gov/categorical_spending.aspx

In 2018, NICHD established a new group to harmonize NIH's pediatric research efforts, the NIH Pediatric Research Consortium (N-PeRC).⁶ Nearly all of the ICs and offices appointed senior level representatives to N-PeRC, including both extramural and intramural scientists. In its short history, N-PeRC has already made progress toward identifying and facilitating collaborations among ICs at NIH. Emerging issues of clear importance to multiple ICs include research on issues faced by adolescents in transitioning to adult health care, drug and device development appropriate for pediatric use, consolidated pediatric data resources, and pediatric research workforce training. In late September 2020, N-PeRC leaders held a scientific conference to help identify common issues that arise when adolescents with various chronic conditions transition to adult health care. These transitions can raise many issues, such as consent and shared medical decision-making, and the use of technologies and telehealth; research is still needed to ensure that the transition to adult care is successfully coordinated, particularly for those adolescents with relatively rare conditions.

The value of a standing pediatric group within NIH that can respond quickly to emerging public health crises became starkly apparent as the number of COVID-19 cases surged within the U.S. As early as March 2020, N-PeRC rapidly formed a working group with representation from 18 ICs, led by NICHD and the National Institute on Drug Abuse, to address pediatric issues related to COVID-19. Its immediate goal was to create a funding strategy based on an analysis of current and potential studies of COVID-19 in pregnant women and children. Of the 700 COVID-19 awards made to date, 51 of these focus on children. For example, one study will examine both the vulnerability and resistance toward COVID infections among youth with varying physical and demographic characteristics to find out who may be more susceptible to infection or its serious consequences, and another newly funded project will examine the impact of COVID-19-related school closures on children's weight status.

Rare Diseases

Question: I often hear from my constituents in SW Washington that have or are the parents of someone with a rare disease. They face significant barriers to finding a diagnosis and a healthcare provider that understands their condition. Additionally, due to the nature and rarity of these diseases, it is also difficult to encourage the private sector to invest in rare disease research. Can you share how, despite the significant cuts to research, NIH will continue to operate in this space?

NIH Response:

With over 7,000 rare diseases, affecting approximately 30 million Americans, NIH remains committed to conducting research to find treatments and cures for these conditions. Research on

⁶ www.nih.gov/news-events/news-releases/new-trans-nih-consortium-aims-advance-pediatric-research-global-level

specific rare diseases is being supported by the multiple NIH Institutes and Centers (ICs) where a particular rare disease falls within their mission.

The National Center for Advancing Translational Sciences (NCATS), however, doesn't focus its research on a particular rare disease, but, instead, is focused on finding ways to speed the development of treatments for multiple diseases simultaneously and ultimately help more patients more quickly. With over 7,000 rare diseases, the approach of tackling one disease at a time will take too long. The Office of Rare Diseases Research (ORDR), which is housed within NCATS, leads these efforts. For example, the recently launched "Platform Vector Gene Therapy (PaVe-GT) pilot program is seeking to develop four gene therapies for four different rare diseases at the same time to gain efficiencies in gene therapy development. PaVe-GT is a collaboration between NCATS, the National Human Genome Research Institute (NHGRI), the National Institute of Neurological Disorders and Stroke (NINDS), and the NIH Clinical Center (CC).

One of the challenges to delivering treatments to patients faster is the long timeframe often associated with disease diagnosis, particularly for those patients with a rare disease. Unfortunately, difficulty with diagnosis is so pervasive with rare diseases that it is sometimes referred to as the "Diagnostic Odyssey." NCATS is working to make this journey shorter and is enlisting experts in clinical diagnosis, computer-assisted technology, and genomics analyses to try to develop new approaches to speed diagnosis and improve accuracy. The desired outcome is the development of a broadly adaptable, facile process with the potential impact of advancing the International Rare Diseases Research Consortium's 2027 goals of achieving an accurate diagnosis within one year of a rare disease patient presenting for medical evaluation. Additionally, NCATS ORDR and NHGRI support the Genetics and Rare Diseases (GARD) information center, which is a free public resource that offers understandable information on more than 6,500 rare and genetic diseases on its website (rarediseases.info.nih.gov/), as well as a free individual inquiry service to patients and families seeking more help. The GARD website and GARD specialists provided more than 12,000 individual patient responses last year. Currently, the GARD program is working on machine-assisted approaches with the desired outcome of developing support tools intended to assist with shortening the diagnostic odyssey for hard to diagnose patients.

NCATS ORDR, in collaboration with nine other NIH ICs, also supports the Rare Diseases Clinical Research Network (RDCRN), which consists of 20 rare disease research centers (called consortia) and a Data Management and Coordinating Center (DMCC). Each consortia focuses on at least three related rare diseases or conditions, participates in multisite studies, and actively involves patient advocacy groups as research partners. Through this many-diseases-at-a-time RDCRN model, more than 250 rare diseases are currently able to be studied with an emphasis on data and best practice sharing, and clinical trial readiness intended to bring more promising therapies into the clinic to benefit patients.

Additionally, NCATS ORDR has recently published a funding opportunity to enable clinical trials based on the shared underlying molecular underpinnings of rare diseases, where investigators will be funded to study two or more rare diseases with the same therapeutic intervention. This “shared molecular etiology” approach has been used successfully in rare cancers (referred to as a “basket” trial), and NCATS is now supporting similar approaches for rare genetic diseases.

Finally, NCATS ORDR has recently embarked on a research pilot study (Impact of Rare Diseases on Patients and Healthcare Systems, IDeAS) to objectively quantify the diagnostic odyssey and healthcare utilization by rare diseases patients in 14-pilot diseases. This effort is intended to delineate the prolonged healthcare journey rare diseases patients undergo leading up to an accurate diagnosis and hopes to be able to identify critical features within this journey that could be used to develop diagnostic tools that could accelerate diagnosis in a larger number of rare diseases, as well as identify research gaps in the treatment and care of rare diseases patients.

Preterm Birth and Birth Outcomes

Moreover, the preterm birth rate remains unacceptably high. Over the next five years, NICHD will accelerate research to improve pregnancy outcomes to maximize the lifelong health of women and their children. To reduce maternal morbidity and mortality, the institute is hastening the development of targeted strategies to prevent placental complications, preeclampsia, thromboembolism, postpartum hemorrhage, and other serious conditions. Considerable efforts are also on the way to characterize the mechanisms of the human gestational clock and the potential causes of preterm birth, and to improve the survival and long-term health of infants born preterm or with low birthweight.

Question: Dr. Bianchi – I was encouraged by the commitment you made to accelerate research over the next 5 years to address the unacceptably high preterm birth rate in the U.S. Could you share how you plan to address the rate of preterm births and improving birth outcomes overall?

NIH Response:

The National Institutes of Health (NIH) is committed to obtaining a better understanding of how pregnancy-related conditions contribute to maternal mortality, severe morbidity, and preterm birth. Twelve percent of infant mortality worldwide is due to being born too early. In FY 2019, NIH funded \$374 million in research on preterm birth, low birthweight, and the health of the newborn. As stated in its Strategic Plan 2020, the prevention and management of preterm birth is a top priority for the *Eunice Kennedy Shriver National Institute of Child Health and Human Development* (NICHD).⁷ Among the specific objectives included in the plan are several related

⁷ www.nichd.nih.gov/sites/default/files/2019-09/NICHD_Strategic_Plan.pdf#search=strategic-plan-2020

to preterm birth and its consequences, such as understanding the composition and function of human milk and the mode of nutrient delivery to the infant, especially preterm infants.

NICHD supports a wide range of research on the prevention of preterm birth and treatment for premature infants through investigator-initiated grants and through its major research networks, the Maternal-Fetal Medicine Units Network (MFMU) and the Neonatal Research Network (NRN). NICHD also supports an intramural program, the NICHD Perinatology Research Branch, at Wayne State University and Hutzel Hospital in Detroit. In addition, NICHD works closely with other NIH Institutes and Centers (ICs), such as the National Institute on Minority Health and Health Disparities (NIMHD) to address disparities in preterm birth.

In one recent study from NICHD's Perinatology Research Branch, researchers found a reason that premature rupture of membranes (PROM) – when a woman's "water breaks" early – may account for about a third of preterm births. Bacteria that enters the space between the fetus and the surrounding membrane (amnion) can cause inflammation, which in turn poses risks of shortening the time between hospital admission and delivery, early preterm delivery, and complications for the newborn. The researchers tested a new device, which can collect fluid when membrane rupture occurs, finding that their noninvasive technique was better able to correctly identify those patients with inflammation and those without it.⁸ Early identification and intervention may help treat infants following PROM.

Necrotizing Enterocolitis (NEC) is the most common gastrointestinal disease affecting newborns. Considered a medical emergency, NEC is most often seen in premature infants. In the fiscal year 2020 State of the Union address, \$50 million more was requested for newborn health. In response, NICHD and the NIH Office of the Director funded several projects to address NEC in newborns and other conditions affecting premature infant, including research to test the idea that bacteria in a baby's gut may cause inflammation and NEC.⁹ Another project is studying how antibiotic use and limited physical contact with parents may affect the native microorganisms in a newborn, disrupting the development of the immune system¹⁰, and another, a small business grant, is seeking to develop a compound aimed at preventing NEC.¹¹

A recent investigator-initiated study explored the immune systems of preterm infants, who have a high risk of infections. Women who have preterm deliveries often do not make enough milk to feed their babies and may rely on donated breast milk. Because pasteurization and freezing of

⁸ Oh KJ, Lee JH, Romero R, Park HS, Hong J-S, Yoon BH. "A New Rapid Bedside Test to Diagnose and Monitor Intra-Amniotic Inflammation in Preterm Birth Using Trans-Cervically Collected Fluid." *Am J Obstet Gynecol* 2020 Feb 27

⁹projectreporter.nih.gov/project_info_description.cfm?aid=9893335&icde=52429987&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

¹⁰projectreporter.nih.gov/project_info_description.cfm?aid=9875291&icde=52430037&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

¹¹projectreporter.nih.gov/project_info_description.cfm?aid=10010634&icde=52430328&ddparam=&ddvalue=&ddsub=&cr=1&csb=default&cs=ASC&pball=

breast milk can destroy antibodies and immune cells, researchers wanted to find out whether donor milk was less efficient at boosting a baby's immune system than milk from mothers who delivered preterm or at full term. They found that cells treated with donor milk made more proteins linked to inflammation and infection than cells treated with milk from mothers who delivered preterm. These results may help researchers develop new ways to prevent infections and other health problems in preterm babies.¹²

In addition to supporting investigator-initiated grants, NICHD funds major research networks that provide the infrastructure to conduct widespread testing in larger groups of pregnant women and infants. The MFMU studies ways to reduce maternal, fetal, and infant morbidity and mortality, with a focus on preventing preterm birth, growth abnormalities, and maternal complications. This network includes 12 centers with 37 hospitals across the United States, with about 160,000 births to a diverse group of women annually. Ongoing studies include approaches to preventing preterm birth in women with a short cervix, and therapies taken during pregnancy to prevent preeclampsia.

¹² Demers-Mathieu V, Huston RK, Dallas DC. "Cytokine Expression by Human Macrophage-Like Cells Derived from the Monocytic Cell Line THP-1 Differs Between Treatment with Milk from Preterm- and Term-Delivering Mothers and Pasteurized Donor Milk." *Molecules*, 2020, 25(10), 2376.

TUESDAY, MARCH 10, 2020.

CENTERS FOR DISEASE CONTROL AND PREVENTION

WITNESSES

ROBERT REDFIELD, M.D., DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION
ILEANA ARIAS, PH.D., ASSOCIATE DEPUTY DIRECTOR FOR PUBLIC HEALTH SCIENCE AND SURVEILLANCE
SHERRI A. BERGER, CHIEF STRATEGY OFFICER AND CHIEF OPERATING OFFICER
DEBRA HOURY, M.D., MPH, DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Ms. DELAURO. The subcommittee will come to order.

We have the Centers for Disease Control and Prevention before the subcommittee this morning. It has been several years, March of 2016, since our last hearing on the budget of the Nation's leading public health agency.

And before I do a formal welcome and so forth, I want to—I was made aware of this issue, which is really very, very troubling. And that is that the administration has ordered the immigration courts to immediately remove coronavirus posters, and it just says that the immigration court staff nationwide have been ordered by the administration to take down coronavirus posters from courtrooms and waiting areas.

The Executive Office for Immigration Review, which falls under the Department of Justice, told all judges and staff members in an email Monday that all of the coronavirus posters, which explain in English and Spanish how to prevent catching and spreading the virus, had to be removed immediately.

I just want to say that whatever one's view is on any issue that we face in this Nation, whatever your personal views are, whatever your ideology is, that we cannot in this public health crisis, play fast and loose with people's health. No matter what we believe, it is a moral responsibility for us to make sure that everyone is protected. So just came to my attention and—

Dr. Redfield, we welcome you, have you here and your colleagues who are with you. Dr. Ileana Arias, Associate Deputy Director for Public Health Science and Surveillance; Dr. Debra Houry, Director of the National Center for Injury Prevention and Control; Ms. Sherry Berger, Chief Strategy Officer and Chief Operating Officer.

I might say I also want to acknowledge Dr. Messonnier who I know is not here, but she was in here and helped to provide us with a bipartisan briefing that we had for the subcommittee in February and sorry not to see her here as well.

In fact, before we proceed with the CDC's fiscal year 2021 budget request, let me start with where we are all probably starting today, and that is with COVID-19. I first want to commend the thousands

of public health experts on the State and the Federal level who are working so hard to keep us safe during this outbreak. That includes you, Dr. Redfield, as well as all of the CDC staff.

We are in a crisis, and there are questions about our preparedness and ongoing response efforts. I am very concerned, and I think we all are, about our Nation's testing capabilities for coronavirus. Other countries have been testing thousands of people for weeks, but the U.S. is woefully behind the curve. The low number of positive tests in the U.S. is likely a byproduct of undertesting as opposed to an accurate count of the prevalence of coronavirus in the United States.

My understanding is that the testing kits are now being distributed across the country, and commercial firms are involved as well. But the delay has been unacceptable. While CDC rapidly developed a new test for COVID-19, the majority of the initial test kits sent to the laboratories were faulty, and there were weeks of delays before replacement kits were sent out.

During this time, CDC maintained a narrow testing criteria that makes us ask if the health of our country was put further at risk because of these actions. I expect there will be a lot of questions today about testing and those delays.

Another concern is emergency funding. The Congress came together last week, and we passed an \$8,300,000,000 emergency supplemental on a bipartisan and bicameral basis. It includes \$2,200,000,000 for the Centers for Disease Control and Prevention. This funding will support CDC, as well as State and local health departments who are critical to responding to this outbreak and to saving lives.

But when this crisis arose, the CDC had only \$105,000,000 available in the Infectious Diseases Rapid Response Reserve Fund. The supplemental added \$300,000,000. I have been a leader for years on a public health emergency fund and have repeatedly introduced legislation, the Public Health Emergency Act, to provide \$5,000,000,000 in emergency funding for the public health emergency fund so that you can act with alacrity and with flexibility.

We can only imagine where we would be if we had had \$5,000,000,000 at the outset instead of \$105,000,000 in the Rapid Response Reserve Fund. The former Shadow Health Minister of South Africa Wilmot James, who was a global public health expert, has said of public health infrastructure, and I quote, "Why do we lurch from crisis to crisis and lapse into complacency in between?"

This outbreak is a reminder of the importance of a well-prepared, well-trained, well-trusted, well-funded public health system. Because beyond COVID-19, professionals at CDC, day in and day out, are working to combat food-borne illnesses, influenza, to promote healthy lifestyles, to reduce and prevent the use of tobacco products, and on and on.

It is important work, and it is why we are proud of what we were able to do in this committee in increasing CDC's funding in 2020 by \$636,000,000, 9 percent above the 2019 level, and it was done on a bipartisan basis. Some of those highlights include for the first time in more than 20 years, funding specifically to support firearm injury and mortality prevention research, the first year of a multiyear effort to support modernization of public health data sur-

veillance and analytics at CDC's State and local health departments, and the first year of a multiyear initiative to reduce transmission of HIV by 90 percent over the next 10 years.

The establishment of a suicide prevention program, tobacco prevention, specifically given the e-cigarette and vaping epidemic among our young people.

Increases for global disease detection. That is global health security. As you outlined in your remarks, Dr. Redfield, the global health security is critical to our national security.

And the Infectious Diseases Rapid Response Reserve Fund.

Unfortunately, the President's 2021 budget proposal reverses this progress. The budget proposes to cut CDC by \$693,000,000, 9 percent below the 2020 appropriation. And despite the presentation of the President's budget, which claims that infectious disease, global health, and preparedness were prioritized in CDC's request, key programs would be cut—the Public Health Data Initiative, the public health workforce program, the Infectious Diseases Rapid Response Reserve Fund that allowed CDC to quickly respond to COVID-19.

This subcommittee will not be pursuing the administration's proposed cuts. To cut from our public health infrastructure during an outbreak is beyond consideration. Instead, we together intend to invest in the CDC and our Nation's public health system. We will not lurch from crisis to crisis and lapse into complacency in between. We cannot. This coronavirus outbreak makes that clear.

I will stop there. We look forward to your discussion of the budget and other policy areas under your jurisdiction and appreciate your being—all being here today.

Before we turn to you, let me turn to my colleague, the ranking member of the subcommittee, my colleague from Oklahoma, Congressman Tom Cole, for any remarks.

Mr. COLE. Thanks very much, Madam Chair. And let me make a few remarks off the cuff before I actually get to my prepared statement.

And this is an area that I think my chair and I certainly strongly agree on. You know, I am never critical of somebody here that comes and presents the President's budget. It is appropriate. It is your job. I always call it the OMB's budget, though, to be fair, and I will just state for the record I am quite sure that we won't be cutting the CDC any time soon. And I would suspect quite the opposite. We will be building on the things this committee has done really over 5 years.

A number of years ago, I actually had a discussion with then-OMB Director Mulvaney and made the point whatever budget you send up here, we are going to increase spending on NIH, CDC, and Strategic Stockpile. And then later on, we added the Rapid Response Infectious Disease Fund, an idea that our chair had been championing for many, many years.

I think those were all really good decisions, and I think we are seeing the benefit of them now. And I suspect we will stay on that course.

What you do, and I thank all of you for doing it, and the splendid professionals you lead are absolutely indefensible—or excuse me,

indispensable. I have got to correct that one right away. [Laughter.]

Mr. COLE. Indispensable in defending the people of the United States. I mean, I really do—and Dr. Redfield and I have had this discussion before—I think of you as the biomedical equivalent of the Pentagon. And what we do there protects the American people in one way, but what we do here protects them in another way. And probably, frankly, on a day-to-day basis, a much more immediate and much more impactful way. Again, we are much more likely to have a problem like we are dealing with now than we are to have the kind of threat to the lives of Americans.

So, again, thank you for what you do, and I suspect this committee on a bipartisan basis will continue to make these investments going forward.

Good morning, Dr. Redfield, and thank you for coming to be with us this morning. I just again was going to do what I did with Francis Collins. How has your week been? I wonder. I think about you guys a lot.

We know this has been an extraordinarily stressful time for you and one in which you are doing great work for the American people. And I know coronavirus is at the forefront of everyone's mind this morning, and you and the public health experts at CDC are front and center in defending our people.

In addition to hearing about coronavirus this morning, I am hoping we can also discuss other priorities I know we all share, such as reducing opioid abuse and overdose deaths, addressing the threat of antibiotic resistance, and preventing the growing problems associated with chronic diseases, all critical public health issues for our country.

As the United States continues to monitor and respond to coronavirus, I am encouraged that Congress and the administration worked together across party lines to deliver critical resources for the days and weeks ahead. In such a highly polarized and partisan environment, I am very encouraged that we could set aside our differences and quickly deliver on such a high-priority item for the health and safety of the American people.

It took just 9 days for the administration to submit information regarding a supplemental appropriation need and bipartisan, bicameral congressional action. The vote in the House was overwhelming, as it was in the Senate. And I hope you can continue, and I suspect you can continue, to count on bipartisan robust support to aid in your efforts to keep our communities prepared and able to respond.

Fortunately, long before the coronavirus ever infected its first patient, Congress was already preparing for this sort of public health emergency in a bipartisan way. Five years ago, Congress began shaping policies and prioritizing investment in our readiness, including boosting funding year after year for the National Institutes of Health, Centers for Disease Control and Prevention, and the Strategic National Stockpile.

But perhaps our greatest lifeline these past few weeks was the prior establishment of and investment in the Infectious Diseases Rapid Response Reserve Fund, which was immediately available to you, the CDC, our number-one public health defender. Indeed, be-

cause Congress had the tools in place ready to deploy at a moment's notice, the administration has been able to direct a swift and decisive response from day one, not losing any time in protecting our citizens.

I want to associate myself with my chairman. I mean, I would like this fund to be larger. We originally proposed \$300,000,000. I know we both, living within the budget realities, would have liked to have done more. I am pleased that Congress did the \$300,000,000 in the supplemental, and going forward, I hope we can build on that, given what we have got to work with. And I know we have many priorities here.

But again, the outcome we got was the aim in our creation of the reserve fund. And while it is unfortunate we had to use the fund, I am glad the resources were available. I hope more available in the future.

While there is still a long road ahead with many unknowns, I am encouraged that one of those unknowns is not whether the funding will be there for our public health defenders to continue in their response. Along with providing generous funding for the resources we need to prepare for, prevent, and respond to coronavirus, I am proud that the supplemental responsibly replenishes the Infectious Diseases Rapid Response Reserve Fund with \$300,000,000 to help us respond quickly to any future threats.

As we have unfortunately seen and are continuing to witness, a deadly new disease is just a plain right-of-way. That is why the global health security is also such a critical component of preparedness. Having our public health experts deployed all around the world, an idea actually you first raised with me, Dr. Redfield, a number of years ago, to respond to new public health threats where they exist in the country of origin before they reach our shores is a really good idea.

We are likely to never know where the next threat may appear. So ensuring a strategy covering all regions is necessary. I look forward to hearing more about your plans for global health security.

There are many other topics I would like to address today. Among them work addressing influenza, combatting the opioid epidemic, progress toward treating chronic diseases that threaten our most vulnerable populations, and reducing antibiotic resistance. But as our time is limited, I will end my statement here and look forward to continuing our conversation.

I yield back my time, Madam Chair.

Ms. DELAUBO. Thank you. I yield to the chair of the full Appropriations Committee, Congresswoman Nita Lowey of New York.

Mrs. LOWEY. I thank Chair DeLauro and Ranking Member Cole for holding this hearing.

Dr. Redfield and the distinguished panelists, we welcome you. Thank you very much for joining us.

First, Dr. Redfield, I want to thank you for meeting with me last week. We spent more than an hour together, and I appreciate your commitment and your expertise.

Two short weeks ago, I planned to raise the Trump budget's continued neglect of CDC, its backward and misguided recommendations to cut chronic health resources, and the harsh impact on health outcomes of Americans. After working for more than two

decades to restart Federal investments in gun violence prevention research, I was eager then to discuss the types of research that may be funded.

We would like to hear about progress on other important investments in the fiscal year 2020 spending bill, including a new data modernization initiative, child sexual abuse prevention research, and combatting the epidemic of youth vaping. And by the way, that is an issue that is pervasive. I first learned about it from my 15-year-old grandchild that 60 percent of the class was vaping, and it is not getting better. It is getting worse.

But unfortunately, today we have a new epidemic on our hands. One week ago, my home county of Westchester, New York, had its first confirmed coronavirus case. Today, we have 98, with a total of 142 throughout New York State, more than 700 nationwide, including, tragically, 26 deaths. This stunning increase requires every level of government to work together and aggressively to contain and stop the spread of COVID-19.

With the recently enacted \$8,300,000,000 emergency supplemental, the Federal Government can aid State and local health departments in assisting patients and mitigate the extent of the virus. However, due to the administration's failure to treat this threat seriously, initial faulty test kits, the administration's slow approvals for laboratories, slow distribution of working kits, more people are likely to be infected. And sadly, we are hearing those statistics.

It is imperative that the Federal Government have a multi-agency approach to ensure tests are available for all who may need one without delay. Can't go backwards. Unfortunately, there was a real delay, and that is why it was spreading.

Earlier this week, I sent a letter to Secretary Azar, Commissioner Hahn, and yourself, urging you to use all powers at your disposal to quickly approve qualified labs in New York. I had a conversation with the Governor of New York that they are ready to move. They need you to approve these labs, including hospitals, private labs, other State facilities, and to permit both automated and manual processing.

I want to stress that again. If it is taking more time for the Federal Government to catch up on the State level, there is real solid movement, and we need you to approve—obviously, all these labs and facilities have to go through a process—but as quickly as possible. There are labs in New York awaiting approval that could greatly expand testing capacity by thousands per day.

I don't know why they are waiting approval. Maybe you can address that in your comments. But that could expand capacity by thousands per day, as may be the case throughout the country, if only the Federal Government would get off the sidelines and approve these facilities. So in your remarks, I would be most appreciative if you could tell me why it is taking so long.

You don't have enough people to check the facilities? I don't get it. Are the facilities not adequate, not up to your standard? We need to know. If the word I am getting from the Governor and his staff and the people involved in this issue that they are ready to move, why aren't they being approved?

As COVID-19 comes closer to pandemic status, we must do all we can to protect the public. I look forward to our discussion, and again, I thank you for the personal interaction we had. I appreciated the opportunity, and I look forward to hearing from you, all of you today. We look forward to the facts so that we can move as quickly as possible. This is an emergency.

Thank you.

Ms. DELAUR. Thank you. And just there was a comment I made earlier, Dr. Redfield, and for my colleagues, because I want to be accurate. Just a while ago, the Miami Herald, after they published a story, right now the Department of Justice spokesman contacted the Herald to say, and I quote, the signs shouldn't have been removed. It has now been rectified.

So the outcry against that really moved things around. But I wanted to make sure that the record is accurate.

Dr. Redfield, your full written testimony will be entered into the hearing record, and you are recognized for 5 minutes.

Dr. REDFIELD. Thank you very much, Chairwoman DeLauro and Ranking Member Cole and, obviously, Chairwoman Lowey, thank you very much for letting us here, and all the distinguished members of the committee.

Let me first really thank you for your support of the CDC. Your investment enables CDC to protect the health and safety of the American people.

As we are seeing right now with COVID-19, infectious diseases can emerge anywhere and spread everywhere. We have slowed the spread of COVID-19 to the United States as a consequence of the positive impact of the investment in public health that has been there at the Federal, State, local, and tribal level.

CDC has identified securing global health and ensuring domestic preparedness, eliminating disease, and ending epidemics as our top strategic priorities. We have also identified the core capabilities that support the entire agency's programmatic efforts, including the modernization of surveillance and data analytic system, the state-of-the-art of laboratories, the building of and maintaining the premier public health workforce, the rapid response fund that you mentioned, as well as building a solid foundation around the globe to address our global health security threats.

CDC has leveraged every one of these capabilities so far in our response to the COVID-19 outbreak. The President's fiscal year 2021 budget provides \$7,000,000,000 to CDC to support these and other important public health priorities.

When it comes to global health threats, though, I believe that CDC is the tip of the spear. As with the Defense Department having forward deployments in strategic regions across the globe, CDC will build a longstanding sustainable regional footprint. This approach will increase CDC's ability to meet the public health challenges wherever they occur.

The world depends on CDC's expertise and the state-of-the-art laboratories. The budget does include \$10,000,000 to help maintain these laboratory capacity, equipment, and specialized training.

The budget also supports the Infectious Diseases Rapid Response Reserve Fund, which has enabled CDC to respond immediately to

the COVID-19 outbreak, and it also helped us provide a sustainable response to Ebola in the DRC.

Like COVID-19, new influenza virus strains can emerge from animals and spread very quickly among humans. Today, influenza surveillance is being leveraged to ramp up for COVID-19 surveillance. Severe influenza pandemics threaten lives and can disrupt our health system, military operations, and our economy. The budget includes an additional \$40,000,000 to protect Americans from influenza.

The budget also includes an increase of \$13,600,000 to address the growing threat of tick-borne disease. CDC's ability to prevent disease depends on accurate, timely data, and the public health workforce that can use that data to predict the next outbreak.

During my time at CDC, we have focused on bringing the reporting time to real time. This request supports the public health data modernization strategic multiyear initiative that brings public health data into the 21st century. CDC relies on data for every important public health issue we attempt to address.

The loss of a young mother due to pregnancy complications is another devastating occurrence in a family. The budget includes \$12,000,000 to increase and improve our maternal health in America, where every maternal death will trigger a public health response to understand what caused that death to try to identify important interventions.

Finally, CDC is committed to ending epidemics. The budget includes an increase of \$371,000,000 to support the President's initiative to end the HIV epidemic. CDC is deploying proven approaches to alter the direction of HIV infection rates in the United States, as we are doing with the opioid and drug overdose epidemic.

Overdose deaths have declined by 4.1 percent between 2017 and 2018. The budget includes \$476,000,000 for overdose prevention and an additional \$48,000,000 to address infectious disease related to drug use disorder.

CDC and our public health partners are the Nation's first line of defense against these disease threats. We are committed to working with you to protect the health and well-being of all Americans, and I look forward to answering all your questions, including, Chairwoman, the question you asked. I will answer that also.

Thank you.

Ms. DELAURO. Thank you. Dr. Redfield, CDC has been working to respond to COVID-19, including utilizing quarantine authority that hasn't been used in decades. And over the last couple of weeks, though, we have moved from a strategy of quarantine to a strategy of mitigation.

People are following CDC's guidance of calling their healthcare provider to get evaluated. Healthcare providers are facing the reality that they can't get their patients tested.

Other countries are testing thousands. South Korea, testing 10,000 people a day. We are behind the curve. My understanding is that testing kits continue to be distributed. Commercial firms are involved as well.

I want to try to keep within 5 minutes for all of us. Why is the U.S. behind other countries when it comes to testing availability?

Why was there such a delay in CDC's ability to replace the test kits sent to the public health labs?

And then I have a question after that. Dr. Redfield.

Dr. REDFIELD. Thank you very much, Chairwoman.

We obviously got first notification of this new disease on actually New Year's Eve, December 31st. And that it was occurring in China, and the Chinese fairly rapidly published the genetic sequence at the end of the first week of January.

We actually worked at CDC based on that and created a diagnostic test that really I think tested the first person on January 17th. So fairly quickly, we had a diagnostic test up and running. The CDC, which is our job to get that technology available for the public health laboratories of the country, and we let them know, and they began sending in samples. I think we had our first diagnosis in January, I think it was 21st, from the State of Washington.

Obviously, at that time, there was—it took time to fly the samples to CDC and run them. Sometimes there was a 3-day turnaround, 4-day turnaround. Occasionally, even a 5-day turnaround.

Ms. DELAUBRO. Excuse me, Dr. Redfield. Why are we behind other countries, and why was there such a delay in the ability to replace the test kits sent to public health labs?

Dr. REDFIELD. Yes, I think we very rapidly developed the test. Then we had to expand that test to go to the public health labs. When that was scaled up by the contractor, the public health labs then need to validate it to make sure the test works.

When they did try to verify it in their hands that it worked, some of the labs found that one of the reagents wasn't working correctly. It is part of our quality control procedure.

We then had to tell them to hold off on using those tests for public health. They can still send the samples to CDC. We worked to correct it with the FDA, and it was corrected in a very short time. And then that was replaced.

I think the most important point about the availability of testing that I want to say is CDC's focus was to provide testing for the public health system. There is a whole other system we need testing for, clinical medicine.

And I am happy to say now, with LabCorp and Quest both operational as of yesterday, there is really laboratory testing availability to any doctor's office that can go through LabCorp and Quest. The CDC's primary job was to get it out to the public health system of this Nation.

Ms. DELAUBRO. But nevertheless, you have got people who are asking for a test who cannot get a test. The overarching question is, did CDC's delay in producing functioning test kits and its insistence on maintaining a narrow clinical definition for testing lead to an increased transmission in our communities? Did the delay undermine CDC's traditional public health efforts of track and trace?

Dr. REDFIELD. I am not going to—I am not willing to concede the second. I am willing to say that we had to go through a regulatory process here to get our test out, and our test was approved for very specific clinical settings. So when the test EUA was approved by the FDA, it was approved for use in high-risk individuals that were coming at that time from China.

And then, later, it was expanded to individuals with pneumonia, and then later, as you know, we have expanded it now to any physician that feels there is a need or public health person can order that test. But it was a series of going through that regulatory process to get that test available.

Ms. DELAUBRO. But I think the conclusion is that we are behind the curve in testing, when South Korea can test 10,000 people in a day.

If I can very, very quickly, if you can, otherwise, I will come back. You have got \$2,200,000,000 for CDC. We want your assurance that these funds will be allocated quickly, and we are also going to need you to outline CDC's plan for its share of the emergency supplemental and deal with what your top priorities are. What should the American public see in the next coming weeks?

Dr. REDFIELD. Well, I can assure you we are going to get that money out very quickly, and much of it to the State and local health departments to operationalize this. But I would like Ms. Berger to comment more.

Ms. DELAUBRO. Okay. Well, I don't want to—we got a lot of folks here.

Ms. BERGER. Well, thank you very much for the opportunity, and thank you for moving so quickly to provide us with the funding. And our top priority is to get funding out to the State and local jurisdictions. Using the congressional language that we received, our top priority is to get 90 percent of the preparedness grant amount out to the 62 current grantees as quickly as we can, and we plan to be able to do that in the next 2 weeks.

Ms. DELAUBRO. Do you have enough resources? Do you have enough resources?

Dr. REDFIELD. I think the most important thing that you all realize is to make sure that CDC is overprepared for a response, not underprepared.

Ms. DELAUBRO. Okay. That means resources. Thank you very much.

Ranking Member.

Mr. COLE. Thank you very much, Madam Chair.

I appreciate those questions on the testing. They were very much mine as well, and so since we have covered part of that, let me ask you something very different that will probably be a more pleasant question in some ways.

Look, we are not going to cut CDC by \$700,000,000. What this committee will wrestle with is what is the appropriate increase, honestly, going forward, and what are the things we need to prepare you as best we possibly can to deal with things like you are dealing with right now?

And again, this committee has seen this coming for a very long time. It has been a bipartisan consensus. Actually, Congress has been ahead, I think, in this area of both the last two administrations.

So, given that, you know, what are the things—because we are going to have to ask you this question at some point. What are the things you really need if you had as much money as you would like, as opposed the budget that you are assigned?

Dr. REDFIELD. Thank you very much, Congressman Cole.

I am hoping that the legacy for the time I get to lead CDC is really one thing—I helped rebuild the core capabilities of the public health system of this country. That is data. Not data when I get presented something that I know what happened 2 years ago. But I want predictive analysis to be the name of the game not just for CDC, but for the entire public health structure of this country.

I need laboratories that we were just talking about to be so prepared that the complexities that we have gone through these last 6 weeks are not going to be an issue because we have invested heavily in laboratory capacity in the public health labs of this thing.

I want to build a public health workforce that right now those of you who know like, for example, Seattle, where I was just out visiting, their—King County and Seattle is probably the best public health—one of the best public health, if not the best public health, in the Nation. They are struggling right now. That is not what we need. We need to be prepared.

I need the rapid response fund to be robust so that it can really roll out. And finally, I need a global health security foundation across the globe that can protect this Nation following the regional strategy.

That is what I need, core capabilities. And it will help every program. It will help diabetes. It will help cancer. It will help smoking. It will help infectious disease. That is what I need.

Mr. COLE. Well, I would suggest in the interim because, again, building a budget takes time, as everybody up here knows, that you work with us to put dollar figures to those, kind of. So we can—you know, the chair is going to have a difficult decision. Our counterparts in the Senate will. But I will make a bet the budget for this agency is going up, not down.

And so the critical thing for us is to work with people that really know what they are doing, honestly, so we can get you those dollars in the appropriate amount so we can go forward.

Second area, and again, not to beat on you for a budget that I know you don't agree with, but I was disappointed to see the Good Health and Wellness in Indian Country program, one of the only programs that funds public health in Native areas, once again proposed for elimination. Let me just assure you that isn't going to happen.

And I know your own commitment in this area. So I suspect I know where that proposal came from. But I would like you to expand on what you think we ought to do because every set of statistics we have puts Native Americans last in just about every health category and risk. And this is everything from trying to make the Indian Health Service more robust, but also this is a unique population in some ways that has some special challenges. So what do you think we ought to do to try and end that disparity?

Again, an area we have lots of minority population. My good friend Ms. Lee always points this out, appropriately so, with African Americans, too. But we need to try and erase these disparities.

Dr. REDFIELD. Thank you, Congressman Cole. I think you know my personal views on this.

You know, we are continuing to make progress. We think that the Good Health and Wellness in Indian Country program is obvi-

ously extremely important. It supports 27 tribes, urban Indian organizations, and throughout our country.

Obviously, there are key areas of critical importance in chronic disease, opiate, injury, environmental health issues. There has been a movement, as you know, the American health block grant and the Public Health Data Modernization Initiative, both of these I think can really help to support. I think we are trying to move away from disease-specific interventions as opposed to allowing the community, the tribal community to help to look and see what are the really important health issues that they need to address and then appropriate the resources in that regard.

But it obviously is an important area that we also would like to see continue to be effective. Hopefully, there would be more flexibility and maybe some gain in efficiency, allowing the local group to decide exactly how to invest the money in chronic disease rather than saying they have to do it this for this, and this for this, or this for this. That was our attempt, sir.

Mr. COLE. Thank you very much.

Thank you, Madam Chair.

Ms. DELAURO. Congresswoman Lowey.

Mrs. LOWEY. Dr. Redfield, as I mentioned, as you know, in my home county of Westchester, New York, 98 cases have been confirmed in just 1 week. New York is trying to take aggressive steps to combat the virus by increasing testing capacity, has asked the Federal Government for approval to use qualified hospitals, private labs, additional State facilities to process tests.

How many test kits does the CDC have the capacity to deliver on a daily basis? And how is CDC and FDA working to increase testing capacity in State? How long will it take for these facilities to be approved, and how long does CDC believe it will take until a rapid response test is available for health providers?

I got the impression that CDC was a stumbling block, and New York was raring to go and producing these kits, and they didn't get approval. I won't tell you the other things I heard.

Dr. REDFIELD. Thank you for that. I probably heard them all times 10, okay?

First, let me tell you that I have worked very closely with Howard Zucker, your health commissioner in Albany. February 29th, he requested that he could co-use our EUA to bring up the Wadsworth Lab. FDA approved it the same day, February 29th.

Actually, we were on the phone last night because he is one of the first State labs now to try to go to a much more automated, what we call high-throughput system. And I am hopeful that the—because we can't just do it. They have to verify. And I am hopeful that the verification run that should have been completed last night, and they will be the first public health lab to be able to use the very high-throughput system.

Secondly, I want to say the same day, February 29th, the administration gave regulatory relief to any CLIA-approved lab that wants to develop the test to develop the test and use it. So there is no delay from the United States Federal Government perspective.

Some major medical centers, for example, in the State of Washington and others, are off and running and doing their tests. All

they have to do is be CLIA approved to do clinical testing, and then they have to verify themselves that the test works. They have 15 days afterwards to file the EUA. So they can actually go forward on February 29th, if they chose to go forward, and develop that test.

Third is we have worked—there are three New York labs that have requested testing from CDC, and we have provided it, and we will continue to provide what they request. They make a request to IRR how many kits they want shipped out. They are shipped out to them, right?

And fourth, and most importantly, was the decision of the diagnostic industry in a meeting we had with the Vice President and all the leaders, they didn't come together as independent companies. They came together all together and said how do we help get diagnostics throughout this country?

And I know the two big ones, major, LabCorp and Quest, are operational as of yesterday in doctors' offices throughout this country.

Mrs. LOWEY. Oh, I have a minute and a half. I will talk quickly.

Dr. REDFIELD. They tell me to speak shorter. I know. It is hard for me. But I am trying for you, Chairwoman.

Mrs. LOWEY. I know. It is hard. One of the reasons COVID-19 appears to have spread so substantially in New York is that a patient was being treated for several days in a hospital before he received the correct diagnosis. We now know that healthcare professionals working in that hospital, as well as two other area physicians, have tested positive.

We are already facing a nursing shortage. I am very concerned about our health workforce and whether the healthcare system will collapse under its own weight if nurses, doctors, and other health professionals are not protected. What guidance is CDC providing to healthcare providers, in particular emergency departments, to minimize the number of personnel exposed to COVID-19?

I guess we have 55—

Dr. REDFIELD. Well, we have guidance, and I think—correct me—I think our updated guidance is going out today on infection control procedures. I will say one of the greatest vulnerabilities of this Nation right now is nursing homes.

And you know that CMS recently upped the resources. They actually have all their inspectors now told not to worry about all the other stuff they inspect for. All they want to do is infection control, infection control, infection control. This is a critical issue.

You know, in the State of Washington, there are 600 healthcare professionals that have been exposed. In the State of California, 600 exposed. We don't have that much redundancy to have that many. So it is critical.

I will say one thing I want to say that I think is important. This epidemic started in China. That was kind of helpful for us because we knew that was the risk. Ninety-nine percent of the cases that occurred last night occurred outside of China. This isn't China.

Right now, the epicenter, the new China is Europe, and there are a lot of people coming back and forth from Europe that are now starting to seed these communities, and we are moving quickly to

understand how to address Europe. But that is why you are seeing more in New York. That is why we are seeing more, though.

And again, we are going to try to really reinforce that early consideration of coronavirus and treating individuals as if they have coronavirus is what the hospital system has to do, and I think the diagnostics now have penetrated to the degree that clinicians will get a very timely diagnosis.

Mrs. LOWEY. Let me just say quickly in conclusion I would hope, based upon these particular incidents, that all those in the emergency rooms, this seems so basic, are tested before they see a patient. Because it would shock—some of the stories we have heard are really shocking.

Thank you. Thank you, Madam Chair.

Ms. DELAUBRO. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you so much for coming out to Washington State. I joined with you and Vice President Pence and almost our entire delegation to come out, and I appreciate your willingness and readiness to be available to our public health workers all the time, all the time, and I am sure you are enjoying the time delay that we experience. And we are very grateful for that.

And the shout-out to our public health workers, I do think that Washington State's public health system is—I think it is the best in the country. And as you said, we are struggling.

I wanted to bring up a couple of questions to clarify. So I know CDC has partnered with a private manufacturer to make test kits available, and the amount of kits is increasing exponentially. It is happening now.

And that being said, I find it interesting that when my colleagues who were in contact with someone who later tested positive were able to get tested almost immediately and quickly received their results, while folks in my district and across Washington State are unable to get their testing results back. So I do find that people are now getting tested.

And I was on the phone with one of my local public health agencies yesterday, but what I am being told is so if they go—so we are trying to get people into the University of Washington, right? But people who go locally and it goes to the State lab, there is still a delay.

I mean, we have been waiting for about five tests for a number of days. Like every day, the headline is “still waiting for the test results.” Could you quickly speak to that?

Dr. REDFIELD. That is a great question, and it is why I hope in the time I get, I accomplish what I want in building core capability.

These public health labs need redundancy. They don't have it. This is when I go back about the core capability of data, lab, people, rapid response fund, and global health. The truth is we have not invested—we have underinvested in the public health labs—

Ms. HERRERA BEUTLER. There aren't enough people to run the tests?

Dr. REDFIELD. There is not enough equipment. There is not enough people. There is not enough internal capacity. There is no surge capacity.

Ms. HERRERA BEUTLER. So we are being told that they also—so even UW—so UW can process about 1,000 a day, and there is ca-

pacity there if the clinicians will send it there versus public health. But does UW then also still have to be validated by the State, because we are being told that?

Dr. REDFIELD. All UW, which they have done, had to do is on the 29th, when the regulatory relief was done and they are a CLIA-approved lab, they just had to develop their own test, and they didn't have to use CDC's. We published exactly how to do it. So anybody can replicate it.

And all they have to do is run to make sure their controls work. They don't have to send it to us. They don't have to send it to the FDA.

Ms. HERRERA BEUTLER. Completely decoupled then?

Dr. REDFIELD. They go. In 15 days, they have to file to the FDA, okay? But I want to say one thing about that, why it is important. Why are they different?

The public health labs, we built the technology in those labs to monitor flu. That uses a certain equipment, which we call thermocycler, right? That equipment, maybe a good lab could do 300 tests a day.

The University of Washington can use these high-throughput machines like New York is about to do. Those machines can do thousands and thousands and thousands. And so they are converting to those high throughputs, but the public health system has never had the equipment to the high throughput.

Ms. HERRERA BEUTLER. Okay. I apologize. I have to reclaim because we don't have a lot of time left.

So there is a lab in my district. So I am grateful that Quest and LabCorp are coming online. That is important. I have a lab in my district who has worked with CDC on HIV well, and they have found it impossible to get in contact with CDC on COVID-19 testing.

And due to the fact that they weren't able to get samples back from CDC, they had to resort to getting their RNA samples from Israel. Now I know they are a smaller—and UW actually in the beginning days had some of this challenge. They to develop basically their own—their own test like. They went through it all themselves.

And I know that the administration has been working with the big guys to get them going for capacity purposes. I would be grateful if they could also be responsive to some of the smaller guys because in the rural areas, we just need more people, and if these labs are willing to do it—go ahead.

Dr. REDFIELD. Congresswoman, if you give me the specifics, I am happy to look into it.

Ms. HERRERA BEUTLER. I will do that. I will do that.

The one last question I had, and I am sorry I am breezing through this, has to do with nursing home guidance. I know that Seema Verma and the administration has a new focus on enforced protocols, right? Had people been following protocols we would be in a better place today.

However, what I am hearing at the ground level is, yes, things go up on a website, but my local public health said I don't have the capacity to go into every single home and make sure everybody is doing—you know, I am paraphrasing.

How can we help make sure that the nursing homes in our communities right now today are getting the information and are at least communicating about what they are going to need or what they will need? And how can you help with that?

Dr. REDFIELD. Well, we have put together specific guidance, and we will continue to try to make sure. I know Seema at CMS is going to be aggressively making sure each of the nursing homes are up. Because this is our vulnerability. When you see, tragically, the 27 people that we have lost, I think 23 of them have been in your State, and many of them have been in that nursing home.

So this is really a priority to get that up and running, infection control up and running, provide the technical assistance. This is our number-one vulnerability right now.

Ms. HERRERA BEUTLER. Thank you. Thanks, Madam Chair.

Ms. DELAURO. Thank you. Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Welcome, and thank you for being here.

During the time that I have been on this subcommittee, we have justifiably doubled the NIH budget once and are on the trajectory to do so again. However, during this same time period, the CDC budget has remained relatively flat, despite the fact that credible research has shown that every dollar invested in public health results in \$67 to \$88 in benefits to our society.

CDC funding is critical for maintaining infrastructure at State and local health departments. Over the last decade, our failure to robustly fund the CDC has resulted in our local and State health departments losing 25 percent of their staff since 2008.

If there has been a failure in our coronavirus response, I do not believe that it reflects on the competency and effectiveness of CDC, but rather on our chronic underinvestment in the public health system. That is why I strongly support the 22-x-22 initiative to increase the CDC budget 22 percent by the year 2022.

I would like to take this opportunity to give you another chance to share your professional judgment about public health funding. What do you consider to be the greatest funding needs for the CDC right now, and is our current level of investment enough to ensure the best Federal, State, and local response not only to the coronavirus, but also while responding to a public health emergency such as COVID-19, do you have the capacity to maintain responses to the ongoing substance abuse epidemic, maternal mortality health crisis, hepatitis outbreaks, and of course, addressing chronic disease such as asthma and diabetes?

Dr. REDFIELD. Thank you very much, Congresswoman.

It gives me a chance to sort of reinforce once again what my goal is as CDC Director, and that is to rebuild the public health infrastructure not of just CDC, but of the whole Nation. As you know, about 70 percent of the funding that is appropriated to CDC is used to go out to the State, local, tribal health departments. We provide the funding really for the backbone of public health across this Nation.

Like CDC, the State and local and territory health departments are underfunded, and I want to rebuild the core capabilities so that we have data and data modernization. Wouldn't it be nice if we had a data system that every health department in this country right

now could see in real time so that we could predict what is going on and where to go and where to put assets? We don't have that.

Wouldn't it be great if we had the redundancy in our labs so we are not arguing about whether they can use a high-throughput system because they don't have the technology to do a high-throughput system? These labs need to be equipped. Not at CDC and New York and California, but the whole country, right?

We need to basically get more people into public health and get programs there. We need that rapid response fund at an area that we can really robustly respond and not try to make priority choices how we are going to use the money that we do have.

And finally, we need to build a robust global health security network throughout the world. I have got a plan to do 8 to 12 regional centers that have full capacity so that we can detect, respond, and prevent infections at their source rather than have to deal with them at home.

That, to me, is the most important. Because if we have that, all the health departments are going to go up. All the health departments in all of your own jurisdictions, I guarantee you, if you go talk to them, they are underfunded.

Ms. ROYBAL-ALLARD. Just a follow-up to what you just said. By the end of 2020, it is estimated that the percentage of health agency employees eligible for retirement will reach 25 percent. So what level of investment do we need to train and hire the next generation of public health professionals?

Dr. REDFIELD. That is one of the critical core capabilities, and I would like to get back to you with more specifics in that exact arena, as we were challenged to come up with a very specific budgetary requirement to deal with this.

But it is critical. We have one program that I just mentioned briefly that my predecessor, Tom Friedman, started, which I think is really an important program. He took young people out of college and gave them 2 years—it is called the Public Health Associates Program—and then put them into health departments all across the country that wanted them.

So now you get young, energetic people at the beginning of their career not quite sure what they want to do, and they see the gift what it is to do public health. You know, it doesn't necessarily come out that way probably when you read career magazines, but they get out there and they practice public health. And a number of them then say, you know, I want to go on to medical school or public health school, and a number of them are actually working at CDC today.

So expanding those programs to get young people to see the value of a career in public health I think is critically important. And then, obviously, to be able to continue to retain the individuals that we have. But I think Tom Friedman's Public Health Associate Program is a really important thing for our Nation.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you very much, Madam Chair.

And thanks for taking time to appear here because you are probably like a one-armed paper hanger right now, running around doing things.

Let me just ask—let me follow up just on that global health security network issue. We could have all the global health security we want, but when China denies the presence of the disease for, what, a month, month and a half, what effect does that have?

I mean, how—the bottom line is that we know the fatality rate in China is probably higher than it is going to ever be here in the United States. What protections do we have against a bad actor like that?

Dr. REDFIELD. You know, Congressman Harris, I just think if we have these regional presence of strong teams, it is going to give us more eyes on the ground of what is actually going on. Nothing is going to be perfect.

You know, this particular outbreak started in a certain area of China. I know I have had direct contact on either New Year's Eve or the day after with my counterpart, head of the Chinese CDC. I don't think he was as in the light that he had a problem in early December. So I can't really comment about the local health department in Wuhan and how that was shared. I know that as soon as he knew, I knew.

Mr. HARRIS. Well, and I will just stop you there. They arrested the physicians who—literally arrested the physicians who tried to talk about this new disease and how bad it was. So, again, we just need to be protective here, but if we think we are ever going to get into that kind of closed system and somehow affect it, no, the Communist Chinese are going to continue that system, and we are just going to have to live with it.

Now what is interesting, though, is one of the things that I hope you do is you are advocates for the kind of innovation that we are going to need to deal with these kind of new viruses, both on the vaccine front and the antiviral front. And I know your background is in virology.

This idea that we produced an mRNA-based vaccine and got it delivered to the NIH in 6 weeks from conception is phenomenal, but it is an American company that has not had a profit for 10 years developing this platform. And if this vaccine works, we will owe it to American innovation, and yet bills like H.R. 3 I think will destroy American innovation.

So I am going to ask you how important is the private sector innovative process, both for this and for antivirals and for treatment, when it comes to these kind of public health threats?

Dr. REDFIELD. Yes, thank you, Congressman. It is obviously fundamental and critical. And I am going to give you the biggest example for me. It is antibiotic resistance.

We have a program right now, and you know this—you are physician—that really looks at surveillance and containment. But we are never going to win that. It is a containment strategy. The only way we are going to win it is new innovation. So innovation is fundamental for us to stay ahead of antimicrobial resistance, for us to be able to rapidly respond, you know, what NIH and Tony Fauci's groups are able to do now in 6 weeks, which normally would have taken them 12 months or more.

So innovation has to drive. And if we lose innovation, we are going to lose our ability to maintain the advances we have in clinical medicine for antibiotic resistance. They are going to go aside.

Mr. HARRIS. Sure. And we made that point when H.R. 3 was being considered that—and even the CBO agreed that there were probably a dozen disease that would—that we would not be able to develop treatments for if, in fact, we punish innovators in this country.

But let me talk about one last, and bring it around back to the testing issue because one thing you said, and I am curious about this just from a public health perspective, is that Quest and LabCorp now are geared up to this. Could they have geared up sooner?

I mean, because you imply that we have to have a parallel track. We have to have this one system that is for public health bodies and then this other system for the private sector, which it sounds like was ready to go. And probably because there is a profit motive, they are ready to go much quicker.

Is that a model we should be looking at in the future, in fact, to do public-private partnership with some of these companies that have the ability for rapidly gearing up and then make these available to the public health sector?

Dr. REDFIELD. My point that I wanted to make clear first is what CDC's responsibility was, the public health side. That said, as a clinician like yourself, I guess I anticipated that the private sector would have engaged and helped develop it for the clinical side. CDC has tried to help because the test that we did develop, IDT asked the FDA if they could now actually commercialize it, and we said it is fine by us. They can do RUA.

But I think those decisions on the commercialized section, I mean, we do have groups that can fill gaps. BARDA, for example, if they see a gap, they can begin to try to promote that. But I think I can tell you, having lived through the last 8 weeks, I would have loved the private sector to be fully engaged 8 weeks ago.

Mr. HARRIS. Yes, I think we have the wrong agency, I guess, to ask that question here.

Thank you, Madam Chair.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Thank you very much.

Good morning, and thank all of you for being here.

And thank you, Dr. Redfield, for being here and for really your tremendous leadership. And all of you, these are very challenging times, but you all have stepped up in so many ways.

Let me ask you, first of all, with regard to hand sanitizers. And I am not sure, and I am trying to unpack how we move forward on this, but I know that and we all know that one of the prevention strategies is to wash hands 20 seconds, and if, in fact, we don't get to wash our hands, we use hand sanitizers, right? That is part of the directive.

Now, unfortunately, you can't find hand sanitizers. This small one I have, fortunately, I have another one at home. So I just fill it every day. Now, and I have been in 3 cities in the last 10 days. Nowhere can I find hand sanitizer.

So what in the world is going on? And how do we make sure that hand sanitizers are available? I mean, unhoused people need them. There may or may not be water around. And so people who just

don't have a lot of money, vulnerable populations, if they were around, they probably couldn't even buy hand sanitizers.

And in fact, our healthcare workers and medical professionals on the front line. So what in the world is going on, and how do we wrap our hands around this so that we can make sure that the directions that we receive from our Federal Government can be adhered to?

Dr. REDFIELD. Thank you, Congresswoman Lee.

Obviously important. We have seen the shelves. This isn't an area that we drive, but I can tell you the Interagency Working Group is looking at a variety of different things to figure out where there are shortages and what can be done. Whether it is respiratory masks or medicine or hand sanitizers. And I can get back to you exactly.

But I do from the public health point of view at least remind people that 20 seconds of vigorous washing with warm water, hot water, and soap is going to work. There are people looking to track where is the supply issue here, and I can get back to you—

Ms. LEE. Yes, could you, please? Because a lot of people don't have access to warm water and soap.

Dr. REDFIELD. And I understand that.

Ms. LEE. And need—

Dr. REDFIELD. I know.

Ms. LEE. And we need to know that.

Dr. REDFIELD. I will get the information from the interagency group and make sure it gets back to you.

Ms. LEE. Okay. Thank you very much.

And the second question I have is on the Grand Princess, first, thank you for your assistance with regard to this very challenging public health emergency and operation that is taking place in my district. I know CDC and HHS, I think HHS has been in the lead with our Governor's office.

Could you clarify what role CDC has in this entire operation, and what do you think in terms of timeframe, how long it is going to last, and what have you learned in the last 24 hours since people have been disembarked?

Dr. REDFIELD. So the operational lead, the mission leader is ASPR. It is actually Assistant Secretary Robert Kadlec. He is in charge of the response.

We provide technical assistance and support under his direction to the response. We obviously also are going to provide some technical assistance support as these individuals move to housing either at Travis or Lackland or in Georgia. But the operation is really under control.

Probably most importantly, we make sure infection control issues are done right, and we do—we are the agency that gives the Federal quarantine orders.

Ms. LEE. Okay, but are you the agency that monitors the whole public health criteria and protocols as it relates to the health and safety of the dock workers, the healthcare workers, the crew, the passengers, the community? Because where the ship is being docked is in an area in my district where historically we have had to deal with environmental racism and injustice. And so, naturally,

we want to make sure this is not another one of those instances where we will, you know, unfortunately feel the impact.

Dr. REDFIELD. We provide the technical assistance to the Assistant Secretary for Response and Preparedness, and our technical assistance is highly respected within the Department. But they are ultimately in charge, but we are there to provide that—

Ms. LEE. Who signs off on the health and safety, public health and safety?

Dr. REDFIELD. Ultimately, it would go back up to the Assistant Secretary's office.

Ms. LEE. The Assistant Secretary does. Okay.

And then—okay, I will ask my next question. Go around, Madam Chair. Thank you very much. I yield.

Ms. DELAURO. Congressman Pocan.

Mr. POCAN. Yes, thank you very much, Madam Chair.

And thank you for being here. I have got a lot of questions. So if we can be succinct, that would be great.

I did a Facebook Live town hall on Sunday, and we had several thousand views in the first hour and a lot of people asking questions. First of all, obvious, we are not cutting your budget. That is why we brought you here. I just wanted to say that.

Now let us go to what everyone is asking about. Are we past containment? Is this strictly mitigation at this point? Just a yes or no.

Dr. REDFIELD. In different areas. We are in a containment in certain areas. I would say in general, we are in a containment-blended mitigation. In some areas, we are in high mitigation.

Mr. POCAN. Okay. When you say nursing homes, does that include assisted living and other senior living housing area? That is a question that people asked.

Dr. REDFIELD. Yes.

Mr. POCAN. Okay, thank you. Succinct is great. "Yes" is a great answer.

I want to ask, at the Friday press conference, the President interrupted you and said anyone who wants to get tested can get tested. Is that true right now? Anyone who needs to get tested can get tested?

Dr. REDFIELD. You can go to your doctor's office.

Mr. POCAN. It is a yes or—really, you don't have to give me a long answer. Just can anyone get tested right now anywhere in the country?

Dr. REDFIELD. Through a physician.

Mr. POCAN. You can? Yes?

Dr. REDFIELD. Through a physician.

Mr. POCAN. So is that a "yes, through a physician?"

Dr. REDFIELD. It is a yes, through a physician.

Mr. POCAN. Thank you. Great. I wrote you a letter last week. You quit keeping track of how many people were tested on the CDC website. I think that is a bad idea from a number of conversations. You don't know what you don't know, which is why we wanted to keep track of those tests.

We had Secretary Azar, as of this morning, say he doesn't know how many people have been tested in this country. That was in an article at 10 to 10:00 a.m. on CNN. Why are we not keeping track of that, and why are we only updating the CDC website now 3 days

a week? The World Health Organization does it daily, and this is information people really want to know.

Dr. REDFIELD. Yes, we are doing it every day now, and we actually got a new reporting system that includes CDC public health labs. We are going to get direct dumps from LabCorp and Quest. So people are going to see all the tests done, where they are done, and we will have a surveillance system that does that.

Mr. POCAN. So the answer from yesterday about 3 days a week is already old news? Now it is going to be daily?

Dr. REDFIELD. Now it is going to be every day.

Mr. POCAN. Thank you very much for that. Appreciate that.

Ron Klain and others have said we should be proactively testing. Dr. Fauci agreed. Medical, anyone in a hospital with pneumonia-like symptoms, as well as healthcare personnel. Are we now actively, proactively testing folks like that and have a policy of proactive testing?

Dr. REDFIELD. We are recommending to physicians that anyone that has a variety of clinical scenarios to be tested.

Mr. POCAN. So how aggressively, though, are we—

Dr. REDFIELD. We are aggressive now. I mean—

Mr. POCAN. But we are proactively testing?

Dr. REDFIELD. We are proactively in individuals with pneumonia or respiratory illness. It does vary by community. Where we have significant community spread, it is—

Mr. POCAN. But the recommendation is proactively testing health professionals as well?

Dr. REDFIELD. Proactive. Not necessarily all healthcare professionals. If they have had an exposure to it in a hospital where we have known cases, yes.

Mr. POCAN. Okay. And how about police officers?

Dr. REDFIELD. Again, we are seeing, as we have seen in Washington, that is one of the things in my trip that really surprised me at how many firefighters were no longer available because they were in 14-day quarantine.

So, again, it goes with exposure. We are trying—we have increased the awareness of how to approach a patient so you don't get exposed.

Mr. POCAN. Gotcha. Okay. How about a question on the test, going back. Other countries used the World Health Organization test. Why did we not use that test, and who made that decision?

Dr. REDFIELD. Again, as I tried to say, our test was probably created as fast as anybody's test in the world.

Mr. POCAN. I got that.

Dr. REDFIELD. Okay? WHO doesn't actually make a test. They have the German—one of the German universities have made a test. So, again, and that test would have then had to come here and go through regulatory review. I think our test was much quicker than they would. I would defer that question, though, to the FDA and—

Mr. POCAN. Okay. I have them in committee tomorrow. I will ask them that. Thank you very much.

Another question. There was an article over the weekend. I am going to pull it up. I don't mean to be rude if I am not looking at

you. Saying that CDC recommended seniors not travel, and then it wasn't part of the White House task force recommendations.

Vice President Pence said it was never a recommendation to the task force, and the story was completely fiction. Did the CDC recommend that older Americans not travel?

Dr. REDFIELD. Yes, CDC now recommends—

Mr. POCAN. Did they recommend at this point—

Dr. REDFIELD. At this point—

Mr. POCAN. Not at this point. At that point, did you recommend to the task force—

Dr. REDFIELD. I don't know exactly when that was.

Mr. POCAN. Over the weekend when there was a report that did not say it, and they are saying that CDC recommended it. At what point did CDC recommend seniors not travel?

Dr. REDFIELD. Probably in the last 72 hours that we recommended. I can get back to you with the exact date and time.

Mr. POCAN. Okay.

Dr. REDFIELD. We do recommend now—

Mr. POCAN. I don't want to have to do a Freedom of Information Act request.

Dr. REDFIELD. No, you won't have to. I will give you—

Mr. POCAN. But I would really love to know when it was recommended by CDC. Because there is a real distrust out there right now, and they don't know who to distrust because we are not getting information.

And this is one where right now I am trying to convince my in-laws not to travel to Las Vegas tonight. They are both in their 70s, and one has health issues. These are the questions we are getting asked in Facebook Live town halls.

So when someone says it wasn't a request, and now I see you are recommending it, I would like to know when it was requested. And if I need to make a formal request—

Dr. REDFIELD. You don't need a Freedom—we will get the information back to you, sir.

Mr. POCAN. All right. Thank you very much. And is that my time? Oh, I am sorry. It went that quick. I apologize.

Thank you very much.

Ms. DELAURO. Congresswoman Frankel.

Ms. FRANKEL. First of all, thank you all for your work. I agree with my colleagues about we should not cut your budget.

First of all, I want to just say—and I am sure you would agree with this—you said that this virus is expansive in Italy and South Korea, now in this country. It is absolutely wrong and inappropriate to call this the Chinese coronavirus? I assume you would agree with that?

Dr. REDFIELD. Yes. China was the first phase. Korea and Iran was the second phase, with Italy, now all of Europe. I mean, just if you looked at even just last night, I think if you have a second, just over the last 24 hours, there was almost 1,500 new cases in Italy, 1,300 in Germany.

Ms. FRANKEL. All right. Let me just—okay. Thank you. You answered the question. Thank you.

There have been some other real misleading statements that are wrong. I am going to read some. If you agree with these statements, just let me know.

Our tests have been perfect. That this like—the coronavirus is like the regular flu. That it is a hoax. That anyone who wants to be tested could be tested. That the number of cases will soon be down to zero. They will magically disappear. You can still go to work, and it is okay to shake hands. These would be misleading.

Since I am not hearing anyone want to correct that, I am assuming that you would agree that those are misleading statements?

Dr. REDFIELD. I don't think I heard any that I would say is not, other than that I do believe that availability of testing in the last 2 days through Quest and LabCorp is finally getting us where we need to be.

Ms. FRANKEL. Okay. Thank you.

And there was a new—I just want to ask you, are you familiar with the public charge rule, the new public charge rule?

Dr. REDFIELD. Yes, I am.

Ms. FRANKEL. I think there is—I am concerned that it might lead people not to go to get the care they need. Could you respond to that?

Dr. REDFIELD. I would concur with you. I talked to some of your colleagues when we were on the trip in the State of Washington. They brought this, and we are looking at it to see its public health implications.

Ms. FRANKEL. Okay, thank you very much.

So would you say we were at the beginning, the middle, or the end of this coronavirus fight in the United States?

Dr. REDFIELD. I would say I can't predict.

Ms. FRANKEL. Okay. Can you say what percentage of Americans you think—you are predicting will get the coronavirus?

Dr. REDFIELD. I think it depends how effective our public health response is right now. I do want to state one thing. We all have a role to play. And it is really serious when we say to practice the washing of the hands, coughing in your elbow. You know, try not to touch your face. I know probably they are going to count how many times I did on this because it is very hard, but you have got to try not to.

And then I think, you know, if you are sick, stay home. Please, stay home.

Ms. FRANKEL. Right. Okay, well, did any health agency recommend to the White House that people over 60 should not fly on planes?

Dr. REDFIELD. I don't know the exact age. I will get back to you. But we have recommended that the elderly and vulnerable, including children with chemotherapy and others, should really reconsider at this point travel.

Ms. FRANKEL. And what is the age of elderly because that is many of us leave the room?

Voice. Careful. [Laughter.]

Dr. REDFIELD. I didn't define it, but I will tell you that in the discussions we had, the individual who brought it up did say it was a year older than they were.

Ms. FRANKEL. What is that age?

Dr. REDFIELD. Right now, we have been looking at—the data we have been looking at, really if you look at the data, the average age in Italy of death is like 82, 83, 84 years of age. It is really the data that Ambassador Birx has gotten from China, Italy, Korea, and our own Nation. It looks like 65 and above where most of the people are that have died.

Ms. FRANKEL. All right. One of the concerns I know we have is especially in these nursing homes, everybody is getting sick, including the care providers. What is the level of your concern about us having enough care providers to take care of people as this disease spreads?

Dr. REDFIELD. This is the importance of what we have talked about before, being overprepared. If you are overprepared, the ability to protect the healthcare professionals—and not just the healthcare professionals. I think the congresswoman knows that in Washington, one of the places, they don't have firefighters. Their firefighters are all in quarantine. They are in self-isolation.

So we have to be overprepared to respond to these outbreaks, not try to catch up. Time matters in infectious disease. We have more time in environmental disasters like hurricanes and flooding than we do when it comes to an infectious disease. Infectious disease, if you are a week late, and some of you have criticized about the testing or whatever, it matters.

Ms. FRANKEL. So let me—I am running out of time. We have another round coming? Okay. One more question on this round. So I have some friends or people who have self-quarantined themselves. We have read about it in the paper and so forth.

So you get exposed. You self-quarantine for 14 days. Is that right? Is the quickest you can have the—is that how long you have the disease for, 14 days?

Dr. REDFIELD. Yes. Right now, the average incubation period from infection to symptoms is 5.2 days.

Ms. FRANKEL. Okay. But how long does the disease last once you get it?

Dr. REDFIELD. It varies if you do get it. But if you get exposed, you will develop symptoms within those 14 days and be able to then either be diagnosed. If you stay asymptomatic, we have no evidence that you still shed virus longer than that.

Ms. FRANKEL. But if you self-quarantine for 14 days, you come to work, and then you meet somebody who else—and you get exposed again. Then you might have to self-quarantine yourself again, which means that we may all be in a process of self-quarantining.

Dr. REDFIELD. You sound like what my wife said this morning, okay? [Laughter.]

Dr. REDFIELD. We fully intend—I do believe if we are all in this together, from individual citizens all the way up, we have a great public health department. We still want to stay with our early diagnosis, public health isolation, and an aggressive use of mitigation strategies. We are in a fight to contain, to basically stop this outbreak at least for now.

Many of us are hoping, not knowing, hoping that this will follow the pattern of the flu and other respiratory viruses. That means the transmissibility in our environment might change. It is inter-

esting that when I look at the cases around the world and I censor out all the export cases and I censor out all of the contacts of exports, and you look in the Southern Hemisphere, there is very few cases in the Southern Hemisphere right now.

It is great possibility that might change, just like as flu changes. So I think we need to stay the course, be aggressive. This is, again, why I think being overprepared is where the posture we want to be in. This is why the supplemental you did in such a fast way and a bipartisan way is so important to us because it gave us resources now to scale up.

Ms. DELAURO. I have to move on. Congresswoman Bustos.

Mrs. BUSTOS. I think you are getting gaveled there. [Laughter.]

Dr. Redfield, thank you for your willingness to hop on the phone yesterday with me. I know the White House called you away, but I do appreciate your willingness to take a little time. So I will start with some of the questions that I was going to ask you yesterday.

Oh, no, it is obviously the White House was calling. So I got bumped. It is all right.

Are we—is this a pandemic?

Dr. REDFIELD. No, I think the word, I think, is really not important. Usually, the WHO is the jurisdiction that makes that call. This is clearly a massive global outbreak.

Mrs. BUSTOS. Okay. So I know that Chairwoman Lowey started out focusing on where she is from, New York City. I am from a very, very different part of the country, a very rural district that I represent in the northwestern corner of Illinois. In fact, 11 of the 14 counties in my district are almost entirely rural.

So as you can imagine, my office is taking the necessary steps to prepare for cases, and we are doing what we can to make sure that we are filling in people with what we know. So we have been in communication with all of our hospitals, our community health centers, our public—our county health departments, et cetera.

So one of the concerns that has been shared with us through this outreach is how the virus could increase provider shortages, especially in rural areas. And so let me just give you an example, to back up a little bit. One of the counties in my congressional district is called Henderson County. We have a patient-to-physician ratio of nearly 7,000 to 1. Now if you want to compare that to Cook County, that is about 1,200 to 1.

So you can imagine if rural doctors need to isolate themselves due to coronavirus exposure, there are limited options for people. So I am just wondering if you could offer and anybody at your table there, we will maybe give other folks an opportunity to answer this as well, but what steps can rural communities take to continue treatment if their providers get sick and cannot see patients? If you have any advice specific to more rural parts of our country?

Dr. REDFIELD. Do any of you want to make a comment? I am happy to make a comment.

Mrs. BUSTOS. Please.

Dr. REDFIELD. This is an issue, and this again is why we have heightened the area of infection control because as we see now in Washington, we see now in California, we have got 600 healthcare providers out of work in both of those environments, and that is causing strain.

The source for most communities, if this is going to happen, is probably going to be a nursing home. And then they go into the hospital, and then the hospital—you don't have diagnosis. Someone gets sick from the nursing home because someone came in and visited who just came back from Italy. They visited their sick mother in the nursing home, and then they got sick and went in the hospital. And then boom.

So I think we just have to be aggressive in the infection control and really work hard because this is what happened in Wuhan, and that is why the mortality was so high. They had 130 infection beds when they started. They had over 20,000 within about 4 weeks.

But you know what they didn't have? They didn't have doctors and nurses and the equipment to staff those 20,000 beds. Their health system fell apart, and that is why the mortality was so high.

Mrs. BUSTOS. And our rural area is more at risk for something like this?

Dr. REDFIELD. Well, you may have the benefit of being more isolated from a large population. So you pray that the virus doesn't really get into a community transmission zone. If it does, it is going to come through a nursing home, I would bet.

Mrs. BUSTOS. Is there anything from anybody else at the table who would have anything to add to what Dr. Redfield just shared?

Ms. ARIAS. And thank you for the question. I mean, rural health has been an ongoing issue for a long time. And like with a lot of other things that we have been talking about here, the coronavirus and the COVID-19 issue is just sort of shining a light on a number of deficits that we have had in our healthcare system and in our public health system for a while.

We have been involved and have some resources. They are very small in terms of how it is that rural communities generally—not in this situation specifically—can have resources that they normally wouldn't have that might be helpful. And we can follow up and send you some of that information and talk to your staff about what is available and what are the kinds of things that we have supported generally that may come to bear for COVID-19 as well.

Mrs. BUSTOS. We would appreciate that. Anybody else from—have anything else to offer?

[No response.]

Mrs. BUSTOS. Okay. Something else that we have heard from nearly everybody that we have contacted as far as health providers is the respirators, latex gloves, eye shields, they all express a need for more of this equipment. And I don't think anybody has asked this yet, but kind of the plan to make sure that this protective gear is out there for our healthcare providers.

Dr. REDFIELD. Thank you for the question.

This really is the important role, and I am sure you will have a hearing there, for ASPR to really look. They manage our stockpile. They manage—I will say that the interagency group has done critical analysis of, as I mentioned before, all the different things we need, you know, masks, protective gear.

I know the Vice President went out to 3M the other day to visit them with masks and try to see—you know, they are making about

35 million masks a day. But unfortunately, only 4 million of those are for medical use, and about 31 million are for industrial use.

And you will probably hear more about that because I think ASPR and others will be coming up with a plan to try to see how maybe some of that could be modulated. But it is an ASPR issue, and we can make sure they get in touch with you to answer that question.

Mrs. BUSTOS. That would be great. Thank you very much.

I will yield back. Thank you.

Ms. DELAURO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Dr. Redfield. Thank you for the information you are sharing, and I associate myself with all of my colleagues who say we are not cutting your budget any way, shape, or form.

I do have some questions. Do you have any idea how many people have been tested?

Dr. REDFIELD. Yes, I have an idea. We are now just getting all the health departments to come out and begin to collect, to collect the data, and we are going to put it out every day, as I mentioned to Congressman Pocan.

Mrs. WATSON COLEMAN. Could you tell me how many?

Dr. REDFIELD. Right now, I have as of yesterday 4,856. From public health labs only. So that doesn't include the clinical labs. That doesn't include the private labs.

We are trying to get it all together, so you will have a single point and daily, and that surveillance should be out soon.

Mrs. WATSON COLEMAN. Do the individuals who get their tests at the private labs still have to have the diagnosis confirmed by the CDC?

Dr. REDFIELD. If their lab is not independently approved by the FDA, we do still do a confirmation of those—of those State labs. So the clinical labs have been reporting their tests as is.

Mrs. WATSON COLEMAN. I have a New Jersey-specific question. Fortunately, we only have I believe 10 is the number today presumptive cases. But there are six people with presumptive positive cases that have yet to be tested by the CDC. So New Jersey, I guess, did its preliminary whatever it is it does, and I understand that this is a rapidly evolving situation. But can you confirm with us why there has been a delay in the confirmation from the CDC on these six cases?

Our staff have checked, and CDC staff confirmed, that there is not currently any delay due to volume. On previous media calls, CDC's Dr. Messonnier—Messonnier, French—it takes about a day to ship tests to CDC, and then we have confirmation within 48 hours. And she also said the CDC does have a secondary test for quality control measures.

Why is it now taking more than 1 week for verification? Why do we have this delay as it relates to the six presumptive cases in New Jersey?

Dr. REDFIELD. Yes, I will have to look into that, but I will tell you if they have confirmed in New Jersey. And I have that there is 11 confirmed cases in New Jersey as of now, they are considered a case, all right? So, and then we follow up and confirm it.

Mrs. WATSON COLEMAN. But do they know that?

Dr. REDFIELD. Yes.

Mrs. WATSON COLEMAN. Okay. Because I got the impression that they are still waiting for confirmation, which suggests to me that they don't necessarily know that.

Dr. REDFIELD. Yes, we will clarify it for sure, and we will get back to you so you know exactly what the reality is.

Mrs. WATSON COLEMAN. Okay.

Dr. REDFIELD. Thank you.

Mrs. WATSON COLEMAN. So I have a question about what happens if you are confirmed to have this virus, and you are isolated. You are in the hospital. You are whatever, right? You are in the hospital. What is the treatment?

Dr. REDFIELD. It is very important for every one to hear this very clearly. A majority of people who get infected with this virus, particularly those that are under the age of 60, are quite relatively healthy, and they would be—go to home isolation. We would ask them to restrict their movement, stay at home for 14 days.

Mrs. WATSON COLEMAN. And do what?

Dr. REDFIELD. And basically do everything they can to not infect anybody else that lives around them. And we have very good—

Mrs. WATSON COLEMAN. So there is nothing that they can do?

Dr. REDFIELD. There is nothing that they need to do other than what we used to say when I was doctor, you know, rest, drink a lot of fluids, take some orange juice.

Mrs. WATSON COLEMAN. And is that what happens—

Dr. REDFIELD. And please, please, please, you know, honor the home isolation. But I will tell you for people that are very sick, and we have a number that are very sick, there is an experimental drug called Remdesivir that is available right now in compassionate use. This country has used it, and a number of people in the State of Washington have been treated with it.

And there is clinical protocols going on by Tony Fauci at NIH comparing that to placebo, both here and overseas in Asia. We are going to know probably by April whether that drug works or not. And that is important because that is a drug that can save lives if it works.

Mrs. WATSON COLEMAN. Should we expect the CDC to not confirm State health lab results?

Dr. REDFIELD. I think we are moving in that direction.

Mrs. WATSON COLEMAN. Why is that? Isn't that primarily what you all do in this situation?

Dr. REDFIELD. What is going to happen is a number of these laboratories are going to come out with their own regulatory approval to do the test. Right now, they are all—

Mrs. WATSON COLEMAN. I am sorry. Are we going to be assured that all States have the same sort of standards that we are apples to apples across this country, not apples to oranges and peaches and pears?

Dr. REDFIELD. Well, we put out our standards for the public health labs. Obviously, as you know, each State has their own. But we do put out our standards.

Right now, all the State labs are working under our emergency operation—our emergency use authority. We are in the process of

getting each State, each lab to get their own with the FDA, and that is ongoing.

Mrs. WATSON COLEMAN. Thank you. I yield back.

Thank you, Madam Chair.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chair, and thank you all for being here today.

As we have been warned about moving from containment to mitigation, and I think the lack of testing that was done has hastened our move out of containment phase into mitigation. Would you say that is true across the country?

Dr. REDFIELD. I would say, Congresswoman, that I think one of the biggest drivers of what we are going through right now is the movement of this outbreak risk from travel from China to travel from Europe. And individuals are coming back from Europe, and they are seeding communities.

We will have to determine and we will know quickly how much is that driving it, or how much was there community transmission before that wasn't recognized because of less testing? We will figure out that answer because we are going back and looking at, let us say, blood samples that we can go back a month ago and do surveillance and see what was there through—and but I will say my own personal opinion right now.

The new cases that we are seeing in the United States are probably disproportionately driven from people that have returned from Europe and then gotten into a community, and then we have seen secondary cases and tertiary cases. That is my own personal opinion, but I am not going to die on my sword on it. I am open to the data to show us, no, that is not true. There was more transmission that we missed.

Ms. CLARK. Well, we want to make sure that we remain data driven. So I appreciate that, but I think that we can—as we look at what is happening, I think we are going to continue to see totals doubling and more of a move to broad-scale actions that we need to take to mitigate this. Because our testing is behind where the virus and infection rates really are.

How are you working with sort of the front lines on this, which is going to be our local public health officials managed by the State and, hopefully, supported by the Federal Government? How are you working with them to give opinions on large-scale gatherings? Should they be canceled? Is there a role for the CDC in that sort of work?

Dr. REDFIELD. Thank you very much for that.

We initially deployed teams into California and to Seattle to work over the last several weeks just on this issue, and I will tell you today the Vice President's office will be releasing a mitigation strategy for all States and territories in this country, guidance that we have worked on for the last couple weeks.

Ms. CLARK. Can you give me any preview?

Dr. REDFIELD. Well, what it is, is it is a framework for each of the States to look at a number of different areas, and we have put into low risk, moderate risk, and high risk and different examples of what they need to do. I will be probably reaching out directly

to Massachusetts in light of the recent cases that they have had. They now are basically one of the top five.

Last night, we had a long call with the health leaders of the top four. And we have asked them now to take this template and edit it very carefully, which they are supposed to have completed by 12. We will incorporate their edits. It will go global. And then we want them to fill it out specifically with the questions you have just asked.

Okay, what are they going to do about the Mariners game? What are they going to do about working from home? What are they going to do about the schools? All of that is in play as an example so that not only we will give them the framework, we are going to have a couple of the groups that have actually been dealing with sustained community transmission for the last 4 weeks say how they are going to do this.

And because I do think this is critical, and they do need—we are here to give technical advice to all of the groups. I will be reaching out to Massachusetts in light of the last couple days and see if they want to engage more directly with CDC. We have sent people to New York, to Seattle, and to California and Florida to help them, and I think Massachusetts is the next one if that health department wants assistance.

Ms. CLARK. Are you making recommendations that people don't have gatherings over 100 people? Have you set that sort of criteria?

Dr. REDFIELD. We are currently working in partnership with the current State health departments to come up with what we believe is an effective mitigation strategy for that—

Ms. CLARK. Is that part of what the Vice President is going to be releasing?

Dr. REDFIELD. He is going to release the framework, right, that will tell them how to do this. And then we will be following up with the specific jurisdictions like I did last night and the day before—actually, for the last couple weeks—to work in partnership to see how they now operationalize that framework in their community.

They are all going to be different, but yes, we are very involved. Rather than CDC give a blanket recommendation, since this is community by community, we are working with the local health departments head on to come up with, obviously expressing our technical systems and recommendation.

Ms. CLARK. I am almost out of time, and I don't want you to interpret this as a flip question, but is there anything in those recommendations that say sort of structural barriers at our borders would be of any use in mitigating the outbreak of this virus?

Dr. REDFIELD. Not that I have seen.

Ms. CLARK. Thank you.

Ms. DELAURO. Thank you. Dr. Arias, I have a quick couple questions for you, and I want to get in a question to Dr. Houry as well.

This is about public health data. And I think what we heard here this morning is that the coronavirus outbreak further confirms the need for modernizing our public health data system. Dr. Arias, I understand you work directly on the Public Health Data Initiative. So let me ask you a couple of questions.

If the data initiative had been implemented over the last 5 years and CDC had a modernized public health data system, how would the current public health response be different?

Ms. ARIAS. So in the spirit of conjecture, it would have been different in two ways. One is—well, in two different ways possibly. One is that we would have detected it much, much sooner and been able to contain it further and more effectively.

The other is even before detecting, depending on relying on different sources of data, which we do not now and we want to do more of, and analyzing that information along with health data, we could have started seeing that there might have been a problem even before getting scared about the number of cases that were being detected.

So it is a both detection and very quick prediction.

Ms. DELAURO. And are there examples of things you cannot do right now, and you will be able to? What can't you do right now?

Ms. ARIAS. What we can't do right now is twofold. One is—and they are related. One is the delay in finding out what actually is happening and who it is happening to. And a lot of that has to do with unfortunate barriers that the current systems have with getting that information from healthcare providers, getting it from States that we can use then to engage in that response earlier.

Ms. DELAURO. In that regard, what we did was to provide in the supplemental to improve surveillance and reporting. Are CDC's public health data system up to the task of handling all of the data coming from State and local jurisdictions in such an emergency? And I make the reference to the 4,856 number that you gave us, Dr. Redfield.

Are we where you are—

Ms. ARIAS. Not 100 percent and not what we would like. Not what we know is possible. And so the initiative—

Ms. DELAURO. What is the percent?

Ms. ARIAS. Seventy-five. And the initiative would then get us to 100, and not only get us to 100, but then allow us to maintain that over time and be able to keep up with—the difficulty that we are running into that you probably can appreciate is that methods are changing significantly faster than they ever have been. Tools are showing up faster than they ever have been. And if we can't keep up with that, then we are going to fall back even more.

And so if we talk 5 years from now and don't make those changes, it may be 50 percent instead of 75.

Ms. DELAURO. Quick.

Dr. REDFIELD. I just want to add one quick thing, and it is fundamentally critical that every State and local, territorial and tribal health department has that capacity, too.

Ms. DELAURO. Yes, and folks had come—we heard from them, and we talked about electronic medical records. They were talking about fax machines, individual Excel worksheets, and you know, data entry, et cetera, which holds up the process. So making your point, we need to invest in this effort.

Dr. Houry, let me just move to you for a second. First time in 20 years, 2020 appropriation included funding for CDC firearm injury and mortality prevention research. Enthusiasm from researchers everywhere to move forward. What steps has CDC taken with

the new funding? What areas do you see as promising opportunities to address this public health emergency?

Dr. HOURY. CDC really appreciates the appropriation, and we have moved very quickly on this funding. February 21st we issued our first funding announcement for our R01 grants. I am pleased to let you know we had an informational call for potential applicants yesterday, had a record number for injury center interested applicants.

Letters of intent are due next week, and then we hope to issue these grants by September to really look at areas like mass violence. How is some prevented? Why are others not? Self-defense abuse of firearms. You know, when is it used against a person, or when does it help thwart a crime?

And then things like school programs, are they effective in really preventing those firearm violence? And then safe storage. What are the best circumstances for it?

Ms. DELAUBRO. There was one—are there any applicants looking at homicide versus suicide or—

Dr. HOURY. So we don't know yet. Our hope is that we get a wide variety of applicants. We have really greatly disseminated this information to a diverse group of stakeholders, and we do think it is important. We appreciate the suicide funding as well to look at primary prevention and community-level interventions for that.

Ms. DELAUBRO. Thank you. I will—I know there are—let me yield to my colleague.

Mr. COLE. Thank you very much, Madam Chair. You actually anticipated one of the questions that I had for Dr. Arias on the importance of healthcare information, which we have all, frankly, mentioned one way or the other.

I would just ask you this. Could you work with our committee? We obviously have a very substantial supplemental that we hope will be helpful in this area. You mentioned that what you had requested might well get you to 100 percent of what you need.

What we also need is a look forward, as you mentioned yourself. And I know you can't estimate every new piece of technology that is going to come along or what might be useful. But when you think through these things, you really have to have a multiyear plan, even though we only budget one year at a time, really helps if you can tell us, particularly on technology. Because we tend to invest once, and the speed of change is much faster than we usually anticipate, and so you end up with equipment that is out of date pretty quickly if we don't have at least some way of thinking proactively about what you might need going forward.

Ms. ARIAS. Thank you for that invitation.

And we are working on a long-term plan that includes all of that, and so we are building as we go along the way. Part of that plan is doing what we have not done as much before, and that is working with the private sector where those advances are really showing up and introducing them into public health way before we are doing now so that we don't fall behind in the way that traditionally we have done.

Mr. COLE. And this is directed to you, Dr. Redfield. And you know, I don't want to ask you to make a judgment here. We have the system we have. But I am struck, honestly, that was one of the

things I learned when I was chairman about how heavily States and locality are absolutely dependent on CDC.

And again, I want a robust partnership, and I want that. But I don't want people to think that there is not a role here for States to actually step up and do a little bit more and localities to do a little bit more. I mean, in my own State, the lack of investment here. So I am not throwing stones at anybody else. I will just pick my own home, and you are providing 60 percent of the healthcare budget or the public health budget, excuse me, for the State of Oklahoma. That is something we ought to be worried about as Oklahomans as well.

And we shouldn't be waiting around for the best equipment, the best ideas. You could give template advice, but we need to do a lot more in this area across the board, don't we?

Dr. REDFIELD. Yes, I agree with you. I also just want to add because, you know, we are all impacted by the degree of preparedness of any State. So if we have one State that is underprepared, we are all underprepared. If anything, I would have loved—and the State of New York is great. They have got a great lab. They have stepped up. They are actually doing their own—they got their lab tests going up. So it is not just CDC now. At the State level, it is CDC and the State develop their own.

Well, I would like every 50—I would like all the jurisdictions to be able to bring up their own tests just so we could have a race and who gets the test as quick. So this goes back to that core investment in public health.

Mr. COLE. A point well made. Let me ask you this, and again, I want to be careful for two reasons. I am going to ask you two related questions. The first one does relate to China, and look, I recognize the delicacy of your position here. We have got to work with China. This wasn't the best result, but it was better than we have seen in the past.

So, but hopefully, there is some candid discussion going on with them. I mean, not letting our folks in as rapidly as they should have, I think we could have been helpful to them, and it certainly would have been helpful to us.

And this kind of closed system does invite, you know, it puts—one out of five people on the planet live there, and they can't just put everybody—I am glad it is coming down where they are at, but it is going up every place else now. A more rapid response from them would have made a big difference to every place else in the world.

They have a special responsibility. They are a super power. They have world-class science, and they have very capable people. So I would just—what are you doing to invite them to sort of integrate themselves more fully into the World Health Organization?

Dr. REDFIELD. Congressman, we have had more than a 30-year cooperative relationship, and the reason it is called CDC China, it was built by CDC America. I actually have a small group of individuals in CDC China, and you will see in my global health footprint plan, expanding that is part of it, at least in China.

We did offer directly to provide amplified assistance to the outbreak back in early January. Our CDC colleague, my counterpart actually requested and wanted that. It had to go up through higher

channels, and that was not done until the WHO did the GOARN report where we did have one CDC individual and one NIH individual from the United States on it.

But we do believe we could have been very helpful early on, and it would have helped us in our own policy decisions.

Mr. COLE. Exactly. And I will just make this plea, and I am out of time here. This isn't directed at you or your counterparts because I suspect they wanted to do it. This is a discussion that needs to happen between our political leaders and their political leaders.

This was a matter of global—it is actually an area we should be able to cooperate with one another on, probably help the overall relationship. So I just hope it is on the radar screen of our State Department and our President as well. They need to have this kind of conversation privately. We are not trying to embarrass our friends or anything else.

But again, they are a big part of the solution or a big part of the problem. They can choose to be one or the other. I know that all of you have urged your counterparts to do that, and I suspect they would want to do that. Those are professionals. They dedicate their lives to defending people just like you do.

But this is one where the political leaders need to get involved, I think, for the good of all. So that was my sermon, Madam Chair.

Ms. DELAUBRO. Taken to heart. Congresswoman Lowey.

Mrs. LOWEY. Thank you very much.

The vaping epidemic, as we know, is a public health crisis that must be met with every level of government. That is why the CDC's Office on Smoking and Health is so crucial and why Congress provided an increase of \$20,000,000 in the fiscal year 2020 bill so all levels of government can have the resources to combat vaping before we lose a generation of children to the harms of nicotine addiction.

Last year's vaping-related respiratory illness resulted in at least 64 deaths, nearly 3,000 hospitalizations. And we know that many, but not all of the cases were attributed to Vitamin E acetate.

Dr. Redfield, why can't the CDC say with certainty what caused these illnesses? Do you consider vaping, regardless of the existence of Vitamin E acetate, to be a risk to public health? And my key question, are you concerned that compromised lung health could exacerbate risk for those who contact coronavirus?

Dr. REDFIELD. First, the last question is yes. The first thing, I, like you, learned about this from my grandson, who told me I was the CDC Director, and I needed to stop it because he has a brother with cystic fibrosis.

I would like to have Ileana tell you more and then answer anything that she didn't clarify.

Mrs. LOWEY. Great.

Ms. ARIAS. Sure. Thank you for the question.

Anything that can actually go into somebody's lungs through vaping or anything else is of concern to us. Vitamin E acetate is part of that. We are concerned that we have shone the light on that, and that may go away, but other things are going to take its place.

So one of the things that has become very, very important for us to do is make sure that although the response has been—the activation for the response has been ended, the activities continue. And especially the surveillance activities, looking at what kinds of symptoms people are presenting in emergency room departments and what is it that they are using in those substances that may be related to that? Like we were talking about before, to catch it before it gets to the point where we were with Vitamin E acetate. So that is continuing.

In addition to that, we are continuing to work on making sure that we understand how it is that adolescents, we are not adolescents anymore, and how it is that they are thinking about these substances, which is very different from what adults think like. And then make sure that we reach out to them and make them understand the choices that they are making and try to redirect their choices so they can make more healthy choices. So that not only continuing the progress that we have made with adolescents on combustible tobacco, but that we are replicating that for vaping as well.

Mrs. LOWEY. But you know it is not working, and you know because I have been to college campuses not only with my own grandkids, but I even met with the president at one of them, and I said what are you doing? And Dr. Redfield, as you and I discussed, I learned about it from a grandchild who told me—this was before she was in college, must have been 5 years ago. And she was upset because she was saying 65 percent of fifth and sixth graders. I mean, these are crazy statistics.

Do you think perhaps now that we know it can be connected with coronavirus, maybe that will shake them up?

Dr. REDFIELD. You know, this is a very important priority for us and Dr. Arias and the team is the bigger picture of adolescent nicotine addiction. When the decision was to take flavored products off, menthol was not taken off at that point in time. And we are tracking very carefully to see if now underage are shifting, and we are going to really be seeing the data. We have gotten a commitment if we have evidence that somehow adolescents are shifting now to menthol, then we will put that public health evidence back up for action and from the regulatory perspective of the FDA.

But my biggest concern, as is yours, mine were actually in middle school and telling me 50 percent of their class was using e-cigarettes on a regular basis.

Mrs. LOWEY. Well, let me, since I have 46 seconds left, you know it, I know it, our grandkids know it. And so far they have been reporting rather than talk about the impact themselves. They are reporting what is happening to their friends.

Are we making any progress? Is anything we are doing working? I hear the statistics are the same, whether it is in junior high or now in college. They are all vaping.

Dr. REDFIELD. Anywhere in the country, man or woman, any age, it is all the same.

Mrs. LOWEY. So what are we doing, anything?

Ms. ARIAS. So it is increasing, and as you know, when things are increasing, it is very hard to start turning them around. And it is going to be a while before that starts to happen. However, what we

are doing is focusing on things that have been effective in terms of communicating and how it is that adolescents understand those communications in order to understand that, no, don't just look at the pretty colors on the package, which they respond to, think about what is inside the package, even if the packaging doesn't change.

And then, of course, there is what other sister agencies are doing in terms of regulation that are going to make it a little bit easier to sort of control the environment so that they basically are protected from that side as well. But a lot of it has to do with finding out why they are using it, how they are using it, and how it is that we can get them to stop.

Mrs. LOWEY. We showed progress—

Ms. DELAURO. Five minutes is up.

Mrs. LOWEY. But I would like to pursue this, Madam Chair, because we are talking about it. Everyone is concerned. You are concerned. You are concerned. I am concerned. But we failed. We haven't done anything. We are trying to do something, but we are not successful.

Thank you.

Ms. DELAURO. Ban it.

Mrs. LOWEY. Right.

Ms. DELAURO. Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Dr. Houry, the fiscal year 2020 final appropriation included \$10,000,000 for the first-ever dedicated funding for suicide prevention at the CDC. And as you know, there are unique populations that are at higher risk for suicide, such as Latina adolescents, veterans, and nurses.

I am co-chair of the Maternity Care Caucus along with my colleague Jaime Herrera Beutler, and I am particularly interested in recent statistics that indicate suicide may be a significant contributor to the unacceptably high incidence of maternal mortality in this country. Can you speak to the connection between postpartum depression and suicide etiology and tell us what efforts your center is leading to track and address this problem?

Dr. HOURY. Certainly, I can start and then turn it over to my panel if anybody wants to add to it. With regards to suicide, the \$10,000,000 appropriation we are going to fund applicants to look at data within their communities to identify who are the most vulnerable and which communities have the highest risk, really rates, and then work with them to focus effective interventions on those areas.

So it might be rural populations. It might be veterans. To your point, it might be young mothers. And to then really look at some of the evidence-based, community-level strategies to drive that.

With regards to maternal mortality and suicide, I believe it is about 6 percent of maternal deaths that are due to suicide. We do know that the age of 10 to 44, I believe it is the fifth leading cause is due to suicide in that group. So we do see that that is increased age for suicide deaths, but we are really focused on primary prevention of suicide deaths, things like making sure that there is good programs in schools around social, emotional learning, that we are improving connectedness, and if those are at risk for suicide, make sure that they are linked to care.

Our Vital Signs found that more than 50 percent of people who died by suicide did not have a known mental health diagnosis.

Ms. ROYBAL-ALLARD. Can you tell me if you are coordinating your efforts with other agencies on this problem, such as SAMHSA and the Veterans Administration?

Dr. HOURY. Very much so. And we have been working closely with the VA around some of the veteran-serving organizations to look at things like why are some veterans not accessing VA when they are having suicidal ideation to look at what we can do more in the community?

We also work closely with SAMHSA. For their Mayor's Challenge, we went out and talked about our technical package and some of the strategies that were done at CDC to really help cities really implement those strategies.

Ms. ROYBAL-ALLARD. Dr. Arias, over the last two decades, we have seen significant gains in the life expectancy for people living with spina bifida, with adults who are living into their 60s and their 70s. This creates new challenges because when young adult patients age out of pediatric care and the National Spina Bifida Registry, there is no system in place to follow and care for them.

The CDC's spina bifida program has been flat-funded at \$6,000,000 for the last 6 years and is currently down 2 staff members. Do you have concerns that progress and investigation into critical lifesaving issues, such as the cause of sudden death in mid-life and prevention of sepsis-related morbidity are possible within the current staffing structure?

Ms. ARIAS. We are working within the confines of the resources that we have to address these issues. It has been significantly difficult. I think that we need support in order to branch out and address the problem in its full complexity.

So right now, it has been very limited in the kinds of things that can be done. It is not just true of spina bifida, it is true of other conditions as well, such as Alzheimer's and multiple sclerosis and other kinds of things that have been very difficult for us to make as much of an impact as we think we can because the resourcing really hasn't be there, and we have had to work with what it is that we have.

A lot of that means measuring it. A lot of it is getting information to the extent that we can about either prevention, but in most cases, sort of managing. And then a lot of information, which is we are getting more—more requests now for dealing with the caregiving community in each of those situations.

Ms. ROYBAL-ALLARD. Well, then what funding level would you need to ensure that the National Spina Bifida Program covers the lifespan of individuals living with the disability, and what are your plans to track people as they age out of the pediatric system?

Ms. ARIAS. So we have been working on a plan sort of looking forward where it is that we need to go, and we can get information to you about what that plan would look like and then what would be necessary in order to support the implementation.

Ms. ROYBAL-ALLARD. In terms of the resources. Thank you.

Ms. DELAUBRE. Congresswoman Frankel.

Ms. FRANKEL. Thank you again for being here.

You would agree that this is not a time to cut any of our global health budget?

Dr. REDFIELD. As I said, I think one of the most important things we need to do is to build a robust long-term foundation of global health. I think CDC is the tip of the spear, and I think this is a time to get that foundation built across that.

Ms. FRANKEL. All right. So the answer is, yes, we should not cut—or no, we shouldn't cut. Or yes, we shouldn't cut. The answer is, yes, we shouldn't cut the global health budget.

Are there enough—I don't know if I want to ask this, but are there enough masks now for our first responders and our healthcare workers? And if not, where do we get them?

Dr. REDFIELD. We can—again, this is something that ASPR is in charge of looking through and making those calculations. So we can get back to you, but I refer that to ASPR.

Ms. FRANKEL. So I have a couple practical questions. So I have an older—my mom is actually older than me. That is obvious, okay? [Laughter.]

Ms. FRANKEL. She is healthy, knock on wood. She was supposed to go to the doctor for a checkup. Now she says she is afraid. She says I am not going to go for a checkup. There could be a room of sick people.

Of course, it is a room of sick people. What do you say to that?

Dr. REDFIELD. I think your mother has a lot of wisdom, okay?

Ms. FRANKEL. I always thought that. Okay.

Dr. REDFIELD. Unless she really has a requirement to do things right now, we are trying to get the elderly and vulnerable to kind of just step back and try to avoid being in crowded places, avoid travel. This is where we are right now.

Ms. FRANKEL. Okay. Got it. Another practical question. So we are told to wash our hands, all that. Don't touch our face. People are coming in contact, even ourselves, with our clothing, with our furniture, and all that. Is it spread that way?

Dr. REDFIELD. Congresswoman, that is a very important question. This virus clearly can live in the environmental surfaces for some period of time. With the ship in Japan, very aggressive studies are being done to see how much virus they find on railings and different places.

Finding the virus doesn't mean it is infectious, but we can detect this virus for prolonged periods of time on surfaces. And the role that we call fomite transmission is still unknown. That is why it is important when you put your hand on the handrail as you are walking down, you probably need to wash your hands afterwards. You don't think about it.

Ms. FRANKEL. Well, what about if you put—you touch the handrail, and then you touch your clothing, but you can wash your hands, but you can't wash your clothing.

Dr. REDFIELD. It is probably more touching the rail and putting your hand to your face.

Ms. FRANKEL. Okay. All right. So is the information coming from the World Health Organization reliable?

Dr. REDFIELD. I would continue to say the World Health Organization is a very well-respected public health organization.

Ms. FRANKEL. So as right now, can anyone go to the doctor and get tested for coronavirus, or do we still have a delay in having enough tests for that?

Dr. REDFIELD. As of—let us see, I don't even remember what today is. Is today Monday? Yes, Tuesday.

Okay, as of Monday, Quest labs and LabCorp labs have made this test available in doctors' offices. Like when you go to the doctor and you get your blood drawn, the test isn't done there. It is done by LabCorp or Quest, and now that same thing can happen if your doctor wants to order a coronavirus test.

Ms. FRANKEL. And I want to just go back, this is another common sense question, though. It seems to me that some of the reasons, I mean, not shaking hands, washing hands, self-quarantining is not just about not getting the coronavirus. Well, it is about that, but the fact is we don't want everyone to get it at the same time because we can't take the stress on the healthcare system or the stress on the economy. Is that right?

Dr. REDFIELD. Yes, and we don't want them to get it the same time they are getting flu. You know, unfortunately, this virus is very similar in the sense it is a respiratory virus. So if you look at hospital capacity right now, much of it is full, up to 95, 96, 97 percent. So we really don't have a lot of resilience in the capacity of our health system.

Ms. FRANKEL. Are there test shortages in any other part of the world? Do we know? Are there test shortages in any other part of the world?

Dr. REDFIELD. I don't know exactly, but I can tell you, obviously, in areas like Sub-Saharan Africa where they have really underdeveloped health systems, clearly they have been spared right now. The reason for that is unclear. If it is seasonal, obviously, we are going to have some challenges.

And more importantly, the most important, you asked me medical interventions before. The one medical intervention you need if you go into the hospital is oxygen, and there are many health systems who don't have the capacity to deliver oxygen to its people.

Ms. FRANKEL. Is that in this country?

Dr. REDFIELD. It is not in our country.

Ms. FRANKEL. But in other countries. Thank you, and yield back.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Thank you very much.

I apologize, I had to step onto the Ag Committee. So if this is redundant, I will ask what the answer was. In terms of pandemic versus epidemic, has anyone asked that question, and where are we in terms of describing this emergency?

Dr. REDFIELD. I said it is really the word is not that important. This is a major global outbreak, but the WHO is usually the organization that formally declares something a pandemic. But clearly, this is a widespread global outbreak.

Ms. LEE. Let me also ask you about sickle cell, the sickle cell trait. It has been estimated and CDC estimated that over 4 million Americans have the sickle cell trait, and the incidence of sickle cell trait in newborn screening was found to be about 7 percent for overall black births and about 1 percent for Hispanic births.

Now are there any standard methods, and I have been trying to get to the bottom of this for 20 years, standard methods of protocols for alerting families or healthcare providers to the presence of sickle cell trait, educating them about the potential health outcomes that might be associated with the trait or counseling them about the impact that trait status might have on families' future reproductive decision-making?

I ask this because once a child is tested at birth, by the time they are 18, they are 19, I mean, who knows if they know or not whether they have the trait. And I have personal examples of that with regard to the interaction between the A1c test and sickle cell trait. If you don't know you have the trait, the doctors aren't required to test for the sickle cell trait if you are from the specific target population.

So how in the world do we deal with this? Because it is really a problem.

Ms. ARIAS. So we can send you information about the sickle cell program at CDC. A lot of that work is done in conjunction or in partnership with providers and with the healthcare community to make sure that they get that information to families and point out resources that are available to them.

Dr. REDFIELD. And you can see that as we operationalize this data modernization and predictive analysis for the whole Nation, we could actually have data that actually could be in a system that the public health system of this Nation could have access to.

Ms. LEE. So why when an adult gets a blood test, if this adult is of a specific population, why isn't part of that panel a test for sickle cell trait? I mean, you know, if I have the trait at birth, at 20, if I am getting married—or at 25—there is an issue there. And I don't even know I have it.

Ms. ARIAS. Sure. I mean, I can get back to you and find out if there are—what are the systemic things that stand in the way of that happening. A lot of it probably—I would imagine a lot of it has to do with the fact that it is known at birth, the assumption being that that is known to the individual, and there is no point in—but you are right—

Ms. LEE. How is it known? If it is known at birth, how do I know at 18 or 20 or 30—

Ms. ARIAS. No, you are right.

Ms. LEE [continuing]. That I have the sickle cell trait?

Ms. ARIAS. The assumption is that if it is part of the birth record you have it, but you are right. It is an assumption.

Ms. LEE. Please, there is nobody in this country, I guarantee you, who is an African American who knows that they have the sickle cell trait based on birth record.

Dr. REDFIELD. We will definitely get back to you. This is something we need to address.

Ms. LEE. Thank you very much.

Now let me just ask you, going back to the REACH program and the whole issue of health disparities, which my friend Congressman Cole raised in terms of just the budget. The REACH program has been really a critical program in eliminating racial and ethnic disparities. But it has been eliminated from the budget again, and I

heard your response in terms of how you are going to make some moves within the CDC.

But with this budget eliminating—being eliminated in the President's budget, I don't think you can compensate for addressing racial and health disparities. You indicated some kind of moving, you know, the aspects of the program around to address this in terms of not disease specific, but you know, community specific or whatever. But this is unacceptable. When you look at people of color, when you look at the Native American community, when you look at every community in this country that exhibits health disparities based on race or ethnicity, to eliminate this program is, to me, unethical in terms of health and medical standards, and it is a shame.

And so are you all weighing in on this? Is CDC saying this is not a good healthcare decision, a good decision to make? Public policy decision?

Dr. REDFIELD. What I can say, I think you all know that we are constrained right now in this environment. That is why I have tried to put so much focus on core capability. It is going to help all programs. All programs, including the health disparity programs, by building this public health capacity.

I do believe the block grant flexibility will give local communities to be able to invest the money they want, and you know, but we are—we are not turning our eyes off to the health disparities of this Nation. And we will continue to try to navigate how we can continue to address those.

Again, I am going to come back, I have done it multiple times. I do think the core capability that goes beyond CDC, but to all the public health structures that we have at State and local, tribal and territorial, that gives enormous ability for these public health departments to function in multiple areas, including health disparities.

Ms. LEE. Yes, thank you very much for that response. But unless directed by the Federal Government with some major protocols in place, with some major research in place, with some major investments by our Government in terms of the REACH program, we are going to be set back.

And thank you, Dr. Redfield.

Ms. DELAURO. Thank you.

I have an additional question, and I know the ranking member does, and then we will hear from the ranking member to close, and then I will close up.

This is about global health security, Dr. Redfield. And you just mentioned Africa, and I just got an email again from my dear friend who was the former Health Director—Health Commissioner in South Africa, the Shadow Commissioner, just said that they now have the first cases in South Africa.

So these are my questions because the viruses don't have borders, and Africa can easily be overrun. What is CDC and global partners doing to assess the risk for immune-suppressed clients with HIV and other infectious diseases? What resources are available to support diagnosis and clinical care? And can this be scaled up with other partners?

Is CDC able to send health specialists to support the Africa CDC and its regional collaborating centers? We provided \$600,000,000 in the past. In the supplemental, we include \$300,000,000 for global health. If you could just answer those three questions?

Dr. REDFIELD. Thank you very much, Chairwoman.

Clearly hit on one of the real concerns in Sub-Saharan Africa in general, obviously, how immune-compromised individuals are going to react to this virus. One would predict it would be more likely to cause more severe illness.

And in Africa, that obviously causes the other problem because more severe illness needs greater likelihood of dependency on oxygen, and many of these nations don't have that capacity to the degree they may need it.

We have, from the beginning, and as you know because of the PEPFAR program, CDC has country offices all through Sub-Saharan Africa. We have them providing technical assistance to their counterparts in the countries they are.

We have worked with actually the Director of the CDC Africa, who is actually a CDC colleague that has gone on loan to the—or actually is now hired by the African Union. He is one of our best. We have helped him build testing capacity. So there is testing capacity now in West Africa in the African CDC in South Africa.

But Africa is a great vulnerability, right? It has been one of my biggest concerns on a global scale because if this virus gets into Africa like it is into Italy, there is going to be a lot of casualties.

Ms. DELAURO. Let me yield to my ranking member.

Mr. COLE. Thank you, Madam Chair.

Obviously, we have talked a great deal about the coronavirus, healthcare security, and I will get to that in my close. But I actually want to shift to another area that—and this would be addressed to you, Dr. Houry.

Probably when I am home, before all of this, I hear more about drug overdose deaths than any other healthcare crisis. More family, more people affected. Obviously, I suspect the death toll there this year will be worse than anything we see in coronavirus. It is just year in and year out.

Finally, last year we saw it come down a little bit, first time in 28 years. Congratulations for some of the great work at CDC to help us in that area. But going forward, what can we do, and where do you need additional help? I have seen different—it is not always opioids. There are different now substances that seem to be more common even.

So give us some view of this emerging—or this continuing problem and what we ought to be doing as a Congress to try and provide the resources to help our fellow Americans in this area.

Dr. HOURY. Absolutely, and thank you for that question.

What I would say is the resources that we have received from Congress have really helped us build that infrastructure. We are now able to collect syndromic surveillance data, and with our current grant, we actually added in a category to look at meth and other psychostimulants because we didn't want to be 3 years later when our grant was over saying what is going on with the trends? So we are able to really pick up that in more real time.

We also realize that linkage to care is really important. So we have built that into our current programs as well, in addition to what more can we do to help health providers? For the past 15 years, I worked in the county ER and have really watched this evolve, and that is one of the reasons why I came to CDC was because I knew it was not just about the individual patient, but what can we do at the population level?

I still work in an MAT clinic once a month just so I can see that integration of the CDC successes that we are doing with things like electronic health records. We are now, as you mentioned, seeing that surge of methamphetamine and other substances.

What I think is important is not to lose sight of how we got here. We need to look at the whole range. We are starting to see a decrease in high-risk prescribing, but still many of the people who go on to use other drugs got started with prescription opioids.

Many of the patients I see in clinic are wrestling with cocaine use now, but they are also wrestling with heroin. And we can treat that with MAT. So having that linkage to care is still crucially important.

And then looking at vulnerable populations like tribes. We are working closely with many tribal organizations and giving direct funding to tribes this year, and groups like the Cherokee Nation in Utah have really been able to integrate prescription drug monitoring programs now so we can identify those high-risk patients and link them to care to prevent them from having overdoses.

Mr. COLE. Dr. Redfield.

Dr. REDFIELD. I just want to add one point. I really think it is important to aggressively engage in innovation here. This is a chronic recurrent medical disease. It should engender the same aggressive research that we are doing to get new cures for cancer or new cures for heart disease.

This is going to be a medical disorder that will have effective therapies. We have them now that are a little bit for opioids, but we really need to have effective therapies at all to recognize this as the disease that it is.

This is not a behavioral choice. This is a medical condition that needs that innovation, that medical research. Private sector has got to get engaged, develop the same passion that they have for cancer cures that they do have for addiction cures.

Dr. HOURY. And I would just add to that, too, as we look at the full picture of substance misuse, looking at what led to that misuse in the first place and primary prevention such as the funding that you all gave us for adverse childhood experiences when the childhood trauma can lead to suicide deaths and overdose deaths. So really looking at that linkage and the whole spectrum is really key.

Mr. COLE. Terrific. Thank you very much, Madam Chair.

Do you want me to go ahead and close?

Ms. DELAURO. Yes.

Mr. COLE. Okay. Well, first of all, I want to thank all of you. I thought, frankly, the last exchange a splendid example of why we all admire you so much because of your commitment to our fellow Americans and all humanity in the search for cures and defending people and therapies. It is an extraordinarily noble profession that you are all engaged in, and we appreciate what you do.

We, I hope, have made it very clear not to you, but to the powers that be that we intend to continue to make these investments on a bipartisan basis. And I will just say to my friends, and they are my friends, at OMB, and I mean this with no disrespect. When somebody in Congress tells you and when they tell you on a bipartisan basis we are going to spend money in these areas, you can either help us figure it out by letting your people to work with us. Okay, where does the money make the most difference? Or not. But we will do it anyway.

So it is just much better. And again, I have had that discussion when I was chairman. I am sure the chair has had that discussion as well. This is just something Congress has decided to do, and it has decided to do it in a pretty substantial way over multiple agencies—NIH, CDC, Strategic Stockpile, mechanisms that help you sort of get into the fight as quickly as you possibly can for all of our benefit.

We all agree—I agree very much with my chairman. This isn't a Republican or Democrat thing at all, and we have just made that collective decision. It is not triggered by this particular event.

As a matter of fact, this event is sort of vindication of the bipartisan judgment over the last several years that this was really an area we needed to make investments, and we want to work with our best people that we think are in these agencies in a very collaborative way so that we don't make mistakes.

So that is not—your requirement is to come and do what you all do, and that is defend the presidential budget. But I would just submit for the record that administrations would be a lot better off had they listened to us several years ago in this area. And we would all collectively be better off, and I hope we all learn a lesson from that. You know, there are some things to be—have a very sharp pencil about and a very keen eye.

And look, I am a conservative Republican. There are other areas where you really need a substantial public investment to protect the American people. I think this is this area probably more than any other single one, although there is certainly a range of activities that we are involved in. But here, we are literally talking about the health and well-being of people in a very individual way, in a very immediate way, and in a way that can come out of nowhere when you least expect it, that something like this has happened.

So I think it sort of has been the collective wisdom of Congress over many years. Again, it was Congress that doubled this NIH budget, and I will tell you, just as a member here, you learn more over sitting through these hearings. I mean, they are very helpful. Appreciate it when you guys come up here. You learn a lot.

I have had the opportunity to go down and visit CDC on a couple of occasions when I was chairman. I learned a lot just sitting down and talking to people and getting an idea of the range of capabilities, and I think we all reflect that over time.

So I want to thank the chairman for the hearing, first one, as she said, since 2016. It is certainly very timely, Madam Chair. But more importantly, I just want to thank my chair for the bipartisan commitment here. Because this is not something that is likely to go away, and I think that is something, again, I hope the executive

branch realizes over time, regardless of who is there. This is a kind of enduring commitment.

And so there is no sense sending us a budget that cuts things that we are not going to cut and doesn't work with us in areas where we want to make investments, but recognize that you have enormous expertise at your institution that we ought to be listening to as we fashion what those investments are going to be.

So we look forward to working with you and continuing this. I wish you very good luck, all of us very good luck in dealing with the coronavirus right now. I suspect things get worse before they get better in this area.

But at some point, they will get better, and at some point, we will turn the corner. But I hope the lessons learned here are enduring lessons. I have no doubt they will be for this subcommittee because they have been. But I hope they are for the American people as well.

I mean, we take a lot of things for granted around here. These are investments that matter. These are investments if they are not made for years ahead of time can't be sort of parachuted in at the last minute. We can't make the difference without a sustained plan for investing in what each and every one of you do.

And Madam Chair, you had that commitment for your entire career. So I appreciate that very much. We are very fortunate to be led by you at this particular time.

Yield back.

Ms. DELAURO. I thank the gentleman, but I am fortunate, which is why we have been able to produce I think quite remarkable Labor, HHS bills over the last several years. There is a compatibility here that I think at the outset someone would say, well, it is not going to work. But because of the competence and professionalism and deep compassion and caring, the values of the ranking member and our ability to work together, yes, there are differences, but those differences don't cloud the goals and the challenges that we see.

And you know, it has been in the past history of this country that Members on both sides of the aisle that crafted the responses to the serious challenges that we have had, they were not naive, but they understood that the challenges were that great that from wherever you come from, that our obligation and our responsibility is to see that we address this issue. And that is the kind of cooperative relationship that I find on this committee with my ranking member, and I think it is true with the subcommittee as well.

So I thank you for being here very, very much to all of you. There are a couple of things. I did look up PEPFAR, which has been so critically important, and that has been cut by half. We will address that issue as well.

On the vaping issue, Dr. Arias, the fact of the matter is, is that e-cigarettes never had an FDA approval, which is why I made my comment on ban until we know. I want to go on science. That is, you know, stop it until we figure out whether or not and who, where we go for.

I would just ask you, Dr. Redfield, because you talked about the masks, and I say this to the ranking member, what I heard yesterday was that, yes, 3M, it is 35 million. It is 4 million in terms of

the hospitals or public health workers. But 31 million is for the commercial sector, but it is only 4 million because that is all the insurance that 3M has.

And without some notion of indemnification or so forth, we need the strength of the administration to say get more insurance and let us move forward with what we need for the public health. And that is something that I am asking to do. It is wrong to stop because—at 4 million because we can't get this.

And then, there is no answer to this, but I don't know for the life of me who is monitoring the self-monitors, you know, who are out there and what they are doing. And that is a hard task. If you want to say something about that, go ahead, and then I will wrap up.

Dr. REDFIELD. I only say one word because we did this with the Ebola outbreak a number of years ago, and you know, it is just heartening to see the cooperation of the American public when they understand what we are asking them to do. I think about 97 percent of them basically did what they were asked to do. Not everybody, but it is heartening to know the American public when they understand, that they will, in fact, abide to these clear instructions.

Ms. DELAURO. And again, thank you very, very much. You heard the concerns of—you know, there are serious concerns. We will keep asking the questions. We want to make sure that the statement is accurate that anyone who needs a test gets that test immediately, and we can allay fears.

The crisis is here. We know that. We are all dependent on the strength of our public health infrastructure. If we are not strong, you said it. If we are not strong in all 50 States, we are not strong. Let us help you with the core capabilities, and I wrote those down. Rapid response, predictive analysis and data modernization, global health security, and a public health workforce that is second to none.

We want to do that, and please let us know, because you know you have listening ears here to what you need, and we want to get you where this country needs to go during this crisis.

Thank you all very, very much for being here this morning.

We bring this hearing to a close.

Dr. REDFIELD. Thank you very much, Chairwoman.

WEDNESDAY, MARCH 11, 2020.

NATIONAL LABOR RELATIONS BOARD

WITNESSES

JOHN RING, CHAIRMAN, NATIONAL LABOR RELATIONS BOARD
PETER ROBB, GENERAL COUNSEL, NATIONAL LABOR RELATIONS BOARD

Ms. DELAURO. The subcommittee will come to order. My apologies for being late to both of you and to the committee, staff, and to my ranking member. We are in the throes of trying to do something for the economic benefit for people, given the public health emergency crisis we have with Coronavirus.

So, good morning to you, Chairman Ring and General Counsel Robb. We welcome you to the subcommittee and thank you for joining us to testify this morning. I might add this is the first hearing on the National Labor Relations Board in 5 years. And today what we are doing is examining the NLRB's budget for 2012, a proposed 10 percent cut of \$27,000,000.

To start, let me just say that after years of flat funding, it is my sincere belief that the NLRB needs more resources and not cuts. Although this is a budget hearing, it is also our duty to conduct oversight of the resources this subcommittee provides to your agency and I, in full disclosure, have serious concerns that I will address today.

2020 marks the eighty-fifth anniversary of the National Labor Relations Act, a landmark law that has secured freedom of workers to represent themselves in the workplace. And the Congress designated the National Labor Relations Board to defend it.

The NLRB's role is to ensure that workers can form or join a union, be represented by that union in collective bargaining, and be free from retaliation from doing so. These are basic rights.

Sadly, I believe that the administration has been undermining protections, unions, and workers, and the NLRB has taken every opportunity to dismantle workers' rights to organize. And now, let me recount some of what I believe are some of the Board's most egregious rulings and regulatory efforts that seek to deny labor protections for thousands of workers, including the SuperShuttle decision where the Board permitted its employees to be misclassified as independent contractors on the grounds of "entrepreneurial opportunity" despite the fact that these drivers had non-compete clauses, totally undermining any entrepreneurial opportunity. This is about, in my view, denying benefits.

The proposed graduate student rulemaking where the Board seeks to strip students of their protections under the NLRA when they perform work for the university. Between 2005 and 2015, the number of graduate-teaching assistants grew by 17 percent, where-

as, tenure-track faculty grew by only 5 percent. The increased reliance on student workers is clear, as is the NLRA, which does not include students in its statutory exclusions.

The Board's new joint-employer rule, which makes it easier for unscrupulous companies to sidestep their legal responsibility to bargain with their employees by hiding behind contractors and subcontractors.

And I have to ask, do you believe the NLRB is advocate for corporate interests?

I will quote from Health Committee Chairman Lamar Alexander who implored the Trump-Board nominees to quote, this is a quote, "Restore the Labor Board to the role of a neutral umpire in labor disputes after years of the Board acting more like an advocate."

And I think it is important in this respect to quote Section 1 of the National Labor Relations Act which says that it is the policy of the United States to encourage the practice and procedure of collective bargaining and to protect workers' rights to unionize for the purpose of collective bargaining. That is what the Agency's requirement is.

We have had 6 major rulemaking procedures, 20 reversals of significant precedent. There should be on both sides of the aisle an outrage at what an advocate for corporations that the, what I view as anti-worker Board has become.

Mr. Ring, Mr. Robb, I also have to address the alarming ethics and what I view as mismanagement issues happening under your leadership. 2017, the Board, including Board Member William Emmanuel, overruled precedent established in the Browning-Ferris decision on joint employment. This was a major victory for business corporations looking to shirk their labor law obligations. Mr. Emmanuel participated in that decision even though his former law firm represented a party in Browning-Ferris. Ultimately, the Board's designated agency ethics official concluded that Mr. Emmanuel had a conflict of interest and should have recused himself from the case.

Mr. Ring, last year I expressed serious concern to you about the procedures that were in place for board members to assure case decisions and rulemakings are compliant with all ethics standards. You assured me that you were hard at work to restore our confidence, but sadly your November 2019 ethics recusal report falls far short. Instead of showing that your Board has learned from prior mistakes and intends to do better in the future, you declared that a member like Mr. Emmanuel can, quote, insist on participating in a case, even when the agency ethics official finds a clear conflict of interest; meanwhile, you would have the Office of Government Ethics adjudicate whenever the member disagrees with the ethics official, but they have subsequently asked you to revise the report to clarify that members do not have a the right appeal their disagreement to OGE.

The director of the Office of Government Ethics rebuts your report and he wrote, and I quote, I am very concerned that portions of the report characterize ethics requirements and processes in ways that could be misconstrued.

Mr. Robb, another area of concern is the Agency's mismanagement of federal funds and its hollowing out of the regional offices.

Under your watch, the NLRB let \$3,000,000 expire in 2018 and \$5,700,000 expire in 2019, 2.1 percent of the Agency's total appropriation; meanwhile, since Fiscal Year 2016, your staff have declined by 17 percent. Multiple regional director positions remain unfilled.

Mr. Robb, you are really frittering away resources that Congress provided for you to enforce the National Labor Relations Act and this committee would like to get to the bottom of it. At its best, in my view, it is mismanagement, which we have condemned, and I might add on a bipartisan basis. At its worst, it is a disregard of congressional and constitutional authority and the result is that working people are hurt. Their rights, their protections are undermined. We have seen regional offices understaffed. It makes it harder for workers to secure protection of their collective-bargaining rights when they file unfair labor-practice charges.

I was grateful to work with Ranking Member Cole and my Senate colleagues in the bipartisan Fiscal Year 2020 labor HHS bill to include language that addresses significant underspending on personnel costs by directing the Board to expand the number of regional staff beyond the amount that were onboard at the end of Fiscal Year 2019.

We intend to learn how your Agency is planning to comply with this directive and I might add, and as you know, I have joined with Senator Patty Murray to ask the Government Accountability Office look into this troubling issue. Deliberate underspending on personnel costs and mismanagement of the Board's annual appropriation will be taken very seriously as we draft the Fiscal Year 2021 appropriations bill.

It appears that the NLRB has become hostile to the well-being and satisfaction of its own workers, in fact, NLRB staff report some of the highest levels of disaffection in the Federal Government. So, the change needs to happen there and everywhere.

Facts on workers' rights are not serious attempts to restore jobs or to boost economic growth; instead, they are designed purely and simply to accelerate a race to the bottom. They can only do further harm to middle-class families who struggle every day to make ends meet.

We thank you for being here. I look forward to a robust discussion to get to the bottom of these issues and now I would like to yield to Ranking Member Cole for any opening remarks that he would like to make.

Mr. COLE. Thank you, Madam Chair.

And just housekeeping, first, if I may, I just wanted to advise you I will probably have to leave early for a hearing at Defense Appropriations, so thank you, again, for convening this hearing.

Good morning. It is wonderful, Gentlemen, to have you, Mr. Ring and Mr. Robb, both of you here and I want to thank you for coming. I look forward to discussing the Fiscal Year 2021 budget and other policy issues with you today.

The NLRB has long been characterized as a partisan and a political institution when it comes to issuing decisions, yet in recent years, over 80 percent of case decisions have been issued unanimously and in some cases like the joint-employer standard, the

Board is returning to longstanding precedent from numerous administrations. I certainly commend you for that.

The joint-employer standard under the NLRA is a matter of consequence because it determines whether a business is an employer of employees directly employed by another employer altogether. Under the prior decision, if two entities were joint employers, both would have to bargain with the union that represents the jointly employed employees and both would have been potentially liable for unfair labor practices committed by the other. Both would have been subject to union picketing or other economic pressure if there were a labor dispute.

Frankly, in my view, the franchise model has been the basis for many successful small businesses. Small businesses are the job-creation engine of our economy and in many cases, subcontractors are an integral part of this model and, quite frankly, in many minority communities, they are the most significant business owners in the districts and this has been a ladder of upward mobility, I think, for our population. So, I support the Board's recent decision on this matter. I think it was the right one and I commend you for it.

Finally, I want to share or raise another matter of personal importance to me, the National Labor Relations Act of 1935 recognized the right of employees to organize labor unions and private industry. All governments were excluded from the Act's definition of an employer. No government is covered by the Act.

For decades, the NLRB recognized Indian tribes' exemptions from the NLRA's jurisdiction as they are sovereign governments. Incomprehensible to me why in 2004 the Board asserted jurisdiction over Indian tribes after so much history and precedent; however, the House actually has twice passed bills, bipartisan legislation, I might add, to remedy that overreach. A majority of the United States Senate actually supported that. We just couldn't get to closure. We literally had 58 senators. So, I think hopefully over time you will recognize there is significant legislative support for looking at this decision, which I think was an egregious bureaucratic overreach and obviously long before either of you were on the Board and I would hope that, you know, over time, it can be reversed.

Finally, you know, while I share some concerns on the budget, I want you to know I appreciate you being careful stewards of budgetary matters. We have extraordinary demands on this committee. It is unusual when we see folks come and actually say, maybe we can do the same job with less money. So, it is welcome, because, believe me, there are many demands on the resources that this committee has allocated, so being able to direct some of them elsewhere is often a very, very welcomed thing and, frankly, something we do not see very much.

So, I look forward to discussion this morning and I yield back my time, Madam Chair.

Ms. DELAURO. Thank you.

And Mr. Ring, Mr. Robb, we are happy to place your full testimony into the record, but you will each be recognized for 5 minutes to summarize your statement and then we will proceed to questions and there will be 5-minute rounds for questions.

So, with that, Mr. Ring.

Mr. RING. Chairman DeRosa—I'm sorry—DeLauro, Ranking Member Cole and members of the subcommittee, I am pleased to be here today to provide you with an update on the work at the National Labor Relations Board.

I am happy to report that the Board has worked efficiently and effectively to carry out the important mission of the National Labor Relations Act. On July 5th of this year, the National Labor Relations Act will turn 85, as the Chairwoman had mentioned.

Like our predecessors who served on the Board over those nearly 85 years, the current board members take very seriously our responsibility to fairly and impartially enforce the Act. General Counsel Robb will update you on the side of the Agency he oversees, which includes our regional offices.

I would like to focus on the successes on the Board's side of the Agency, which includes the members, their staffs, the offices that support the Board's work. On the Board's side we have 148 employees, full-time equivalent, and the Board's funding allocation represents approximately 11.5 percent of the overall Agency's budget.

The Board's primary area of focus over the past fiscal year has been our case-processing effort. The Board instituted a pilot program to focus on enhanced oversight of case management and case-status transparency. We paid particular attention to issuing decisions in some of our oldest pending cases.

After only a year of this effort, I am pleased that our overall case-processing statistics for Fiscal Year 2019 reflect positive results. The Board issued 303 decisions in contested cases in Fiscal Year 2019. We reduced the median age of all cases pending by almost 33 percent and significantly reduced the number of cases pending by almost 20 percent to its lowest level since 2012.

These statistics are strong evidence that our efforts to reduce case backlog and ensure timely decisions for the parties are bearing fruit. Seeking to build on these successes, the Board intends to focus its attention on eliminating our oldest cases by the end of Fiscal Year 2020. We know that the purposes of the Act are not served by making parties or American workers wait years and in some years up to 10 years for cases to issue.

Another area of emphasis by the Board over the last year has been our rulemaking. Although the NLRB historically has made most of its policy through adjudication, the current Board believes that there are significant advantages to rulemaking. Rulemaking allows the Board to provide far more comprehensive and detailed guidance to our stakeholders in adjudication. Rulemaking also offers the opportunity for substantial input from the public and not just those who can afford a lawyer to write a brief. We have had significant public participation in our rulemaking efforts to date and the Board has found the input valuable.

I am pleased that we have issued, as was mentioned, our final rule covering joint-employer standard under the Act. Although the rule took us almost a year to complete, we considered nearly 29,000 comments and those comments allowed us to craft a very well-informed rule. The rule resource, as was mentioned, the joint-employer standard, the Board applied for decades prior to 2015 and it does so with a greater precision, clarity, and detail that rulemaking allows.

We are also engaged in rulemaking regarding the Board's current standards for blocking charges, voluntary recognition, the formation of 9(a) bargain relationships in the construction industry, and we also have ongoing rulemaking regarding standards for determining whether students who perform services at private colleges and universities in connection with their studies, are employees within the definition of the Act.

The Board issued a final rule amending the Agency's representation-case procedures, retaining some essential elements of the Agency's existing representation of rules, our final rule modified only sections, selected sections to create what we believe is a fairer and more-efficient election process.

Finally, I am pleased to report that the Board completed a comprehensive 18-month review of our Agency's ethics and recusal procedures. The Board found that the Board's—the review found that the Board's practices for identifying conflicts, establishing screening arrangements, and obtaining our designated agency ethics official's input on recusal matters are very strong, fully compliant with applicable government ethics rules and will protect against conflicts of interest. Based on this review, the Board also identified certain areas for improvement, the most important, which I have summarized in my written testimony.

I thank you for the opportunity to appear before you today to provide this update and I look forward to your questions.

Ms. DELAURO. Thank you very much.

Mr. Robb.

Mr. ROBB. Thank you.

Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, I am pleased to testify before you today.

As general counsel, I have a dual role in directing the litigation of cases under the Act at the Administrative Board, Federal District Court, Circuit Court, and Supreme Court levels, as well as overseeing the operations of approximately 90 percent of the Agency. General counsel is also responsible for overseeing the investigation of unfair labor-practice charges, processing representation petitions, enforcing courts' orders, and supervising the operations of NLRB regional and satellite offices, as well as headquarters staff, who are responsible for case-handling, operational, administrative, financial, security, facilities, technology, and personnel functions.

The prompt resolution of labor disputes is essential to enforcing the Act and a key part of the Agency's mission. Expedited case processing by the Agency is necessary to achieve the timely resolution of labor disputes thereby helping to minimize interference with the free flow of commerce.

Over many decades, Agency case processing times and case backlogs have increased, causing the delayed resolutions of disputes. In the 1980s, the median processing time from the filing of an unfair labor practice charge to the issuance of a merit complaint was between 44 and 55 days. By the end of Fiscal Year 2018, the median processing time had risen to between—had risen to 128 days.

Backlogs in the number of overage, unresolved unfair labor practice cases also grew; for example, at the end of Fiscal Year 2012, there were 524 pending overage cases. By the end of Fiscal Year 2018, there were 724 pending overage cases, a 38 percent increase

in case backlog. These lengthened case processing times and backlogs surprisingly occurred during a period in which unfair labor practice case intake dropped from 21,622 to 18,866, a nearly 13% decrease.

My major objectives as general counsel are to reverse this trend, to ensure the processing of cases in a timely manner and to improve our service to the public while maintaining the quality of our investigations and litigation. To that end, at the beginning of Fiscal Year 2019, the Agency issued a Strategic Plan which established case-processing objectives for the disposition of unfair labor practice charges at all levels.

The goal was to reduce case processing time by 20 percent over the next four years. During Fiscal Year 2019, the Regional Offices made exceptional strides toward meeting that goal. In just one year, the regions nearly met our 4-year goal by reducing the overall average time of filing to disposition of unfair labor practice cases from 90 to 74 days, a decrease of 17.5 percent.

The regions also reduced the time from informal settlement to final disposition of an unfair labor practice case, which affects how quickly alleged violations are remedied, from 173 to 153 days, a decrease of 11.5 percent. These results were achieved without any detriment to the quality of case processing, the number of cases the field offices decided to prosecute, or the amounts recovered by the Agency on behalf of wronged employees.

Over the past two decades, the percentage of charges that have been found to have merit has hovered between 35 percent and 37 percent, and Fiscal Year 2019 was no different; the percentage of merit cases was 36.1 percent. Additionally, since Fiscal Year 2012, the median amount collected annually for employees has been approximately \$55,200,000. In Fiscal Year 2019, the Agency collected over \$58,400,000, well above the median. Not surprisingly, given the expeditious handling of unfair labor practice cases, the regional offices' settlement rate was 99 percent.

Finally, the Divisions of Operations Management, Advice, and Appeals, which review the quality of field work have confirmed that the quality of the work performed remains high.

The NLRB plays a critical role in ensuring that workplace disputes are resolved efficiently and effectively. I assure you that the Agency will continue working to ensure that labor disputes between or among workers, employers, and labor unions are resolved effectively and efficiently, as we have done for the past 85 years.

Madam Chairwoman, thank you for allowing me this opportunity to explain publicly to the committee the achievements of this past year and congratulate all NLRB employees on a job well done.

Thank you.

Ms. DELAURO. Thank you both for your testimony. I will proceed to questions.

Mr. Ring, as I have pointed out, I am concerned about the ethics issues that have been playing the NLRB. Again, Mr. Emmanuel participated in the 2017 Hy-Brand decision which overturned Browning-Ferris. He participated, even though his former law firm, Littler Mendelson—and I might add about Littler Mendelson, this self-described, which defense corporations by taking on workers'

rights to unionize—he participated even though that was his former law firm.

A representative of one of the companies in Browning-Ferris, the designated agency ethics official understandably concluded that Mr. Emmanuel committed an ethics violation because he had a conflict of interest.

Your Board's commitment to upholding basic ethics standards was already in question and, again, sadly, your November 2019 ethics recusal report raises more concern that it eases. You somehow conclude that a member Mr. Emmanuel has no obligation to enforce an ethics official's finding and recuse himself when a clear conflict exists.

Mr. Ring, do you believe that Mr. Emmanuel, a former Littler Mendelson shareholder, had a conflict of interest when he overturned Browning-Ferris?

And in the interests of time, because I only have 5 minutes here, yes or no?

Mr. RING. It is not a yes-or-no answer and let me tell you why, if I might. He wasn't overturning Browning-Ferris. The case was a different case.

Ms. DELAURO. But let me just say your ethics people concluded that it was a conflict of interest. Is it—do we just ignore what the Ethics Committee said? Is that what you did, you just ignored what the Ethics Committee has said about conflict of interest?

Mr. RING. Well, let me say, if I might, what the unfortunate facts of the situation you are describing is that the ethics official concluded that he had violated the ethics rule—

Ms. DELAURO. Yes.

Mr. RING [continuing]. After the fact. It was after the fact because of the way the case was decided.

This all happened before I was chair, before I arrived there.

Ms. DELAURO. I understand and I am just saying it was a complete violation found—a finding that there was a violation. So, I am taking this as he was in violation. There was no explanation for flying in the face of the Ethics Board saying conflict of interest.

Your September 18th proposed joint-employer rule effectively established the same joint-employment test included in Hy-Brand and if Mr. Emmanuel committed a conflict of interest in Hy-Brand, how is his participation in the rulemaking not another egregious conflict?

Mr. RING. Well, the standard for ethics is explained to us by our designating ethics official at the Agency is different than for adjudication of cases. In the adjudication of cases, it is you look at a particular matter and whether there are specific parties.

In rulemaking, there are no specific parties, so the standard is different and I will just add that the ethics officer has approved his participation in the rulemaking.

Ms. DELAURO. Let's talk about rulemaking for a second. Chairman of the NLRB for less than 2 years initiated 4 rulemaking efforts. You are currently working on 2 more; 6 rules, unprecedented. Proactively using rulemaking as a tool to advance, in my view, and I said, my view, an anti-worker agenda.

Obama-controlled Board published 2. The Bush-controlled Board published none.

Instead of holding public hearings like the previous Board did with its election rule, you conduct automatic 6 rulemakings behind closed doors. This contributes to the appearance that you have little interest in transparency.

We should be concerned in light of serious conflicts of interest what is happening behind closed doors. Mr. Emmanuel participated in the joint-employer rule, despite committing an ethics violation in Hy-Brand earlier on.

I would just conclude my round by saying, I just—under your leadership, the Board is a classic case of the fox guarding the henhouse, where a group of conflicted individuals are rewriting the rules of the road to benefit the industries where they have a financial interest or have had a financial interest. It is wrong. We cannot do that. We live by, you know, if you want to tell me this is—you know, perception is reality. Optics are real hereof conflict of interest, which appears to run rampant in this Agency.

I will yield to my colleague from Oklahoma.

Mr. COLE. Thank you very much, Madam Chair.

Chairman Ring, your case processing, as you pointed out in your testimony has really gone down in recent years. Under a pilot program the Board began to focusing on issuing decisions in your oldest cases, as a result, the median age of all cases pending before the Board was reduced from 233 days to 157 days, more than a 30-percent reduction.

In addition, as you pointed out, I think, Mr. Robb, in your testimony, as well, the Board significantly reduced the number of cases pending to its lowest level since 2012, a nearly 20-percent reduction. I think that is very commendable.

And I just want to ask you, number one, how you achieved it, and number two, how do those efforts, frankly, help both, employers and employees across the country?

Mr. RING. I will be happy to start. You know, one of the—I think as long as I say in my written testimony, as long as there has been a Board, there have been complaints about how long it takes to get a decision out of the Board. As a practitioner before the Board, I have waited for many years to get decisions out of the Board and during that period of time people, workplaces are in limbo.

You know, I think of individuals who have stood up to their employers and have been told, You will get your job back, and have to wait 3 and 4, up to 10 years to get their job back. So, really, you know, justice delayed is justice denied when it comes to the Board. So, that is one of the ways that I think that we really need to advance the mission of the Act is to, as quickly as possible and effectively, resolve our cases.

I did a lot of reading about a lot of studies. There has been GAO studies and a lot of law review articles about case processing at the Board. The reality is what it all comes down to is commitment by board members to actually focus, give full attention to their obligation to decide cases.

So, we have, as a Board, including our former member, Member McFerran, committed ourselves to fully—full attention to deciding cases and processing cases. And we meet, and this is unprecedented, as a board and we look at the status of every single case and we hold ourselves accountable to that.

This is not about staff delaying. This is not—it is all within the targets of the staff that we already had. It is really about board members being committed to moving the cases and more transparency and a little bit of internal competition among board members to make sure you get your cases decided. So, that has been our approach.

Mr. COLE. Do you care to add any additional comments, Mr. Robb.

Mr. ROBB. Sure. In 2018 in the fall when we looked at trying to improve our case processing on the GC side, I had a conference with all of my regional directors and there had been some suggestions made by people in the field as to how we could speed things up. And when we talked about it, I asked the directors how we could get this done and they said, Look, do not dictate from on high. Let us handle it and we can work it out individually in the regional offices.

I said, Fine, go ahead and do that.

And as you can tell from the results, they did a tremendous job, but I want to emphasize that all of this work is done by our field attorneys and field examiners who do the investigations and process the R cases. So, they are the ones who deserve the credit for this.

Mr. COLE. Just quickly, because I do not have a lot of time let, Chairman Ring, obviously there is—and we are going to be talking a lot about rulemaking this morning, I'm sure, and you have overturned a number of previous decisions—can you sort of tell us your philosophy as your approach these, how you look at them. Just, quite frankly, I agree with most of the decisions you have made. I see you as returning to traditional practices with the Board and overturning some overreach from the last administration, but I am curious as to how you approach these matters.

Mr. RING. Well, you know, I think rulemaking makes a lot of sense for a lot of reasons. It allows us to deal with complex areas of law in a more comprehensive way. It allows us to give better detailed description and guidance to our stakeholders and allows public input. So, you know, I would do more rulemaking if we could.

We are building that capacity out at the Agency and so, you know, we have to kind of balance between adjudication and rulemaking, and with our focus on deciding cases, you know, and making sure we have a real focus on that, I do not want to distract from that with the rulemaking. So, it has been a balance, but that has been our approach.

Mr. COLE. Well, I am out of time, so I look forward to continuing the discussion.

Thank you, Madam Chair.

Ms. DELAURO. Thank you.

Congressman Pocan.

Mr. POCAN. Thank you, Madam Chair.

And thank you both for being here. I do want to say I associate myself with the concerns of our chairwoman on the perception issue; perception is reality. You know, the problem is if you have a board member who doesn't know better that they are obviously doing an ethics violation and then something to related they act, it is just bad judgment, period, and I think you have to get a better

control over that, otherwise, the perception looks like this is a rigged Board.

You know, your last non-answer, unfortunately, to Mr. Cole, you didn't describe your philosophy. You said rulemaking is good. I want to do more rulemaking because I like rulemaking. That is not a philosophy that you are using to set standards.

I understand lawyers, you know, give answers in certain ways, but I think it is a problem when you have, like, a guide by the U.S. Chamber of Commerce that has 10 recommendations for your agency and every one of them you hit, you got 100 percent, but I do not know if that is necessarily good for your mission, which is to also make sure that workers feel like they are represented by the Agency, not just employers. And this as a 30-plus-year employer, I am saying that, because I just think that that perception makes you less credible and less able to do your job. So, I just wanted to put that out there to that.

And I do have some questions around, you mentioned all this efficiency you are doing. Actually, the perception and the reality and the ground is just the opposite, and I think you need to hear this and I am sure you are, but when you made some of your new rules around union elections, for example, you mandated longer time. You went through—well, actually, let me go to this one first. On the efficiencies within the regional offices, let me go to that first, you have not filled a bunch of spots.

While you are claiming you are getting rid of some of the backlog, you have had memos changing the performance of how regional directors will be evaluated. You are discouraging the use of subpoenas in investigations. You are reducing staff and leaving positions vacant. I have folks telling me that they are not even bothering to do claims anymore because they do not feel like they are getting heard.

So, I guess the question is, while you may be taking care of some old cases, what we are hearing is people are not even filing cases because they do not feel like they are even being given a chance because you are short-staffed in some areas and you are not allowing the normal practices to happen.

Can you just briefly, because I have a limited amount of time, respond to that.

Mr. RING. So, this is actually a General Counsel Robb question, because he runs the regional offices.

Mr. ROBB. Sure.

Mr. RING. Thank you.

Mr. ROBB. Certainly. With respect to whether charges are being properly investigated, all our reviews indicate that they are. As I said before, the merit factor is exactly the same as it was with my predecessor.

Mr. POCAN. So, let me—

Mr. ROBB. So, there is no factual reason for anyone to believe that we are not going to—

Mr. POCAN. Well, let me try this fact, Mr. Robb, see if this helps. Not only do you have many unfilled vacancies, but your regional offices are issuing 27 percent fewer unfair labor practice complaints than they were just 2 years ago. So, people feel that it is many of those changes is why you are not going after these cases and it is

not like, I think, and I can say this, again, as an employer who is involved in many chambers of commerce, we are not suddenly good actors, nothing has changed on our end, but you certainly are going after fewer people.

And there are bad actors, I think we all agree, out there. You know, when people see that statistic, that is not a good statistic.

Mr. ROBB. Well, the statistic that you cited was issuing complaints. We resolve more cases by settlement prior to complaint issuance, 800 or, excuse me, I think it is around 6,000 of them last year. So, that is where the difference is. It is not that the violation—

Mr. POCAN. And that is where I disagree, because what I am being told is that people are not filing the complaints. So, you may think that is the perception, but the perception is the reality is people are not even putting complaints in because they feel like the system is rigged against them.

So, let me go to where I started on the question on the election rules, again. You made some rule changes even when your members on your Board said that the average election now will go from 23 days to 78 days later. So, your own members on the Board said that, and yet you did this without any public comment whatsoever because you said these were common sense.

I do not find that to be common sense if you do not go out and get any public comment. Can you explain very briefly why you didn't get public comment.

Mr. RING. Sure. These are procedural rules and the Board, historically, has handled their representation of rules by the final rules. I mean, that they have issued the final rule without any rulemaking.

In 2014 where there was a wholesale change to the rules, including rules that affected rights of individuals, and we were very careful in this rulemaking not do that, they did go out in 2014 for—

Mr. POCAN. So, again, the perception is that you guys are operating differently and not asking for public input, which is making your Agency less efficient.

The last thing if I can really, really quickly, Madam Chair, is I am just trying to understand a ruling you had in January of 2019 where you expanded the definition of independent contractor in the SuperShuttle case to these people who were driving the shuttles and, yet, at the same time, they are independent contractors. They are supposed to sign non-compete agreements, which, again, I think is absolutely idiotic. What is the inside information to driving a shuttle?

And, yet, that was the ruling you had. Can you explain that. That makes no sense to me as an employer or as a lawmaker.

Mr. RING. Yeah. Well, the SuperShuttle decision restored the independent contractor test to what it had been for decades. That was the standard for decades. It had been expanded during the Obama Board years and we restored it to the prior standard.

Mr. POCAN. So, you didn't answer my question, so let me try again. I am sorry if I wasn't clear. Again, I am just trying to understand, just because something was, you are not telling me why it should be an independent contractor, but if it should be an inde-

pendent contractor, why are they forced to sign a non-compete agreement as a shuttle driver?

Mr. RING. Yeah, I cannot speak to the non-compete aspect. We did look very carefully at that case. We looked at all the facts, considered all the arguments.

Ultimately, the decision was, I think, and our analysis of the case is laid out in the decision, we think that the common law standard for independent contractor is what the standard should be.

Mr. POCAN. I thank the chair for the extra time. Thank you.

Ms. DELAURO. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chairwoman.

And thank you both for being here today. Just to pick up on my colleague's line of questioning, in this SuperShuttle ruling that the drivers should not be classified as employees, but actually as contractors, the Board ruled that it is entrepreneurial opportunity that is at the core of the test.

How is it true that an indicator of entrepreneurial opportunity test, which is one's ability to work for another company, how does that possibly square with a non-compete clause for these drivers?

Mr. RING. Well, I mean, I will just speculate, but I will say, I mean, there are many businesses where you hire a contractor, a subcontractor and you say, you will only work for me or you won't work for other businesses. I mean, if you have the economic control, you can do that.

What we were talking about with entrepreneurial control there was what the D.C. Circuit had talked about and that really is the animating feature of the independent contractor test in our view.

Ms. CLARK. I just do not see any way how those two work together. You know, if we are talking about entrepreneurial opportunities, I agree with you, we look at non-compete and businesses have right to do it, but it is hard to say they are independent contractors when they are being told they cannot compete, cannot seek entrepreneurial opportunities.

I think that your former board member, Lauren McFerran got it right when she said that this approach might be easily called the economic unrealities test. You know, I do not know how you square those two things and I am concerned about the direction that you are taking, which brings me to my next line of questioning in some of the rulemaking that you are doing.

One of them is a proposed rule in December that classifies graduate student workers—I'm sorry—graduate student workers as students and would strip away their right to collectively bargain and join a union with better wages and better working conditions.

Isn't the role of the NLRB to safeguard employees' rights to organize and form a union if they so choose? Isn't that your mission?

Mr. RING. One of the objectives of the Act, an overarching objective of the Act is labor management stability and to make sure that there is some—there is not labor strife.

Look, the student rule is a rule that, and that issue is an issue that the Board has flip-flopped on many times, I think it is 3 or 4 times in the last 20 years. Each time the Board looks at it, it is in the context of a particular set of students at a particular university under a certain set of facts.

In our view, rulemaking is the perfect way, the perfect vehicle to take that complex issue and look at it in a really comprehensive way.

Ms. CLARK. But what you describe as flip-flopping actually affects 1.5 million student workers. If you just take Harvard, which has been looking at this issue in my district, the average salary for student graduate workers nationwide was just under \$14,000. For professors, it was \$121,000. But those student graduate workers are grading papers, holding classes, holding office hours, all the same functions and yet now you are saying that they are not workers at all, but they are students, and I do not understand how you are coming up with this new rule and why you want to be securing the rights to organize for these 1.5 million workers.

You have said at one point, this is over a concern of academic freedom. Can you explain to me what you meant by that?

Mr. RING. Well, I think where you start imposing collective bargaining and collective-bargaining obligations that could impact the ability of a whole host of things, scheduling of classes, what courses are taught, and that could impact economic freedom.

Ms. CLARK. I do not understand the connection between allowing workers who are doing the exact same work many times, except that they—as professors, except that they are also going to classes, themselves, how that in any way impinges on anyone’s academic freedom to allow them to organize to have better working conditions and fair wages. I just do not even see the connection.

Mr. RING. Well, this is part of the reasons that rulemaking makes sense because we can look at these comments and input like that and then make a judgment. Our proposed rule was a proposal that is subject to comment and we are open-minded about changes to the rule.

Ms. CLARK. I see that my time is expired.

I certainly hope that you will not go forward with this rule and respect these workers’ rights. Thank you.

Ms. DELAURO. If I might, there is a couple of pieces—I just want to—points that my colleague from Massachusetts made, which I said in my opening remarks. 2005 to 2015, the number of graduate teaching assistants grew by 17 percent. The tenure-track faculty grew by 5 percent. As she has pointed out, what these—I have worked with the graduate students. They are dealing with classes. They are grading papers. They are doing the same kind of work and NLRA does not include students in its statutory exclusions. Why we would strip these folks of their ability to be able to organize is something that is not comprehensible.

On SuperShuttle, I might add—by the way, including that, and I am not going to get into personalities, but my understanding is that a board member who worked on this issue also had a family that worked for Columbia University and the individual on the Board participated in the graduate worker rule. You have got all kinds of conflicts of interest running here, there, and everywhere and not, you know, paying attention to what the stated purpose of the Agency mission is, is to collective-bargaining rights and workers to be able to organize.

SuperShuttle, on the non-compete clause, as I understand it, Mr. Chairman, that was you discounted the fact in the decision there

was no analysis of the non-compete clause. Do we put a non-compete clause on a plumber?

No, we do not, you know.

I mean, about your issue on rulemaking, it sounds good but rulemaking is behind closed doors. There are no public hearings and that is—if you want to be transparent, let's be transparent and let it fall where it may with the decisions that are in the best interests of those that you are supposed to represent, and that is the workers.

Mr. Robb, two consecutive fiscal years, you let resources by the Board lapse, \$3,000,000 in 2018 and \$5,700,000 in 2019. Under your watch, NLRB staff levels have dropped by alarming rates. Government-wide analysis of staffing levels under the Trump administration from 2016–2018 shows that the NLRB suffered reductions of 14 percent, the most significant reduction for any non-cabinet Agency with at least 1,000 employees. At the end of 2019, that reduction grew to an astounding 17 percent.

You have the responsibility to use the funding this subcommittee provides. We did this in a bipartisan way. 2020, the Labor H bill directs you to expand regional staff. You have talked about giving more authority to regional staff and that way you are looking at you have 33 fewer staff in the regions than you did at the end of 2019.

So, yeah, they are moving cases and they are doing it with a lot of short staff. It is not about quantity; it is about quality that we are talking about today.

So, my question is, will you comply with the directive and ensure the NLRB has more regional staff onboard than it had at the end of 2019 and how are you planning on complying?

Mr. ROBB. The last time that I had a report on our staffing situation for the field, we had 815 field staff. The number at the end of—that is FTEs—the number at the end of Fiscal Year 2019 that you are referring to is 830. We have 16 people currently that are in the hiring process. We are just waiting for them to be able to come onboard. So, we are on track to have the same or more field employees as we did at the end Fiscal Year 2019, which was the directive in the report.

I will note, though, that we have had a 5 percent decline in caseload, 5 percent. That means that there will be a lot less work for people to do if we have the same number of people.

Ms. DELAUBRO. You know, I was the chief of staff for Senator Dodd for a number of years and we had a copy machine that the whole staff said to me, it is not usable, we cannot get copies, et cetera. So, I went to our office manager and I said, you know, we need a new copy machine. That is what the staff is telling me, and she said, if we get a new copy machine, more people will use it.

Whoa. Okay. Why is it there? Why do you have regional staff? Why are we understaffing them?

Yes, the caseload will drop. Why? You do not have staff there to do the various investigations, the analysis, to go through each and every one of these cases. You are dealing with a—my colleague talked about you issued a memorandum discovering regional directors from issuing subpoenas when investigating whether to issue a complaint.

Last year there were 64 percent fewer cases. So, you are in the mode of if you pull back and not provide the staff, if they do not have the tools of the trade to deal with this effort, then we will have fewer cases because they cannot deal with them. It really is—look, I just want to say to you that Congress expects you to implement these bipartisan directives. Fill vacant regional director positions expeditiously.

What you did was you went in St. Louis, as I understand it, conducting a search for the St. Louis regional director position. You concluded you could not find a qualified candidate. You know, that is a charge that is often made when you are, you know, not wanting to find that director.

And I have to apologize to my colleague from Florida because when she wasn't here I was up next, but then she is here now, so let me—

Ms. FRANKEL. I'm sorry, I have been running back and forth between two meetings.

Thank you, folks, for being here.

I wanted to just follow-up on your last round of questions just to, in terms of your cutting your Agency, the budget. Is it true—I read—I don't know if this is true—it is hard to believe, so hopefully I am wrong—that in 2018 you ended the contracts with the health units, which were the on-site health clinics that served the NLRB and you cited budgetary constraints.

Did that happen?

Mr. RING. I was not at the Agency I am happy to say.

Ms. FRANKEL. Did that happen, sir?

Mr. ROBB. Yes, it did.

Ms. FRANKEL. All right. Okay. Well, going back to the question of my esteemed chairman, it seems to me that you didn't really have budgetary constraints. Again, this is what I read, so it is really hard to believe, but it says that the most recent cost of the program was \$331,000 per year.

Well, your Agency has been under investigation for the GAO for failing to spend the funds, our funds that we allocated. And let's see, you returned \$5,100,000, so it seems—I don't know. My math isn't that great, but I think \$331,000 is much less than \$5,000,000, so I do not want to be cute here.

Here is what I would recommend and suggest to you, that especially in light of this Coronavirus situation and people's need for health care, that you reconsider bringing these health units back and making sure that your employees have access to health care. That would be my suggestion to you.

One more question on the public hearings. I think it has been asked by my colleagues, I just want to echo that I think it is unfortunate that you do not have public hearings for these rulemakings, because not everybody is sophisticated enough to either write their thoughts out or have the money to hire a lawyer and so forth, and you could probably get a lot of insight by actually hearing from real people, especially workers, which gets me to another question, which is, let's see, the rule on the blocking-charge policy, which pauses union elections when a party is charged with committing an unfair labor practice until the charge is resolved.

So, in situations where there is an election to decertify the union, this policy is critical to prevent employers from intimidating employees into voting against the union. I am sure you know that. So, you overhauled the policy.

The Board presented data that it claimed to show that the policy was, created great delays in elections after a blocking charge was filed, yet the law reported December 5th, 2019, and I am quoting them, Review of the data supporting the rulemaking found dozens of cases in which the Board overstated the length of delays attributable to blocking charges over the last 3 years, overshooting the mark in one instance by more than 12 years and another by 5 years. The dissent from the proposal also pointed out these errors.

So, again, this is a—I do not understand this, but I guess is it correct that, or is it, yeah, correct is the word, that you did not correct the errors before issuing the notice of the proposed rulemaking. Was nothing changed?

Mr. RING. We use the Agency data and Member McFerran in her dissent actually had her folks go through the data case-by-case and apparently found some deviating circumstances, but we did use Agency data.

I will say on this issue, sometimes the best policy is not made with statistics. One person denied an election is, in our view, worth looking at the issue and that is one of the reasons that we are doing that.

Ms. FRANKEL. Madam Chair, I just got a note to go back to my other committee, but I want to thank you.

And I yield back.

Mr. RING. Thank you very much.

Ms. DELAUBRO. Thank you very, very much, and I apologize to you, again, for—

Ms. FRANKEL. Do not worry about it.

Ms. DELAUBRO. Okay. Anyway, Mr. Ring, I am delighted that you did not participate in the Board's recent McDonald's case, due to your former law firm's work on the company's response to the fight for 15 minimum advocacy; however, I am astonished, once again, that Mr. Emmanuel found himself fit to participate, despite a clear conflict of interest.

Mr. Emmanuel's former law firm, Littler Mendelson, was retained by McDonald's corporate effort to set up a hotline for franchisees with fight for 15 concerns. Today, you can still dial 855-MCD-LAWS and you are greeted with, you have reached, it is what we have here, you have reached the McD laws hotline provided by Littler Mendelson and are then provided the direct contact information of three attorneys ready to provide legal advice.

This a pretty extraordinary. This is staggering in terms of conflict of interest here with the Agency. How can we trust the NLRB under your leadership when it has been proven to be ineffective at stopping conflicts of interest?

This document right here lays this out and McD laws is 855-623-5297. How do we trust what you are doing?

Mr. RING. Let me answer that. Well, first of all, my participation—I did not participate in the McDonald's case because, not because of any recusal issue, but rather because of our normal panel rotation. So, that is the only reason I didn't participate.

Ms. DELAURO. So, having worked for this law firm, you would have participated?

Mr. RING. If—

Ms. DELAURO. You do not see the conflict of interest?

Mr. RING. No, I see a perception that you are raising, but because of that and because we are committed to ethical standards and making sure that our recusals are in compliance with government ethics rules, this was run there our designated ethics officer—

Ms. DELAURO. I am going to stop you for a second because it is the recusal process, let me see if I get this right, your recusal process which says that you shouldn't do this is what guided you, but you, personally, didn't have a view that your being engaged and involved with the law firm should not—I mean, I do not need to have somebody tell me that you cannot do this, you cannot do that. You have to have an underlying fundamental view as to what kind of conflict of interest that we have. And we are under scrutiny all of the time for conflict of interest here and, you know, so designate. But I do not understand why you do not think that it is a conflict of interest and, thereby, I guess you answered my question, is that Mr. Emmanuel, why should he recuse himself from this process, as well.

Do I have this right?

Mr. RING. Well, let me say this. We are labor lawyers. We know labor law.

Ms. DELAURO. Yes.

Mr. RING. And we rely on experts on government ethics to guide us on what the rules are and that is really what we have to do and that is what we are expected to do and that is what the government ethics rules tell us to do. That is one of the reasons we embarked on this very comprehensive review in our ethics report to make sure that we were in full compliance.

And when something like this comes up, our ethics officer does a thorough analysis of the conflict, potential conflict and appearance issues, and based on that, provides a recommendation that we follow. I mean, that is—you can change the government ethics rules if you want to, but we are bound by those and we follow them.

Ms. DELAURO. Yeah, but no you didn't, not in the case of Mr. Emmanuel and Hy-Brand. You had an Agency that told you there was a conflict of interest and then you proceeded to move forward and to say that he could participate, that he could insist on participating.

Mr. RING. Well—

Ms. DELAURO. You know, you cannot have it both ways. You just cannot have it both ways, which is what you are trying to do here.

You do not listen to the Office of Ethics, then you say that you are following their guidelines and you are not. You are rife with conflict of interest in this Agency.

And with that, I will yield to my colleague from Washington.

Ms. HERRERA BEUTLER. Thank you, Madam Chairwoman.

Chairman Ring, I appreciate you being here today. And being from Washington State, obviously, the Coronavirus is a topic of mine, just about any issue we are working on. And I have about

1,500 franchise businesses in my district and I appreciate the work that you all are doing to give clear joint-employer rules, including the rule you issued in February.

With the recent outbreak of the novel Coronavirus in my district or in my state, what does this new joint-employer rule do to provide any clarity for employees that are looking to encourage, and responsible policies, with their franchises and contractors like paid sick leave during the outbreak?

Mr. RING. Well, what I think our rule does is it does provide clarity and some certainty about who is the employee's employer and instead of employees looking to an employer that ultimately would not be their legal employer and not legally responsible, they could hold their employer, and their employer knows that they are responsible and that the direct employer, the employer that actually has control over the employee's essential terms and conditions would be the employer that takes the action.

So, I think the major benefit to our joint-employer rule, besides restoring it to its traditional test, is that we provide greater clarity and predictability and certainty and I think in a way that is a benefit to workers, to unions, and to employers.

Ms. HERRERA BEUTLER. So, there is not really any, I understand in terms of legal liability the clarity it has created, and I think it has been welcomed just because nobody wants to operate in the uncertain environment. That has been a huge issue amongst small businesses in my district. So, we do appreciate that predictability.

I think more in my mind is, is there any kind of support mechanisms or guidance or, basically, yeah, or is it just kind of, you know, have you all put any guidance out with regard to how people can support their franchisees and the folks that are part of their, for lack of a better term, co-op?

Mr. RING. Well, I think our rule does provide with definitions and I think greater depth and broader clarity, some lines between employers. We have not and we did not and have not put out anything that I think kind of does what you are talking about where it gives guidance on kind of responsibility in the context of, you know, this health situation we have now.

Although, I would say, I mean, I go back to my first answer, which is I do think having those clear lines and understandings of who is responsible and who is not is critical in a situation like this.

Ms. HERRERA BEUTLER. Thank you. So, as public events continue to be cancelled due to recent outbreak events in my state, they are closing venues, and a lot of the discussion is around how do we continue to support hourly workers or those who are affected directly by government-mandated closures, people, generally at the lower end of the income spectrum? Is the NLRB doing anything to ensure employees who may be impacted by these cancellations are protected?

Mr. RING. The NLRB really doesn't have any statutory authority over that type of thing. I think that is probably with the Department of Labor, but I will say that there are obligations under our statute, with respect to bargaining over-layoffs if there are unionized employers and—

Ms. HERRERA BEUTLER. For example, like food service workers who are not going to be working a venue at a major sporting event.

Mr. RING. Right.

Ms. HERRERA BEUTLER. So, I do foresee this coming. I mean, it may not be the immediate, but in terms of the secondary and maybe even tertiary impacts, I do see this coming.

Oh, sorry, Madam Chair, my—oh, no, I still have a couple.

I do expect this to be something that I think is going to touch all areas of our economy, whether it should or not, right—

Mr. RING. Yes.

Ms. HERRERA BEUTLER [continuing]. My expectation is it will be on your desk?

Mr. RING. Yeah. Well, I will say our Act does provide those types of protections in a unionized context for those that, you know, where there might be a layoff or other kind of job disruption.

Ms. HERRERA BEUTLER. Thank you.

I yield back.

Ms. DELAUBRO. If I might, because you have asked a very pertinent question, what, in essence is the case here is that those folks that are, if the venue is cancelled, if an employer shuts down, you know, only 27 percent of people who work in the private sector have paid sick days. There are no—not even one paid sick day.

So, honestly, you have exonerated the franchisee, the local, and the parent organization, I might add, from having any, I do not even want to say legal responsibility, having a moral responsibility. These are people who serve all of us. Nobody is taking away your sick days, my sick days, anybody else.

But those folks who are washing dishes, who are serving meals, who are distributing food at a venue, et cetera, they are on their own. They are on their own. And what we are trying to do here is to say that businesses that have 50 or fewer employees that they provide the 14 paid sick days to people who, through no fault of their own, are out of work, and they have children and they have expenses every single day and they work hard.

But not my problem, big corporation. I do not have to do it. Franchisee, I do not, I am not legally responsible.

More than likely, these folks have not been able to organize or to unionize and they cannot deal with collective bargaining. When the reality of what is being done is placed in the context of people's lives, it describes what a lack of understanding we have about workers in this country and how hard they work every day and what our obligations and moral responsibilities are when a situation that they cannot control, cannot do anything about is hoisted upon them. Then I believe it is the Government's responsibility to step in and do something about it and that is my hope, is that what we are going to do over the next several days is to make sure that these workers get paid sick days and that we will deal with the appropriate authorization or the appropriation of dollars to do it, because you would exonerate businesses from doing anything about that.

Mr. Robb, your testimony paints a rosy picture of what it is like to work at the NLRB under your leadership. Unfortunately, for your employees, the data tells a different picture. Since 2016, employee satisfaction under the Federal Employee Viewpoint Survey for the NLRB have declined by a stunning 30 percent for Agencies of your size. The decline since 2016 has been just 2 percent. The

Board ranks second-to-last in satisfaction overall, just ahead of the Department of Education.

Are you at all concerned or alarmed about what these dismal statistics say about the management of the effort here, your organization?

Mr. ROBB. I am certainly concerned about it. I would much prefer that the survey yielded better result for the NLRB. We are trying to do more in terms of communication with employees and giving more understanding both, to managers and to the employees, with respect to why things are being done. So, yes, I am concerned about it.

Ms. DELAURO. And, again, under your leadership, a concern has really got to translate into an action, because under your leadership, you eliminated the Health Unit for your employees at the D.C. headquarters, as I understand it, and I am told you were concerned about the cost of maintaining it, which, quite frankly, flies in the face. If it weren't so sad, it might be laughable because you are not spending the Agency's money, the appropriation, which on a bipartisan basis, we have questioned you on, but you are spending money on resource-intensive rulemaking efforts. You have cut back your spending, but you eliminated the Health Unit for your employees at the D.C. headquarters.

Why have you not reinstated the Health Unit for the headquarters staff?

Mr. ROBB. As you know, the Health Unit was eliminated because of budget concerns in the 2018 year and that was done pursuant to a task force that included the unions, the representatives at the Agency, and a variety of managers. It does done not by me; it was done by my predecessor.

That report indicated that there was \$16,000,000 that needed to be saved in order to make sure that there were no layoffs or furloughs of Agency employees if the budget funding came in at the appropriation level that was requested by OMB. So, that was ultimately implemented because of the recommendation to me, which I pushed onto the Board, that unless we started to implement those cuts by January of 2018, we would have been in a serious situation where we may have been required to furlough people, which is something that nobody wanted and I didn't want.

So, once it was eliminated, then the question became a matter of how effective it was, vis-a-vis, other things that we needed. There was a lot of infrastructure in our computer systems that needed to be updated, as you know, because we provided the materials to the committee.

The reason we didn't spend the \$5,100,000 for 2019 was because a series of contracts that were either disallowed—

Ms. DELAURO. Let me just stop you for a second, and I hear you, and I want to hear the explanation.

But you traded off a Health Unit for your employees to computer technology. You also have—you let resources that we provided, a bipartisan basis, we challenged you guys on this, you lapsed \$3,000,000 in 2018, \$5,700,000 in 2019. Well, 5.1—you could have dealt with this if you didn't just let \$5,700,000 lapse.

There is no explanation. Health Unit, today's cost for health for people in this country, my God, how can that be a trade-off? And we have provided you with allocations.

My time is—I am stunned. I mean, that is—you know, look, budgets are documents that have values. It is not about its people and what the repercussions are.

The Health Unit and not—let me just ask you this, would you reinstitute the Health Unit? Will you reinstitute the Health Unit?

Mr. ROBB. The Health Unit for next year would be under consideration. I heard a request here that we would reconsider whether we would institute it or not and we will certainly consider that. It has been brought up in negotiations with the unions, so it will be under consideration. Whether when we look at the budget it is the right thing to do or not is something that I cannot answer now.

Ms. DELAURO. But morally speaking, you as an individual, what do you think about reinstating the Health Unit for employees as some sort of a priority that makes sense? I mean, I have managed, if I think about my staff what I would do, what I would trade off, you know, this is—we all have these considerations.

What do you believe we ought to do with this?

Mr. ROBB. What do I believe?

Ms. DELAURO. What do you believe we should do about reinstating a Health Unit, yes or no? Do you—

Mr. ROBB. At this point, I didn't see the justification for reinstating the Health Unit.

Ms. DELAURO. Okay. Fine. Thank you. You answered my question. Whoa, that is something.

Mr. Ring, again, at the American Bar Association's recent law conference, you were asked whether recent Board decisions advanced workers' rights. It was reported and, you know, you look at what is reported and ask a question, it was reported that you replied, quote, are you suggesting that our job is to advance employees' rights?

I remind you of what I said at the outset in my remarks, Section 1 of the National Labor Relations Act states that it is the policy of the United States to encourage the practice and procedure of collective bargaining and to protect workers' rights to unionize for the purpose of collective bargaining.

Under your chairmanship, every major decision that the Board has issued overturning precedent and every rulemaking is antithetical to this policy. If you disagree, can you give me an example?

Mr. RING. Sure. First of all, I am not familiar—

Ms. DELAURO. Familiar with your quote?

Mr. RING. Yeah. And, certainly—

Ms. DELAURO. I get that. It happens to us all the time.

Mr. RING. Certainly, I would agree with you that one of the purposes of the Act is to protect employee rights; there is no question about that.

I think what I did say and I do believe is that where this Board is not here to put their finger on the scale or their thumb on the scale for any particular group, employees, unions, or employers, but rather, the Board is to fairly and impartially enforce the Act and that is what we are supposed to be doing.

Ms. DELAURO. But it says to encourage the practice and procedure of collective bargaining and to protect workers' rights to unionize for the purpose of collective bargaining.

It is not to be a neutral umpire, which is what was said, which is what a senator said. You are not a neutral umpire in this regard. I understand you have to balance things, but this is the stated purpose of your Agency.

Mr. RING. I will have to disagree with you because you are taking one quote out of a—

Ms. DELAURO. Well, no. Forget the quote.

Mr. RING. Yeah, but it also says—

Ms. DELAURO. Forget the quote.

Mr. RING [continuing]. That it is for those who choose to be unionized or choose to organize or those who choose not to.

So, we are balancing and we are supposed to fairly and impartially not look at the cases and the issues that come before us and decide those based on the facts fairly and impartially, not putting a finger on a scale for—

Ms. DELAURO. Right. But you, apparently, with some of the rule-making you have made, you have put the thumb on the scale for very big corporate interests—

Mr. RING. No.

Ms. DELAURO [continuing]. Like McDonald's, like the Shuttle example, et cetera, here, which people are forced to sign non-compete clauses and entrepreneurial opportunity. They have no entrepreneurial opportunity, but we put our thumb on the scale here to put them in a category where they are in limbo.

You know, there is a new economy out there and what we have done is to say we can contract, we subcontract, and we do not have any responsibility here at the corporate level and the folks there, well, it is up to them; if they want to do it, fine, if they do not, we do not have any. So, people are just hanging out there without any opportunity for the ability to organize, to get health care rights, to deal with unionizing, benefits, or anything because we have said adios.

Isn't your mandate in terms of the new current economy, a gig economy, whatever you want to call it, responsible then for what is happening to workers and workers' rights and not put your thumb on the scale for corporate interests?

Mr. RING. Well, I think if you look at what we have done over the last year or two, we have restored the joint-employer standard to what it had been. We restored the independent contractor standard to what it had been.

Ms. DELAURO. Well, the joint employer changed. It changed.

Mr. RING. Well, it is really actually back to essentially what it was before—

Ms. DELAURO. Right. And focused on a new time and a new place because we are in a new economy. We have set up different efforts and there is this move to subcontract, to contract out, to do that, to label people as independent contractors so, in fact, no benefit need to be paid.

That is, you know, it is not my view. It is what all of the data and all of the literature tells us about what is going on, and I have

to interrupt because my colleague has come in now because he is doing business in a variety of committees, I am sure.

Congressman Harris.

Mr. HARRIS. Thank you very much.

And thank you very much, Gentlemen, for being here today. First of all, with regard to the joint employer, you know, personally for the 2,000 franchise businesses that operate in my district, you know, the vast majority of them are very small businesses, some of whom I am sure will be hit by the Coronavirus economic disruption, you know, I want to thank you for returning it to the joint-employer standard from before. The previous standard made sense.

I mean, the bottom line is these are not jointly employed. I know these franchisees. I know them personally. So, thanks for bringing common sense to that.

And just to clarify, I think I was here when you testified that with regard to Mr. Emmanuel and the question of ethics, involvement in the judgments, the Board's designated agency ethics official did clear him on his participation in that case, right?

Mr. RING. Well, so this is an important point. I am glad you raised this.

He was cleared. There was no ethical concerns raised with his participation in the Hy-Brand case.

Ms. DELAURO. The rulemaking case.

Mr. HARRIS. Right.

Mr. RING. No, this is in the joint-employer case. The joint-employer case—

Ms. DELAURO. No, I know that, but for the rulemaking on joint employer, not in the prior case.

Anyway, go ahead. I'm sorry.

Mr. RING. I think, Dr. Harris, what you were asking was about the cleared for the Hy-Brand case?

Mr. HARRIS. That's correct, yes.

Mr. RING. So, he was cleared to work on that case or to sit in and hear that case. After the fact, there were concerns raised about how that case had been adjudicated. Frankly, there were unprecedented concerns about how that case had been adjudicated and based on that and the concerns, the designated ethics officer retroactively said he should have recused himself from the case.

And, frankly, that is why we embarked on our ethics report, was when I came to the Agency—this all happened before I got there—I had a number of concerns. I hear them, you know, and I share your concerns about the perception of the Agency when those types of things happen.

You know, I think the average worker says, what in the world is going on where you have people that are cleared to sit on a case, decide a case, and then after the fact, they are now called unethical because they did that. So, that is what we tried to clarify in our ethics report and we wanted to make sure that we had transparency and a clear understanding of what the rules of the road are on ethics.

You weren't here before when I said it, we are labor lawyers; we are not ethics lawyers. There is a whole body of law in government ethics and we tapped into that to understand it to make sure we had a clear understanding of what the rules are. And, you know,

one of the things that we learned, whether we like it or not, is that a board member has the ultimate right to decide whether or not it will sit on a case. You can change the law if you want to, but that is the law.

And what we did with our ethics report was make sure we had a process so that we could manage that in the future and so that people will have confidence in the way that we manage it in the future.

Mr. HARRIS. Thank you very much.

Now, with regards to the lapse in funding and allocations, of the \$5,100,000 unobligated balance, it looks like all but \$1,200,000 is the result of unforeseen contracting issues.

So, isn't it true that close to half of the unobligated balance is the result of the GSA decision preventing a contractor from accepting a contract offer because of an unrelated issue with an underlying agreement with the GSA?

Mr. RING. But that accounts for most of our surplus, yes.

Mr. HARRIS. Right. And so, of course, that is not anything that you control over.

And are any of the functions of the Board impaired by the failure to spend, you know, these taxpayer dollars?

Mr. RING. No. And, in fact, I think while we did spend less than expected, our shortfall did not affect our overall performance, our ability to accomplish the mission. We were able to add personnel where they were needed. We were able to spend the resources on things like IT infrastructure, which is critical, we are way behind on that, as well as training across the Agency, while looking for more effective ways to accomplish the mission.

Mr. HARRIS. Sure. Thank you.

And just, finally, you know, there are criticisms of partisanship on the Board, but, look, the law says that, you know, the President appoints people and I will tell you that I think there was partisanship when the joint-employer standard was changed and it was pretty clear. There was a pretty clear bias.

But, look, if Congress doesn't want that, then constitute the Board in some different way, but the fact of matter is that elections have consequences. The President won the election. I know some people still deny it. The President won the election and has the right to appoint people to the Board who may have a different philosophy from the previous Board.

I yield back, Madam Chair.

Ms. DELAURO. Thank you very much.

And I would just like to make a point about the NLRB member. It is important to note that the NLRB tried to change the joint-employer standard first through adjudication in 2017, but the NLRB member, William Emmanuel, had committed an ethics violation by participating because he had a conflict of interest.

So, you first went the route of adjudication. Then, given that they said that he had a conflict of interest, what the rulemaking proceeding and moving to that, where he then was allowed, then, to be a part of the rulemaking, so it was an effort to circumvent the ethics rules that would prevent him from participating in other cases raising this issue. So, it was a way to get around the adju-

dication process, because that is what we used to do in the past, but you can do a rulemaking behind closed doors.

So, I love to save taxpayers money, contrary to what some of my colleagues believe, but if there are contracts that come up that we cannot handle or we cannot do something about, then that says something about management and, you know, at the least about how the Agency is managing itself because we do not have any other Agencies that have lapsed 2 years in a row or 3 years in a row, and we have to have a bipartisan deliberation and passed in a law that says you cannot do this, friends, you cannot do it. And we asked you to fill these capacities and these things by the end of 2019 and we are not there yet.

So, look, there are probably more—I don't know if my colleague has any more questions. I think we have some serious issues here.

I go back to the mission statement. Now, I also do want to mention SuperShuttle. SuperShuttle, the Board permitted its employees to be misclassified as independent contractors on the grounds of entrepreneurial opportunity, okay, despite the fact that the drivers, they were forced to sign non-compete clauses, undermining any entrepreneurial opportunity. One has to conclude that this is about denying benefits. Now, that is where I conclude.

And a final comment before we bring the hearing to a close. Look, yes, people do have different philosophies, elections have consequences. I don't deny that the President is the President of the United States. I have a view of who I would like to see as President next time around. I believe in the system. I believe in democracy and government and that is the way we proceed.

But I will tell you that stay true to your mission. I think we have so much evidence that allowing for workers to have their rights protected and to be able to organize and collectively bargain, that so far you have been in the business of eroding it, whether or not they are drivers for SuperShuttle or it is about the graduate students who are doing major, major work for the academic community are being denied their rights.

I know my colleagues support the new ruling, but as my colleague, Congresswoman Herrera Beutler said, those folks today who are going to be out of work, not through any fault of their own, but because of Coronavirus, business may be shut down. We have got The Center for Disease Control saying, Stay home. Stay home.

But they do not have sick days. And the likelihood under the system that you have crafted and constructed, they will not have paid sick days and, unfortunately, we, and I say we as a congress, is going to address that issue in an economic package for American families, for American workers in trying to recognize and understand the role that they play in our society.

None of us, Congressman Harris and myself, if we were told to go home for 2 weeks, 3 weeks, 5 weeks, whatever it is, you bet we would continue to get a salary and we would get our sick benefits paid for. If it is good enough for Members of Congress, then it is good enough for the American worker.

This hearing is concluded. Thank you.

WEDNESDAY, MAY 6, 2020.

COVID-19 RESPONSE

WITNESSES

TOM FRIEDEN, PRESIDENT AND CEO, RESOLVE TO SAVE LIVES, AND FORMER DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

CAITLIN RIVERS, SENIOR SCHOLAR, JOHNS HOPKINS CENTER FOR HEALTH SECURITY, AND ASSISTANT PROFESSOR, DEPARTMENT OF ENVIRONMENTAL HEALTH AND ENGINEERING, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Ms. DELAURO. The hearing will come to order. Good morning and welcome to the Labor, Health, and Human Services, and Education Appropriations Subcommittee. Today's hearing is on the Nation's ongoing response to the coronavirus.

Like all other efforts on the supplemental package, it has been bipartisan. Let me commend my colleagues on both sides of the aisle, including my friend and ranking member, Congressman Tom Cole.

Before I begin, I want to extend a very warm welcome to our witnesses: Dr. Tom Frieden, President and CEO of Resolve to Save Lives and former director of the Centers for Disease Control and Prevention, the CDC, from 2009 through 2016; and Dr. Caitlin Rivers, senior scholar at the Johns Hopkins Center for Health Security and assistant professor in the Department of Environmental Health and Engineering at the John Hopkins Bloomberg School of Public Health.

Dr. Frieden, in his testimony, will provide a perspective based on 30 years of fighting epidemics, including leading the CDC's response to Ebola, of where we are, and what we need to do to protect Americans.

Dr. Rivers makes the case why, in the months and years to come, will we need additional capacities and diagnostic testing, contact tracing, and the health systems to combat the virus.

I am also so glad to have my colleagues here. I want to thank them for being here this morning. On the Democratic side, Congresswoman Katherine Clark, Cheri Bustos, Bonnie Watson Coleman; and on the Republican side, Congressman Tom Cole, Congressman Andy Harris, and I hope we will have Congresswoman Jaime Herrera Beutler.

We are all disappointed that others could not be here, because of distance, reduced flights, and the health issues raised by the House Physician. Chairman Nita Lowey, Ranking Member Kay Granger, Congresswomen Lucille Roybal-Allard, Barbara Lee, Lois Frankel, and Congressmen Mark Pocan, John Moolenaar, and Tom Graves, they could not attend, but they did send questions, which we will ask on their behalf.

But I want to underscore that members should not be blocked from participating in the committee's hearings. All committee members should be heard, and that requires moving as quickly as possible into the 21st century and conduct virtual hearings. Every member should be able to participate.

I am angry that the White House mismanaged America's reaction to the pandemic and the President has done everything he could to avoid accountability. I am particularly upset about the lack of the necessary testing and the personal protective equipment capacity, both of which could help us to gain control.

And then, yesterday, President Donald Trump told reporters that he would not permit Dr. Anthony Fauci to testify before the Democratic House Committee because, and I quote, the House is a bunch of Trump haters. Quote, they frankly want our situation to be unsuccessful.

But they are allowing Dr. Fauci to testify before the U.S. Senate next week.

This is a bipartisan panel. Dr. Fauci has appeared before our subcommittee dozens of times. He has testified whether it was a Democratic or a Republican chair. He has testified hundreds of times on Capitol Hill, working with Democratic and Republican Presidents. Yet, now, the White House said no, leaving no doubt it is just frightened of oversight.

The Labor, HHS Subcommittee provided billions of dollars of funding for the CDC, NIH, the National Strategic Stockpile, hospitals, and BARDA. We have appropriated \$175 billion for hospitals and other healthcare providers, most recently \$25 billion to expand testing and improve diagnostics, including \$11 billion for State and locality testing capacity.

The purpose of today's hearing is to get a clear-eyed view of the path forward for responding to COVID-19 in the near term, as we work to mitigate the spread of the coronavirus; in the medium term, as we develop the therapeutics to treat the disease and a vaccine to inoculate millions of Americans against the coronavirus; and, in the long term, as we make investments to enhance our Nation's public health and global health systems to better prepare for the next pandemic over the horizon. These are the three pillars we will look to build.

In today's hearing, I would like to explore the recommendations of our two public health experts on the necessary measures that must be put in place and the benchmarks that must be met to move forward while keeping Americans safe. Science and facts must drive our policy, and that demands hearing from doctors, scientists, researchers, and experts who command those facts and drive science to public policy. It is urgent that we do so.

Disease modelers predicted, according to The New York Times and The Washington Post that in the coming months, 3,000 Americans could die every day. There is no time to delay. Our witnesses today will give us the analysis, the facts, the science, and the strategy that will help us to make the right decisions.

With that, I would like to recognize my good friend, the ranking member of the committee, for any opening remarks that he would like to make.

Mr. COLE. Thank you, Madam Chair, and let me make a few extemporaneous remarks before I get to my prepared remarks.

First, I just want to really thank you for holding this hearing. I think it is a very important hearing to have, and I want to thank all my colleagues that were able to make the trip here. We all understand why others couldn't, but I really appreciate each of you on both sides of the aisle for coming.

And I want the record to show I joined the chairman in urging that Dr. Fauci be allowed to testify here. I think it would have been good testimony, useful to this committee; I think useful to this country. Frankly, I think going forward this subcommittee, probably more than any other, is going to need administration input, expert input, as we make the important decisions in front of us.

And, while I am not naive enough to believe that there is not a certain amount of partisanship on Capitol Hill and some committees are more partisan than others, frankly, the Appropriations Committee in general and particularly this subcommittee are not hyper partisan committees in my view, and the record shows it.

In the last 5 years, working together on this subcommittee and with our friends in the United States Senate, particularly Senator Blunt and Senator Murray, you know, we have increased NIH funding by 39 percent. We have increased CDC funding by 24 percent. We have increased the Strategic Stockpile funding by 34 percent. We have established the Infectious Disease Rapid Response Fund. I think that is a bipartisan record of accomplishment to be proud of, and I don't—I think, in retrospect, we all wish we had done more, but the reality is, we are so much better off where we are at, because of the actions taken in a bipartisan sense by this committee. So its record shows that it knows how to work together.

I just note for the record, my friend, the chairman, when I was chairman, voted for final passage of the bill every single time. We negotiated, got to a place where we could agree, and she helped me get it across. I was able to do the same thing with her when she last year assumed the chairmanship. And I hope that is the way we can continue to work going forward.

So, again, I think we are going to be called upon to make some really important decisions, and having read the testimony of both Dr. Rivers and Dr. Frieden, you know, a lot of that is going to call for sustained investment in the public health sector. Frankly, I think it is going to call for us looking at the caps agreements on some of these accounts as well. I don't think you can probably get to where we need to go within the cap. So we need the input, which I know our two witnesses here today will give us, and again, I look forward to working with every member of this committee, and particularly with you, Madam Chair, to arrive at the right decision for all our country going forward.

So, with that, again, I want to thank you too for the many calls and briefings that you have held over the last few weeks to keep all of us updated on efforts to overcome this pandemic. Over the last several weeks, the spread of COVID-19 has caused unthinkable disruptions to life as usual, and it will continue to do so for some time, even as we flatten the curve.

Following the unprecedented strain on our healthcare systems and the devastating economic hits to hardworking Americans as a

direct result of this coronavirus, the desire for normalcy to return is certainly a sentiment shared by us all. But as State and local economies slowly and cautiously begin to reopen, it is important to remember that getting back to business does not yet mean getting back to normal.

Even though the fight against COVID-19 is far from over, keeping businesses closed and workers at home is not a sustainable option for the long term. While the Federal Government has provided some short-term relief to help individuals, households, businesses, and communities stay afloat during this period of extreme social distancing, our economies need to get moving again and Americans need to get back to work.

However, any such efforts to reopen must continue to keep the health and safety of Americans at the top of mind and not undo previous progress in slowing the spread of coronavirus. This will indeed be a balancing act. Until there are working treatments, effective therapeutics, and ultimately a vaccine to control COVID-19, the risk and the danger for disease remains.

Returning to more regular functions and operations requires gradual action, completed in phases and based on data. President Trump and the Coronavirus Task Force recently recommended criteria for States and communities to achieve before moving into phases of reopening. This includes a consistent downward trend in reported symptoms, consistent downward trend in documented cases, where positive tests as well as hospitals being able to treat all patients without crisis care, and robust testing in place for all at-risk healthcare workers.

While this is a helpful reopening blueprint, States are not strictly bound to it. Indeed, just as there are 50 separate and unique States, there may be well 50 different approaches to reopening that carry the same spirit of caution and decisionmaking based on sound data.

However, the idea behind these three phases is to gradually allow businesses and workplaces to open back up, but not immediately full speed ahead or without adaptations to prevent crowded environments. In the earliest phases, this may include limiting the number of employees inside of workplaces, continuing telework practices, vulnerable and other older Americans remaining at home, or limiting the number of customers inside retail stores and restaurants. Clearly, life is going to be different going forward for a while than it was in our immediate past.

Regardless of the phase of reopening in our communities, we must remember not to abandon practical and hygienic precautions like thoroughly and frequently washing hands, not touching our faces, daily disinfecting of surfaces, keeping a safe distance from others, and staying at home when you are sick.

Finally, it is critically important that the Federal Government learns from this crisis and actively prepares to face down another pandemic in the future. While I am proud that Congress has generously invested in worthy tools and response resources to strengthen our readiness in recent years, it must be an even higher priority in the days to come.

Though the United States was as prepared as any country to face the emergency, you can never be fully prepared for what you don't

know is coming. In this case, a mysterious and deadly virus, originating in China, only identified early this year, and for which a vaccine does not yet exist.

I look forward to hearing more recommendations from our witnesses, Madam Chair, this morning, and I yield back the balance of my time.

Ms. DELAUBRO. Let me say thank you to the ranking member and assure you that we will continue as a subcommittee to work together in a collaborative spirit to do what is right in this area and other areas that we have jurisdiction over on behalf of the American people.

And let me also welcome our colleague, Congresswoman Jaime Herrera Beutler, you have come a long way, a State that has really been hard hit by the coronavirus. So thank you so much for being here. Really appreciate that.

And now I would like to introduce our witnesses. Our first witness is Dr. Tom Frieden. Dr. Frieden is president and CEO of Resolve to Save Lives, a global initiative and part of the global public health organization Vital Strategies. Dr. Frieden was director of the Centers for Disease Control and Prevention, the CDC, from 2009 to 2016. Dr. Frieden is recognized as one of the world's leading experts. His current organization is assisting more than 60 countries during this COVID-19 epidemic, as well as providing technical assistance to New York State and other jurisdictions here at home.

During his time at CDC, many will recall that he led the response to the Ebola outbreak along with his colleagues at the State Department. He also spearheaded many new health initiatives here in the U.S., including initiatives to address the opioid epidemic and to reduce chronic disease.

Dr. Frieden, we are so pleased to have you here today. Your full written statement will be entered into the record, and you are now recognized for your opening remarks.

Dr. FRIEDEN. Thank you very much and good morning, Chairwoman DeLauro, Ranking Member Cole, distinguished members of the subcommittee, I appreciate the opportunity to testify. In the next few minutes, as you say, I will provide a perspective based on three decades of fighting infectious diseases in the U.S. and globally. The bottom line is that COVID is a terrible tragedy. Families have experienced devastating loss. Parents have lost their jobs, and all of our lives have been disrupted.

Our war against COVID will be long and difficult, and we must act strategically now and establish a new way of preventing future health disasters. At an appropriate time, we can assess what went well and what didn't. I am acutely aware that hindsight is 20/20. It is far too easy to second-guess decisions that others have made.

We are just at the beginning of this pandemic and must focus on the future. There is only one enemy here: a dangerous microbe. It is us against them, humans against the virus. We will get through this best if we work together, learn from each other, and support each other.

Here are 10 plain truths about COVID-19. First, it is really bad. In New York City, where I live, I have heard for the past 2 months the sounds of ambulances day and night. In New York City, it is

on the order of 1918–1919 pandemic, more than 20,000 people, when you look at all of the excess deaths in the last 2 months, killed in less than 2 months. That is as bad as the worst phase of the pandemic a hundred years ago.

Even now, with deaths decreasing substantially, there are twice as many deaths from COVID in New York City as there are on a usual day from all other causes combined. And, sadly, looking at the U.S. as a whole, just calculating forward from the number of people whose infections have already been documented, there will be tragically at least 100,000 deaths from COVID by the end of this month.

Second, as bad as this has been, it is just the beginning. Until we have an effective vaccine and unless something very unexpected happens, our viral enemy will be with us for many months and possibly many years.

Third, data is a very powerful weapon against this virus. Real-time monitoring of trends, finding cases before they become clusters, clusters before they become outbreaks, outbreaks before they become explosive epidemics that risk the lives of healthcare workers and others.

Fourth, we will be able to reopen as soon and safely as possible by basing decisions on data and creating together a new normal. We are all so impatient to restart our activities. Sheltering in place is a blunt but effective weapon. It suppresses spread of the virus but inflicts severe economic hardship on individuals and the economy.

We need to deploy all of the effective weapons in our arsenal. After flattening the curve, the next step is what we call the box-it-in strategy. There are four corners to each of the box-it-in aspects: testing widely and strategically; isolating people who test positive; using contact tracing to confidentially warn people who are exposed to the virus; and quarantining contacts, providing essential services so that they can be sure that infection stops with them.

If any corner of that box is weak, the virus can escape and spread explosively again. Each of the four is important.

Fifth, find the balance between restarting our economy and letting the virus run rampant. We are conditioned to think in terms of dichotomies, A versus B. But in this case, open versus closed is not a dichotomy. It is more accurate to think of a dimmer switch or a dimmer dial than an on-off switch, with gradations to avoid undue risk.

Even when we are closed, many essential activities continue, and when we reopen, our new normal will be different. With care and creativity, we can open sooner and safer. Our new normal will change the way we travel, work, learn, and go about our lives. The virus can create a new generation in minutes, but in human populations, it takes weeks to see the result of repeated spread. So, if, as we reopen, there is a lot of spread, it will take weeks before we actually see it.

Another false dichotomy is between public health and economic security. In fact, the very best way to get our economy back is to control the virus, and economic stability is critically important to the public's health.

Sixth, we must protect the healthcare workers and other essential staff who are the frontline heroes of this war. They should never have to put their lives at risk to care for us. Having safer healthcare facilities is essential to enabling more societal activity to resume.

It is one thing to take risks for yourself, but if the risk that you take for yourself ends up infecting a nurse or doctor and then their mother or father or child, that is something quite different.

Seventh, we have to protect our most vulnerable people. Unless we take urgent action, there will be at least 100,000 deaths in nursing homes throughout this country. All congregate facilities and high-risk settings require intensive protection. We must also act now to reduce the higher rates of both infection and death among African American, Native American, and Hispanic people.

Eighth, governments and private companies must join forces to make massive continued investments in testing and distributing a vaccine as soon as possible, ensuring rapid and equitable access in this country and around the world. Nothing else will enable life to get back to a pre-COVID normalcy. Treatments can help and should be available sooner but are unlikely to be the kind of game-changer that a safe and effective vaccine would be.

Ninth, we must heighten, not neglect, our focus on non-COVID health issues. This is a very important lesson from around the world. Not only do underlying conditions increase the risk of severe illness from COVID, but if we don't continue non-COVID conditions, there will be many deaths that could have been avoided, not from people infected with COVID but from people affected by the disruption of services that COVID causes.

And, when fall comes around, we will need to do the best we have ever done at getting people vaccinated against influenza because that will make our job easier in the next phase.

Tenth, never again. It is inevitable that there will be future outbreaks. It is not inevitable that we will continue to be so underprepared. This is an interconnected world. A disease risk anywhere is a disease risk everywhere, and when the world is safer, we will be safer.

It was very difficult, as you all know, to secure funding for global health security. It took years of effort, and funding was only allocated after the Ebola epidemic hit, and that only one-time funding.

Therefore, Congress and the administration deserve congratulations for quickly passing comprehensive, bipartisan legislation for supplemental funding for the COVID response, but supplemental funding is a temporary fix. It is a Band-Aid.

Without sustained support, our health will be avoidably at risk. One-time funds are very problematic. From the point of view of someone running an agency, you can't hire the best staff; you can't enter into partnerships with countries and organizations where you can keep up your end of the bargain; and you can't hold contractors accountable for an ongoing contract.

You, in Congress, have a unique opportunity to take strategic action and protect Americans from another microbial sneak attack. To protect us from health threats, we have to change the way we allocate funds. We have all been through this. Discretionary fund-

ing is subject to caps and sequestration. Even mandatory funding doesn't ensure stable support as we have seen.

We propose a new approach for specific public health programs. These are programs particularly to prevent, detect, and respond to health threats, and we suggest calling this the Health Defense Operations, or HDO, budget designation. It would exempt only these critical health protection funds from Budget Control Act caps. So our public health agencies can protect us.

HDO programs should be required to submit a bypass professional judgment directly to Congress annually just like the NIH does for HIV, Alzheimer's, and cancer. That way, Congress and the American people can understand what is really needed for a public health defense, and Congress can appropriate the resources required to sustain the public health system we need to keep us safe.

This investment can save millions of lives and potentially, as we have seen, trillions of dollars. Good public health is good business. In my 30 years in global public health, I have never seen anything like this. It is scary. It is unprecedented. We are learning more each day. I have outlined some of the things that we can do at home, in business, in government, right now, to slow the spread of COVID and rebuild our economy.

We must make sure this never happens again by investing in systems to find and stop emerging health threats before they spread, whenever and wherever that is possible. Thank you, and I look forward to answering your questions.

Ms. DELAUBRO. Thank you very much, Dr. Frieden. And appreciative, I think so personally about this issue. I never knew him, but my grandfather died in the Spanish influenza in 1918, at age 36, leaving a widow and five children and one on the way, and so it really brings it all home that we could be now experiencing this and our families could be experiencing all of this.

Now I would like to introduce our second witness, Dr. Caitlin Rivers. Dr. Rivers is a senior scholar at the Johns Hopkins Center for Health Security, as well as assistant professor in the Department of Environmental Health and Engineering at the Johns Hopkins Bloomberg School of Public Health. Dr. Rivers has been a leading public health voice during the response to COVID-19. She co-authored a report, along with Dr. Scott Gottlieb and their colleagues at the American Enterprise Institute, AEI, A Roadmap to Reopening, which outlines a series of milestones and capabilities that States should meet as they consider easing restrictions on businesses and social life.

Dr. Rivers is also the lead author of a report, "Public Health Principles for a Phased Reopening During COVID-19: Guidance for Governors," which is being used by the National Governors Association, as well as Maryland and Washington, D.C., to guide their reopening plans.

I would also note that Dr. Rivers worked as an epidemiologist for the United States Army Public Health Center as a Department of Defense smart scholar.

Dr. Rivers, we are so pleased to have you with us here today. Again, your full written statement will be entered into the record. You now are recognized for your opening remarks.

Ms. RIVERS. Thank you. Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the committee, thank you for the chance to speak with you today about the COVID-19 response. As Chairwoman DeLauro described, I am an epidemiologist at the Johns Hopkins Center for Health Security at the Bloomberg—Johns Hopkins Bloomberg School of Public Health. I have co-authored a number of reports and guidance documents on reopening safely, and it is lessons from that work that I want to share with you today, but first a little bit about the current situation.

The United States still faces 25,000 to 30,000 new cases every day and approximately 2,000 deaths, a range that held steady for the entire month of April. Many States are either moving towards reopening or looking ahead to those decisions and wondering, as we all are, how to do that safely.

It is clear to me that we are in a critical moment of this fight. We risk complacency in accepting the preventable deaths of 2,000 Americans each day. We risk complacency in accepting that our healthcare workers do not have what they need to do their jobs safely. And we risk complacency in recognizing that without continued vigilance, we will again create the conditions that led to us being the worst affected country in the world. And so, with that in mind, I want to highlight a few critical capacities that I think we should be prioritizing.

The first critical capacity is diagnostic testing. Last week, we performed about 1.6 million tests, which is a big improvement over March and even over early April when we performed about 1 million tests per week. These gains are a testament to the impressive biomedical enterprise that we have built through sustained investment in science and medicine.

But estimates of the number of tests that we will need to gain control of this outbreak start at 3.5 million per week and go up from there. We urgently need a national plan for how we will close that gap. We need to understand what national capacities we can expect at the end of May, at the end of June, at the end of August. Where are the bottlenecks? Where are the untapped resources? And it is not just for the test kits. It is all for all of the consumable supplies that are required for testing: the swabs, the PPE for the care providers, the viral transport media. There are a lot of components involved in diagnostic testing, and at various points, all of those have been implicated in interim in shortages. And we urgently need to understand where we are going with diagnostic testing and how we are going to get there.

If this work has been done, I have not seen it, and I fear that neither have the Governors and the mayors and the business leaders and the university presidents and the school principals, all of whom are having to make decisions about how and when to reopen. So it is not just the Federal Government that needs this information. It is really all of us who are trying to navigate how we will get from where we are to where we want to be.

The second capacity is contact tracing. You heard from Dr. Frieden that contact tracing is really a key component, a key approach that will allow us to reopen safely. One thing that I don't hear a lot about, about contact tracing, though, that I want to bring to your attention, is that it is also a key source of data that

we badly need. We currently have very little understanding about where people are getting infected. Are most new cases in long-term care facilities or correctional facilities, which we know are high-risk settings, but we don't have a good sense of whether 99 percent of our cases originate in those special settings or whether it is a small fraction.

We don't know whether people who are essential workers still performing duties in the community are getting infected, or we don't know whether most infections are happening at home. Getting a better understanding of what that looks like will help us to guide better interventions. If it is special settings, we know we need to be doing more to protect people there, but we might also assess the risk to the general community to be lower.

On the other hand, if most people are getting infected at home, that points for a need for some sort of central isolation capacity, by which I mean if people feel that they would be safer recovering in a hotel away from their families, for example, that should be an option that should be made available to them. But we would want to know what fraction of cases are originating in the household to understand whether that is an important investment.

This information on where transmission is occurring is of critical importance, but it is not currently being prioritized, and it is contact tracing that allows us to collect this data. So, in addition to being a key tool for containment, it is also a key tool for helping us to guide our response and the decisions that we need for that.

The third pillar is healthcare capacity. We were able to secure enough healthcare capacity to treat everyone with COVID only through extraordinary measures like canceling elective procedures and turning operating rooms into ICUs, but rightas we start to think about unwinding some of those decisions is when States are moving to reopen. And so we need to be exquisitely careful in this period that we do not allow our healthcare systems to become overwhelmed by drawing down our surge capacity as we increase time spent in the community.

We need to be careful that we do not again create the conditions of New York or Lombardy or Wuhan. We should plan now for how we will staff and fund deployable medical teams to move from hotspot to hotspot. And I will point out too that we are making these decisions as we face hurricane season, which will draw on many of the same resources. And so I think we need to plan for the worst-case scenario and understand that we may be needing these surge-capacity resources in the coming months.

And we should also continue to fight for sufficient supplies for personal protective equipment to keep our healthcare workers safe. This has been a continuous problem, and it is one we need to solve permanently. It is not acceptable that our healthcare workers don't have what they need to do their job safely.

So these three capacities—testing, contact tracing, and healthcare—will enable us to transition safely from staying at home to slow the spread into a gradual reopening. We should be working now to ensure that we have the tools to do that successfully.

I now want to touch briefly on a longer term priority that I think we should keep in our sights. We have seen in the White House

task force briefings and on the nightly news that infectious disease modeling, or outbreak science, is playing an important role in guiding the COVID-19 response, and it is not just COVID. This was also an important capacity during 2014 Ebola, during H1N1, and it will certainly be an important resource in the future pandemics that we can be confident we will face.

But what many people don't realize is that the expertise to produce those models is not a standing national capacity. It is mostly a volunteer force of academics who produce those models. This approach stands in stark contrast to weather forecasting which the Nation has invested in for decades through the National Weather Service. We don't have anything like that for outbreaks. But this pandemic underscores why that must change. We should consider establishing a national center that would perform epidemic forecasting and analytics.

And just briefly, one other longer term priority that I think we should be considering, or opportunity rather, is that we put enormous resources into developing medical countermeasures for threats that we have previously identified, but we don't have dedicated programs for what we call disease X, or these new pathogens that we didn't know existed until suddenly they are an enormous threat. And so I think we should be thinking about how we could stand up programs and fund resources to develop the tools we need to expand our capacities and raise the bar of readiness for those pathogens that we don't know anything about, but that we could be facing at any point.

So, in conclusion, thanks to the leadership of the House Appropriations Committee, the country has made important progress towards combating this pandemic. We must prioritize the strengthening of capacities in diagnostic testing, contact tracing, and the health system so we can successfully combat the virus in the weeks, months, and years to come. Thank you.

Ms. DELAURO. Thank you so much, Dr. Rivers.

At some point, I would love to talk to you about your idea on a center akin to the National Weather Service. I will try to find more about it.

As in the past, we will proceed to 5-minute rounds, alternating back and forth by seniority as members were seated at the beginning of today's hearing. We are going to be respectful of our witnesses in trying to give them enough time to respond to questions. I will move forward.

Dr. Frieden and Dr. Rivers, both of you have provided recommendations about the type of State and local capacity that needs to be in place before scaling back limitations on economic or social activity. According to reports, disease modelers are projecting the country is moving in exactly the opposite direction. According to a range of projections, new daily cases of COVID-19 could surge this month, and some are projecting that deaths could rise to 3,000 each day. And I would just like to ask a series of questions of each of you. To the best of your knowledge, is there a single State that has met the necessary parameters to ease restrictions?

Ms. RIVERS. We suggest, in our AEI report that you mentioned at the beginning of the session, that there are four criteria that States should meet in order to safely reopen, and not all States

have adopted these criteria, but I will review them just as a starting point. The first is to see the number of new cases decline for at least 2 weeks, and some States have met that criteria. But there are three other criteria, and we suggest they should all be met. The other is enough public health capacity to conduct contact tracing on all new cases, enough diagnostic testing to test everybody with COVID-like symptoms, not just those with severe illness, and enough healthcare system capacity to treat everyone safely. To my knowledge, there are no States that meet all four of those criteria.

Ms. DELAURO. Dr. Frieden, is there any single State that meets the criteria laid out?

Dr. FRIEDEN. I have not looked at all of the data from all States, but I would make two comments. One, there may be areas within States that are closer than others to meeting that. And, second, as I said in my opening testimony, open versus closed is not a strict on-off switch. There are things that are always open: essential services, essential retail, hospitals, emergency facilities. And there are things that might be first to open. Out of doors is way less risky than inside. Lower risk businesses, takeout from restaurants, outdoor recreation, even daycare if done very carefully and safely, may be lower risk. So I think we need to think of this as a dimmer, rather than an on-off—

Ms. DELAURO. An on-off switch. Just a quick followup here, and then I want to get to a couple of other items.

Any State testing 1 percent of its population every week?

Ms. RIVERS. [Nonverbal response.]

Ms. DELAURO. No? No?

Okay. Thank you.

Any State or region been able to reduce the basic reproductive number below 1, meaning that the epidemic is no longer growing?

Ms. RIVERS. There is some evidence that some States have.

Ms. DELAURO. Okay. Dr. Rivers, you are the lead author of a report where you are making recommendations to the Governors. To be clear, reopening will increase the risk of COVID-19 spread. Therefore, it is important for leaders to know that getting things open again will increase the risks of individuals contracting COVID-19, and there is no way to completely guard against that. Let me ask this of both of you. Should the country be reopening now? Are we ready? Is it irresponsible to open the economy without adequate testing?

Ms. RIVERS. I think there is an enormous need to balance public health with the economic pressures, and so I think that is what we see factoring into decisions. I think even as we move towards reopening and as some States make that decision, we still need to be focusing on increasing our capacities to do diagnostic testing and to do contact tracing. The time—the window we have to implement those interventions is still open, and so I don't think it is either/or.

Ms. DELAURO. Thank you.

Dr. FRIEDEN. I would say that we need to continue to rapidly ramp up our ability to do all of the four things I mentioned, not just test, but also isolate people who are infected, contact trace, and quarantine. By having all of these things in place, we can come

out safer and sooner, and we start our economy without a risk of explosive spread.

Ms. DELAUBRO. I believe it was—I know it was, it was Dr. Fauci who in the last several days has said, how many deaths and how much suffering are we willing to accept if you want to get back to some sense of normalcy. What is your sense of what is acceptable in terms of deaths or suffering to be able to get back to normalcy, if we don't have the public health professionals advising us?

Ms. RIVERS. I think we need to continue to prioritize public health. We have seen that several other countries have regained control of their outbreaks: South Korea, Singapore, Australia. We can do that too. It is going to be difficult, and it is going to take a lot of investment in our communities, but that option remains open to us.

Dr. FRIEDEN. I would just add, we have to ensure that we protect our healthcare workers and other essential workers. They are not making a choice. They are doing their duty in protected and providing essential services. And we have to do everything possible to keep them safe. And we have to pay particular attention to the most vulnerable, such as our nursing homes, large congregate facilities, homeless shelters, correctional facilities, large factories where many people are working together, where we can see explosive spread that can not only cause a lot of suffering and death but can also seed infections to elsewhere in the community.

Ms. DELAUBRO. Just quickly, the issue is, is that what the criteria is, how many deaths and suffering are we willing to accept in your view?

Dr. FRIEDEN. I think this is a balance. We need to reopen so we can restart important medical care. We need to reopen for our economy, but we need to do that in a way that is careful and doesn't risk an explosion of cases that sends us back into our homes.

Ms. DELAUBRO. Okay. Thank you. Thank you.

I yield now to my colleague, Congressman Cole.

Mr. COLE. Thank you, Madam Chair, and I want to thank both of you for your excellent testimony, and again for the papers you submitted.

Dr. Frieden, let me start with you. I am very intrigued by the idea you have presented about a special health defense budget, sort of the equivalent of what in defense we call OCO spending. That is something outside the cap. We just recognize for war, we spend what it takes to win the war, regardless of whatever budget mechanisms. And I think this is—you know, you and I have had this discussion and the chairman and I have had this discussion about particular accounts that need perhaps to be exempted.

Could you go through in a little bit more detail and talk to us about what specific accounts in your view we would need to sort of set outside the normal budget process and say, when it comes to public health and threats that emerge, we are going to have to be free to spend what we need these areas?

Dr. FRIEDEN. Thank you very much, and I appreciate all of your commitment to this issue over the years. We have discussed it for many years. And what we have seen is, if it is in discretionary, no matter how well intentioned everyone is, there are going to be problems. If it is in mandatory, no matter how fixed we think it

is, it isn't. So what we have suggested is something similar to the overseas contingency account that allows for a professional judgment of what is needed, and if we can enter into the record a letter sent to both Senate and House leaders yesterday and signed by former Senate majority leaders Frist and Daschle, as well as myself and multiple other former CDC directors—Bill Fahey, David Satcher, Jeff—

Mr. COLE. Madam Chair, I would ask that we could enter that letter, if we may, to the record.

Ms. DELAURO. Yes, yes, be happy to.

Dr. FRIEDEN. And that also includes budget line examples of which would be included. They are squarely in the area of protecting Americans. We wouldn't want to choose between our military radar defense and another part of the budget in the same way we shouldn't have to choose between this kind of defense and another part of our budget.

Mr. Cole, you have said over the years that Americans are far more likely to be killed by a pandemic than by a terrorist attack, and I am afraid the past month has shown that to be quite prescient. In the same way, I think we have to recognize that, other than nuclear war, there is nothing else that can kill 10 million people around the world except a biological event, and we have to do everything in our power to prevent that from happening. So the approach is essentially twofold. One, you identify the budget lines. You make them off budget through this HDO or some other mechanism similar to the OCO account. And, second, tightly related to that, you require a bypass professional judgment: Do not stop at go; do not get cut 200 by OMB. Give the actual professional judgment from what is needed so that in Congress and in public you can assess that and then put in all of the accountability metrics for what we expect to see for the moneys that are being spent. This is not a piggy bank. This is a specific investment in building up our national defense.

Mr. COLE. Madam Chair, I would suggest that is something we need to work on together and maybe submit together for the consideration of our colleagues because it will take, you know, obviously agreement between the House, the Senate, and the executive branch, but I think it is a very good idea.

Dr. Rivers, let me turn to you, if I may—and again I very much enjoyed reading your paper and your testimony—you made two points that were particularly striking to me, probably because I agreed with them, which was, one, your concern about—you know, we just appropriated \$25 billion for additional testing. I am not sure exactly what we are doing with it, you know, whether we really have a program set up and running for it.

Same thing about your point on contact tracing. This is an enormously, you know, intensive manpower-type operation, particularly in something this size. So what are the sorts of things you would recommend that we do that you would say, okay, this would be an adequate testing program, this would be an adequate contact tracing program?

Ms. RIVERS. We have heard from many experts over the last few weeks different plans for what testing capacity we should have and what we would do with that capacity. I am suggesting we actually

start at the other side and figure out what are the components, and where is their room to go up on all of those components. That is the part that is not clear to me. As an epidemiologist, I could say, sure, if we could test everybody once a week, that would get us this. If it were every 2 weeks, we would have these options, but it is not clear to me which of those plans is actually feasible. And so I think it is really important that we go step by step and figure that out. And I think we need a national plan in order to do that effectively. I don't think States should be left to do it independently.

In terms of contact tracing, in addition to using that as an approach for containment, I think we should be prioritizing data collection. CDC recently put out new guidance for how data collection during contact tracing should—rather, how data could be collected during contact tracing, and it does incorporate many of the data elements that I think would be really useful. So progress has been made just in the past week on that. I think next we should be sure that that data gets reported and analyzed. I think all of the State health departments should be reporting in, and I think the CDC should as well.

Mr. COLE. Thank you very much.

Thank you, Madam Chair.

Ms. DELAURO. Thank you, and now I would like to recognize Congresswoman Katherine Clark. Thank you for being here.

Ms. CLARK. Thank you very much, Madam Chairwoman.

It is good to see everyone here, and thank you so much for being with us.

We understand that testing is part of what we need to collect, the data that you so aptly described as the weapon that is going to help us defeat this virus and get our economy working up. And I very much like your image of a dimmer switch, where we can dial things up and down because we want parts of our economy or places in our different States to be able to open if they can safely do it. But I think it comes back to your box diagram, and it starts with testing.

And as you describe, Dr. Rivers, we are undertesting right now, if our goal—and I would be interested if you both agree the goal is 1 percent of the United States population once a week. So that would be roughly 3.8 million tests, and we are now at 1.6. So do you agree that that 1 percent is the right benchmark we should be aiming for?

Ms. RIVERS. I think that is in the right ballpark, but I would make the point that we don't want to test 1 percent of America evenly distributed.

Ms. CLARK. Right.

Ms. RIVERS. We want it to be focused on people who are symptomatic, healthcare workers, essential workers.

Dr. FRIEDEN. And I would just add to that, we issued an outline, a briefing note, of who we think needs to be tested by priority level because you could test 1 percent, but exactly as Dr. Rivers said, if you test the wrong 1 percent, you are not going to be optimally controlling. You have to look at those with symptoms most likely to spread, most likely to die in congregate facilities, healthcare workers with symptoms, contacts who are symptomatic, hospitalized pa-

tients even without symptoms because they can spread it widely, all people in a nursing home if there is a case there because they can be exposed to the spread, essential workers who are symptomatic. So I think it is key to look at the numbers, but our estimate is that you would need at least two or three times current volume even if you only tested the highest priority people to do it, but that doesn't mean there isn't a lot we can't do at the same time to ramp up our other things because it is not going to be one thing that gets us out of this, except a vaccine.

Ms. CLARK. That is right. And so we have to do all these things, but with the test, to get to where we need to be, to best testing those essential workers, part of my understanding is the test that we are using now is inefficient and expensive and requires a lot more of the swabs and other equipment that we frankly are just having shortages of. So where are we with point-of-contact testing, more instant testing? And even if their accuracy is not as good as the current tests we are using, is it worth it if it is more widely distributed and lets us test more of these essential workers and people at the greatest risks?

Dr. FRIEDEN. There are two broad ways of testing. For the virus itself, they are looking for the genetic particles like the PCR that is being done and looking for antibodies. I will leave antibody testing aside because there are many unknowns about it.

With the point-of-care testing for the virus, there are some systems that are relatively rapid now, but they are low through-put. So you are only going to be testing a few people each hour—or people over a 4-hour period. So that rapid point of care needs to be looked at. There are newer technologies and older technologies that may be helpful, but you are always going to have to take a good sample, and you are always going to have to be looking for a tiny amount of genetic material. So your idea of a test that would have what we would call a low sensitivity but still a high specificity—in other words, some false negatives, but it could rule someone in—would be very helpful but does not yet exist on the market.

Ms. CLARK. Okay. What are some of the limiting factors for reaching just the sheer number of tests that we are going to need, and how can we address them as we look at putting together a budget that can really use this, develop the data we need?

Ms. RIVERS. I tried in earnest to find this out, and I wasn't able to determine what the gaps are, and I think that in itself is a big problem. I think continuing to bring new platforms onto the market will be helpful, but then what about swabs and what about the PPE that the healthcare workers need to take the samples? It is opaque to me, and I think that is something we could fix.

Ms. CLARK. Great. I have just a few minutes left. I would just say that, at this point, I can't underscore and agree with you more on the need for a national plan, and that States are too interconnected, and we need to be learning from each other on how this virus is being spread and how we can best do these things, test, isolate, trace, and quarantine, and safely bring our economy open. That is the goal of everybody here, but we need to support that in a national way.

Thank you, Madam Chair.

Ms. DELAURO. Thank you.

Congressman Harris.

Mr. HARRIS. Thank you very much. And since I come from one of the stay-at-home States and represent a fairly rural district, you know, a lot of what I am going to talk about is why we should treat everything uniform. I mean, rural areas can be treated differently because the disease burden is less, the strain on the hospital system, et cetera, et cetera.

So, first of all, well, Dr. Frieden, you said—and I think I quote here—shelter in place is blunt but effective. We don't really have scientific data on that for coronavirus; do we? Because if you plot actually what the States have done versus their—or the severity of the measures States have gone versus their case counts, you actually find that the States with less restrictions in place, sometimes have lower case counts. An example is Florida. So we really have no data, specific objective data about that, do we? Prospectively looked at? For the coronavirus, for COVID-19?

Dr. FRIEDEN. For COVID-19, if we look at information from around the world, it is very clear that, when people stay home, it reduces the spread. But it is also clear, Doctor, that there are countries, including Singapore and South Korea, that have been able to limit the amount of physical restrictions or physical distancing and still control the virus. And there are differences in different environments.

Mr. HARRIS. So Florida, for instance, didn't put in stay-at-home, but their case rate is lower than Maryland's, for instance, right?

Dr. FRIEDEN. There are many factors that go into what the case rate is.

Mr. HARRIS. Sure. That is right. So my point is that shelter in place might work, but it might be just the social distancing that shelter in place obviously implies.

Now, Dr. Rivers, I looked at the recommendations from AEI. They are a month old. Is that right?

Ms. RIVERS. Yes.

Mr. HARRIS. So we have learned a lot in the last month, haven't we, about this disease? So, for instance, as we ramp up testing, the first criteria is that your case count has to go down. Well, as you ramp up testing, you are going to find cases that you wouldn't have found. So, for instance, I am sure you are aware, there is a Michigan prison where they tested all their prisoners. Sixty percent tested positive; they were asymptomatic. In an Ohio prison, 73 percent tested positive, the vast majority asymptomatic. So there are clearly asymptomatic cases around, and as you ramp up testing—so what you are going to be doing is you are going to be chasing your tail.

Now, since the entire purpose of restrictions was to minimize stress on the healthcare system—right, because we want our healthcare system to take care of people so that they don't die—then why wouldn't hospitalizations or ICU occupancy, even more importantly, be the benchmark? Because in Maryland, we have plateaued in ICU utilizations, but our case counts continue to go up as we begin to go into a hot spot. For instance, the processing facilities, poultry processing facilities, well, you go in there, there are a lot of healthy people. They may have coronavirus, but they are otherwise healthy. They are asymptomatic. You are going to

start testing; you are going to find a whole lot of cases. But that doesn't mean that your community's healthcare system is overstrained. So why would you choose cases and not hospitalizations or ICU utilization as your benchmark?

Ms. RIVERS. I would add to your statement that the purpose of lockdowns or stay-at-home orders, it is true, was to prevent overwhelming our healthcare system, but it was also to give us time to build up our capacities to do case-based management, and I think we shouldn't lose sight of that.

Mr. HARRIS. So let me talk a little about case-based management because a lot has been said about contact tracing. Dr. Rivers, what is the—for every case that we have diagnosed, what is your estimate of the number of cases that exist that are asymptomatic? People that are asymptomatic, they never had symptoms. So they would never be detected for contact tracing?

Ms. RIVERS. Emerging evidence is that about 25 to 50 percent of cases are asymptomatic, but those people would still be affected by quarantine.

Mr. HARRIS. Now, you do know the—in Stockholm, the estimate is that, for every case that is identified, there are 73 cases that haven't been identified. Is that right? Do you know that? Are you aware of that statistic?

Ms. RIVERS. They have not shared their scientific data. So, although we have the top-line number, we don't know.

Mr. HARRIS. Okay. It is reported. You can Google it. It is reported.

So, if we concentrate on contact tracing—and that is, you know, that is our gold standard is we have to have contact tracing—for every patient we contact trace, we could have 10, 20 people who are out there asymptomatic, not contact tracing. And the description of contact tracing as well, you know, we are going to educate the people who are infected and the people they could have come in contact with about what the good, you know, public health measures are. Wouldn't it be more effective if we just educated everybody because we really don't know who is an asymptomatic carrier? That is, educate everyone, you know, wear a mask when you go out in public so you don't spread the disease, make sure you wash your hands, make sure you don't touch your face, or your nose or your mouth. You know, these are the things as doctors we have known for years. Look, we know how to prevent the spread of respiratory viruses. What we are doing is now educating the broader population, but to say that we are going to do this through contact testing and not very broad education, I think, means we are going to set a standard—you know, to train a hundred thousand people nationwide and to institute contact tracing could take weeks. I have small business owners in my State, in my district, who tell me they can't last weeks; they are going to go out of business. So you tell me, Dr. Rivers, why a business owner in his district who sees five customers in a store for an entire day can't safely operate with social distancing, masks, and hand hygiene?

Dr. RIVERS. I don't think the economy will be able to recover robustly if people are afraid of getting infected in the community. And so I think it is to the advantage of the economy if we can implement and regain control using case—

Mr. HARRIS. So you think it is dangerous for that store owner to open up their store using CDC guidelines, and we won't even get into—because I was going to ask, and maybe in the second round, I will—the WHO guidelines, the World Health Organization guidelines are so much different from the CDC guidelines. So you think it is dangerous for that store owner to open up?

Ms. RIVERS. I think the customers won't want to visit if they don't have confidence.

Mr. HARRIS. That is their choice, isn't it, on the customers?

Thank you. I yield back.

Ms. DELAURO. Congresswoman Cheri Bustos.

Mrs. BUSTOS. Thank you, Madam Chair.

And Dr. Rivers and Dr. Frieden, thank you very much for taking the time to be here with us today. I want to ask you about COVID-19 in rural communities. The district that I represent in the northwest corridor of the State of Illinois, 85 percent of the towns are 5,000 people or fewer. 68 percent of the towns are a thousand people or fewer, so that gives you a picture of the kind of district that I represent.

There are people who think that COVID-19 is less serious in rural areas, outside of, you know, not highly populated, not high density of a population. And so a couple examples that I want to share with you of what we are seeing in this congressional district. We have 102 counties in the State of Illinois. Two of those counties—one is called Warren County which is in the congressional district I serve has a population of about 17,000 people so not a large population. It now has the fifth highest number of cases per capita in the State of Illinois.

Another county is Stephenson County. It is on the Wisconsin State line. It has a population of about 44,000 people. The number of cases, COVID-19 cases there are doubling every 5 days, all right, so that is the third fastest rate in the State of Illinois, so I just wanted to give you a little perspective.

So, you know, I know, like, if you look nationally, we have many, many Governors now who are pushing for our country to reopen and certainly in their own States looking at reopening. And there are also these ideas that you can—we can reopen in a State in tiers, you know, where it is less populated versus where it is more populated.

So I am wondering if you can address that along the lines of what resources and practices do we need to know in more of these rural areas? Do we need a certain level of testing? Maybe if you can just drill down of how it is different in rural America versus, you know, towns like, cities like Chicago or New York, and this is addressed to both of you. I would like to hear from both of you on this, if I could, please.

Dr. FRIEDEN. Well, first, I would say that in general, the challenges in urban areas may be more severe. What to do about crowded subway systems, bus systems, very close quarters in the U.S. and globally is something that we have not yet figured out and is an enormous challenge, but no area is immune. We don't have immunity to this virus. And in each community, there may be nursing homes, there may be factories, there may be other facilities where there is a potential for a lot of spread, and there may

be less access to the kind of intensive care that is needed in some rural areas of the country.

I think something Dr. Rivers said is really important to highlight, and that is the importance of data. We are learning more about this virus every day. The famous Nobel Laureate, Josh Lederberg, used to say that microbes outnumber us. It is their numbers against our brains. And we have to use intelligence to figure out what the weaknesses of the virus are, to understand, for example, where it is spreading. What are the highest risk things?

I talked about two dichotomies in my testimony, open versus closed. It is really a question of degree, different things. The second was public health versus the economy. In fact, together we can resolve them. Another false dichotomy is safe and risky. It is really safer and riskier to make as much of our environment by design, by changing the way we go about our business as safe as possible, reduce risk, and we will do that by understanding more through things like contact tracing where the disease is spreading and how to reduce its spread most effectively.

Doctor.

Ms. RIVERS. Thank you. I would just add that rural areas have seen less explosive growth which is encouraging, but they also tend to have less capacities. And so I worry that a community may have a manageable level of transmission until a congregate setting like a correctional facility or a nursing home becomes infected. And then suddenly, the local hospital might have 25 high acuity patients that need to be admitted, and the hospital might not be able to accommodate that.

And so I think that is the kind of surge capacity that we need to be planning for is supporting rural communities when they do have a change in their epidemiology.

Mrs. BUSTOS. I have got 34 seconds left. Rosa, may I ask a second question that follows up on this?

So speaking of correctional facilities, we have two Federal prisons in the congressional district I serve. And I don't know if you have been following this case or this topic very closely, but the Marshals Service has turned over inmates to the Bureau of Prisons to go to 11 different prisons throughout the country, a transfer of patients that are not tested for COVID-19. One of those prisons is in Thompson, Illinois. This is in a county called Carroll County, zero hospitals there. You would have to travel over across the Mississippi River to Iowa to go to the hospital or a county to the north or a county to the south.

So I am wondering about screening, the proper screening that should happen before the transfer of any patients, or I am sorry, any inmates to another prison. If you can talk about what would best practices look like for transferring prisoners from one facility to another?

Dr. FRIEDEN. Well, the best practice would be to minimize transfers, first and foremost because any time you are mixing more people, you are creating the possibility of explosive spread. You would certainly want to ensure that no one who is symptomatic is transferred.

The challenge is that we recognize that there are a lot of asymptomatic people, some of them presymptomatic. They will develop

symptoms in the next couple of days, and some of them will remain asymptomatic, and they do appear to be able to spread the infection. That is why even symptom screening will be a problem, and in every congregate facility, we need a comprehensive approach to reducing the risk that the virus will get in, increasing the likelihood we will find it quickly if it does, and improving our ability to stop it from spreading widely if it is spreading.

Ms. RIVERS. And I would just add if there was an opportunity to use diagnostic testing, one misstep or miscalculation that people sometimes make is to think that just because you have a negative diagnostic test means you are not infected. The situation you would want to avoid is when you test someone early in their incubation period, and so they are already infected, but there is not enough virus yet for the test to pick up, and so it builds over the coming days. And you think you are in the clear, and you are not. So coupling or timing the testing with a quarantine period would be recommended.

Mrs. BUSTOS. All right. Thanks to you both.

I yield back.

Ms. DELAURO. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

So one thing—and this is probably for both of you all. One thing we have learned from this pandemic is that the importance of domestic production of essential medicine and medical supplies, and I could add to it many other things, but obviously, this is what is being highlighted, especially an overreliance on China. However, knowing how many tests we need, what we have just talked about, and how many vaccines, 300 million plus, et cetera.

I worry there is no way to completely produce all of that within the United States at present, possibly even with our adjacent allies. This presents a serious threat to our security and our public health. I know that is something we are going to look at, prospectively but we are still in the middle of this. How would you rate our current domestic production capability, and what steps do we need to be taking right now today to improve them?

Dr. FRIEDEN. I think this pandemic has emphasized the interconnectedness of the world, including both the ability of viruses and other infectious agents to spread and the fragility of some of the supply chains from a variety of products, including the active pharmaceutical ingredients of many of our medications.

When it comes to PPE, personal protective equipment, there are means to increase production of safely reusable PPE such as elastomeric half face piece N-95 respirators. This was an important technology that is not new. It has been around for a while. It has been used increasingly, but it allows a healthcare worker to have an N-95 that can be safely disinfected between uses and used for months at a time. So there are some technological improvements that can improve our supply chain.

In terms of vaccines and therapeutics, we don't yet have any, so we don't know how difficult they will be to manufacture when they do exist. I believe there will be a global commitment to ensuring that there is essentially open source so that once we know how to make it, anyone can make it. And in fact, immediately, even companies that had strongly opposed this for many years have agreed.

So I think there is a recognition that it is a global good, but the manufacturing capacity is something that needs to—

Ms. HERRERA BEUTLER. I apologize. I have a couple more questions. I appreciate that very much. Did you want to add that or should I keep going?

Okay. As was mentioned, I flew very far to get here, and I want to try and get through as many of these as I can. This is so important. I appreciate your time.

What we have seen thus far, it appears that underlying health conditions, diabetes and others impact the likelihood that a COVID-19 patient will require hospitalization. Additionally, shutdown orders and concerns about exposure have left many impacted with chronic illnesses, I think of end stage renal disease and others, delaying medical care, pursuing alternative care sites such as home. I think about people who are waiting for transplants, perhaps a kidney transplant, and they are getting told, you know, they have a donor, a living donor, and they are being told that is elective. I don't know if you have ever been on life support waiting for a kidney which is essentially what dialysis is. It doesn't feel very elective.

Can you speak to the impact of the virus on those chronic disease communities and what you anticipate going forward? And maybe they are not the immediately hospitalized ones, right, where there not in this immediate attention sphere, but they are certainly impacted. Can either of you speak to that?

Ms. RIVERS. Just to acknowledge the importance of this question, there are so many secondary impacts of this pandemic. And those underlying health conditions, as you say, not only are more likely to get severe disease when infected with COVID but are also struggling with managing their conditions. And so I think this does need to be a priority both for this response and also as we do preparedness planning going forward.

Ms. HERRERA BEUTLER. Thank you. As folks here know, Lucille Roybal-Allard and I chair the House Maternity Care Caucus. And while medical doctors are taking all necessary precautions to protect mothers, patients, front line workers, women are still giving birth. Surprise, surprise. Certain things don't stop just because we all said it should. We are seeing mothers often forced to labor without partners or family members or midwives. In fact, I have a case of a mother who was potentially going to lose her baby, and she could not—and they knew it was a preexisting condition, and the father couldn't come with her. She had her own miracle and the baby lived, but these are the types of things mothers are facing right now.

As we work together to prepare our country and our communities for future pandemics, what recommendations would you give to providers and the maternal healthcare community to protect new and expectant mothers?

Ms. RIVERS. This is an area somewhat outside of my expertise, but I think access to personal protective equipment should be one of the primary resources. Our strategic national stockpile is not able to support all of the PPE needs for this pandemic, and I think that is a lesson that we can take going forward that would benefit the maternity community and also healthcare workers, probably.

Ms. HERRERA BEUTLER. Thank you.

I yield back.

Ms. DELAURO. If I might just tell my colleagues that what we did do in terms of the manufacturing effort of \$2 billion, certainly not enough for BARDA to support advanced research and development of vaccines, therapeutics, diagnostics, prioritizing platform-based technology with U.S.-based manufacturing capabilities. And in the CARES Act, there was at least \$3.5 billion for BARDA for the same efforts so that the conversations are trying to move in the direction of having more independence in that area.

Congresswoman Bonnie Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chairwoman.

I want to thank both of you for coming here today and your testimony and also the work you have been doing in this area. I know that we are going to be safest when there is a vaccine. I know we are going to have dust ups when there is a vaccine as to whether or not everyone will take it. My understanding of the development of a vaccine and its testing takes a while and that it could be years.

Is there any substitution in the efficacy of developing the vaccine that will countermeasure years? Dr. Frieden, Dr. Rivers?

Dr. FRIEDEN. There is nothing more important in the fight against this virus than developing a vaccine. The quickest vaccine development so far historically has been about 4 years. Dr. Tony Fauci has suggested that 12 to 18 months is possible, and all of us would like to see a vaccine as soon as possible.

There are many, many vaccine candidates being considered and different models of assessing vaccine efficacy being developed. Already some of them are in phase one trials. Fundamentally, we need on the one hand to do everything possible to get a vaccine as soon as possible. On the other hand, we need to recognize that vaccine development is uncertain.

Mrs. WATSON COLEMAN. Right.

Dr. FRIEDEN. And it may be a long time, and it may not be as effective as we would like. So we need to do everything possible to make a vaccine, but we can't assume that we will have one, and we need to act accordingly with all of the other measures that we can.

Mrs. WATSON COLEMAN. Do you want to say something, Dr. Rivers?

Ms. RIVERS. I would just add that identifying a safe and effective vaccine is just the first step and that we also need to think about manufacturing, production, and distribution because those are steps that can take a long time too. But if we think and plan now, we can also, I think, speed up the timeline on that, those components.

Mrs. WATSON COLEMAN. Thank you.

Under what circumstances are asymptomatic people being tested now in this country?

Dr. FRIEDEN. There are various different situations. Most important is when there is an outbreak in a congregate facility. So if there is a case in a nursing home, we would think everyone in that nursing home needs to be tested.

Mrs. WATSON COLEMAN. What about outside of a facility?

Dr. FRIEDEN. We are seeing some testing done to release people from isolation. That may not be necessary or effective. You don't really know what a faintly positive test means in that circumstance, but contacts of cases could ideally be tested to see if they are infected because if they are infected, then contact tracing needs to be done with them also, but Dr. Rivers may have more to say on this.

Ms. RIVERS. I agree with that. Testing people without symptoms is not currently one of the higher priorities on the CDC priority list, and so there is not a lot—

Mrs. WATSON COLEMAN. So that is a concern to someone like me. I am over 65 years old. I have got some of those conditions that have been raised as potential issues. I can't just stay home. So I need people to be tested in general so that I know that I am in a more safe environment than a less safe environment. How long do you think it will take us to get there? And isn't it reasonable, if not feasible, isn't it necessary to get there?

Ms. RIVERS. Universal testing is a strategy that it is not clear to me we will ever have the capacity to carry out, and I mean it is not clear to me. It could be that we do, but I am not sure. But an alternate approach is contact tracing that would allow us to regain control if done at both the level and scale necessary.

Mrs. WATSON COLEMAN. So you have outlined a series of conditions that are more optimum for us to be able to open up and come out and do things. Where are we exactly right now? This week, right now, where are we on that sort of spectrum of enough testing, enough contact tracing, enough isolating, enough alternative facilities for quarantine? Where are we right now? And either one and both can answer.

Ms. RIVERS. I can start us off. Right now, most States and most communities are still staying home to slow the spread. As we start to move into phase two which would be a gradual reopening, many, some communities do have sufficient diagnostic testing. Many communities do not. States, thanks to the appropriations of this committee, have funding now to hire more contact tracers, but I think that that capacity is still in progress.

Mrs. WATSON COLEMAN. So we are in phase one and a half?

Ms. RIVERS. We are looking ahead to phase two, I would say.

Mrs. WATSON COLEMAN. Dr. Frieden.

Dr. FRIEDEN. The way we think of it is there are three things you want to look at. One is what is happening with the virus, are severe infections coming down, and are estimated number of cases coming down, controlling for the amount of testing?

Two, are our healthcare systems robust so our healthcare workers aren't getting infected on the job and so that we have the capacity to treat a surge, to manage ongoing conditions like pregnancy safely. And three, is our public health system ready to box it in with contact tracing and isolation.

I would say that there are some communities in some parts of the U.S. that are getting ready to do that, but all of us need to have vigilance. It is not about relaxing, it is about increasing vigilance so that we can prevent explosive spread and save lives and restore our economy.

Mrs. WATSON COLEMAN. I would just like to know how close we are to that. See, I am confused as to where we are, and when we do allow States and when the Governors allow them to open in cities, I would like to know what kind of indicators are public health professionals willing to say or should say that you need to shut it back down or that it is okay to continue in that direction. And I just am not knowledgeable about that, and I don't get the impression that in general, we are.

Dr. FRIEDEN. We have looked at that specifically, when to loosen and when to tighten again, and the things that we would look at are things like consistent increase in case counts, increases in what is called syndromic surveillance which is an early indication, healthcare systems that are beginning to get overwhelmed and a public health system that can't do the job it is well, so we don't know where the cases are coming from, and there are unlinked cases in the community.

That is the optimal way, but I think we recognize that part of the stay at home may be able to be changed without undue risk, for example, outdoor activities and other things with physical distancing. And when we go out, it is not going to be back to normal. It is going to be to a new normal with hand sanitizer and perhaps face masks where it is spreading widely and no touch doors and no touch elevator buttons and lots of ways to engineer risk out of our lives.

Mrs. WATSON COLEMAN. Thank you.

I yield back. I forgot I had my mask on. I can just breathe for a second. Thank you very much. I yield back.

Ms. DELAURO. Please breathe, Bonnie. Please breathe.

Just to follow up for a second, for a question, but the American people deserve the truth. The American people, on the one hand, it is here, and on the one hand, it is that. Where, and we are looking to you to understand, you know. We hear on TV, and this is the ordinary person. We have access to probably other kinds of information, but it is vaccine, how many are being reviewed, what is all these different lines of reviewed, what are the main ones. Are there 40, and of that 40, there are only two that are real. Is there a national testing plan?

I believe you said no, we do not have a national testing plan. We do not have a national contact tracing plan. We do not have PPE, no command and control of what that is and where it is going. And the American people are scared. They are scared. They don't know what to believe. And they may not go into that business that Dr. Harris talked about, and they are not. Look at the polling data. They are not going.

So what do we get to—and we need the answers. Let me ask. Are the CDC guidelines on testing being followed? A yes or no because I want to be mindful of my colleagues' time as well. Are those CDC guidelines being followed about who gets tested and who doesn't, or is it just a jump ball? That is the way it appears to me, that we do not have kind of a central control of what is happening, as you have pointed out, in the worst pandemic going back to 1918.

So how are the American people going to get the answers that they need? How are we? You need to tell us what public policy initiatives need to be put in place. You have a subcommittee here. It

is bipartisan. It is critically important, and so many of these pieces are within our jurisdiction that we need to understand. We are not foolish enough to know that there is not absolute clarity, but hell, give us more clarity than we have now in order to be able to provide the wherewithal to those who are in charge to carry out their mission.

On testing, quick question. Should the CDC be in charge of that effort? Should the States be in charge of that effort? And again, I need quick answers because I am going to run out of time.

Dr. FRIEDEN. The Federal Government needs to establish the guidelines, provide the resources. The implementation is done at the State and local level.

Ms. DELAUBRO. Okay. The State and local level does not have the resources today that it needs to do its job. Yes?

Dr. FRIEDEN. There are not enough tests currently.

Ms. DELAUBRO. Well, but in a normal set of circumstances the public health infrastructure in this country is weak, and it is being overrun. Not that it hasn't wanted to do the job, it is being overrun. So as your point earlier, we need to do something about that.

Look. You know, is there a plan? If we have a vaccine, how does it get manufactured? How does it get prioritized? Are there people sitting down as far as you know now, and I am looking to the scientists. I am looking to you because we know what havoc politics can play, and put that aside. You are the guideposts.

Give us the plan and let us know absolutely, and when the American public can say it is not going to happen for 18 months, they are not dumb. We need truth and facts at this time. I was not prepared to just go in this direction, but we cannot say on the one hand this and on the one hand that if we are going to get out of this.

And give us the posts to get us out of this, the pillars that help us to gain back control so that we can move forward as a country. I went over my time.

I apologize, Tom.

Mr. COLE. You are the chairman. You never go over your time, Madam Chair, and I respect that and respect the concerns that you went through.

Let me get—because I think the chair is right. We are looking for specifics, so let me ask a very specific question to both of you. I think one of the, you know, early lessons from this is we certainly didn't have the public lab testing capabilities, let's say, that we needed to respond as quickly as all of us would have liked to respond. So I would just ask you in your professional opinion, is that true, and number two, how would you go about remedying that, so that would be point one.

Number two. And I could be wrong about this and would be happy to be corrected. I also thought we were a little slow getting our private sector partners into the fight for whatever reason. I don't know if there is a barrier there. I don't know, you know, if we have to assure the market. I realize these are for profit companies. They have to make money, but I don't think we mobilized them nearly as rapidly as we probably should have in retrospect.

So the two questions would be what do we need to do to get our public health labs up to where they need to be? What mechanisms

do we need to be in place so that if we find ourselves in an all-out war with a microbe, we have everybody on the field as quickly as we can get them there.

Ms. RIVERS. Just to tie together your two questions, we have spent a lot of money and time on hospital preparedness and making sure that our private medical facilities are able to respond to a mass casualty event. We don't have something like that for diagnostics, and I think we should because it is not just public health labs, although we should be working to increase the capacities. It is also the private sector as you mentioned, and so I think we should have some sort of unifying preparedness program for how we will make sure we are not caught in this position again when it comes to diagnostics.

Mr. COLE. Dr. Frieden.

Dr. FRIEDEN. It is certainly the truth that the public health laboratories at national, State, and local levels are antiquated. They are not using the latest technologies. They are still using fax machines. It is the testing methodology, it is information technology, and so that is something that needs to be upgraded.

It is also the case that we need to look at new platforms and newer diagnostic technologies. There are innovations coming, and they are not cheap. They will be expensive, but you want to keep your fire department there in case there is a fire in the same way you want to keep your lab ready.

Unfortunately, the lab is often the poor relation in the healthcare infrastructure, and for this kind of a response, it is really a three-legged stool. You have the public health system doing public health laboratory testing, you have hospital laboratories developing their own tests, and you have the private sector coming in with large volumes. And in this case, all three of them had problems.

Mr. COLE. We actually dealt a little bit of that in one of our last hearings before we were overtaken, and the CDC was actually talking about developing a plan in terms of the technological updates they needed to bring to us.

So I would hope—you know, they obviously have been dealing with a lot, but I hope that has not slipped through the cracks because we are going to need something like that, I think, going forward, and that is a very specific investment that we could make.

Let me ask you a very different question, if I may. We have talked a lot about vulnerable groups, and we know we certainly have vulnerable—we have health disparities in the country. We have minority groups. We have lower income groups. We have a lot of people that find themselves with a higher degree of vulnerability, much worse outcomes than the population in general. And I want to talk about that maybe in a later round, but I also want to ask about children.

I had an interesting occasion I was mentioning to Dr. Harris where I was talking to an ambassador from a friendly European country during all of this. I said what are you doing, and he said one of the things we are doing in terms of getting back is we are actually opening our schools a lot faster than you guys are because our children are not particularly vulnerable, and a lot of their parents are in their 30s and 40s. They are the workers that we actu-

ally need to get the economy going up again, and they are not as vulnerable, obviously, as others.

So do you have any thoughts in terms of, number one, what is happening with younger people in this, and number two, I am not asking for master blueprint on what we should do, but do you have concerns about the school system and getting kids back up and operational and parents more able to get to the workplace?

Ms. RIVERS. Thankfully, we are able to observe that children are at lower risk of severe illness. That is something we have seen in other countries. It is something we are seeing in the United States, and so that is encouraging. What we don't know is what role children play in transmission. We know from pandemic influenza or rather influenza generally that children are really central to transmission in the community, not just in schools but the community broadly.

We haven't been able to pin down the science yet of what exactly the role is of children in transmission, and so that is where you see a lot of the uncertainty. These two factors weigh against each other, and they get very difficult to come to a decision, so I suggest as other countries move towards reopening which is happening, some countries are going back to school in the coming weeks, they will be collecting data and doing the analyses that will let us understand what the role of children is, and I think that will be helpful for informing our decision.

Dr. FRIEDEN. I agree with all of that. I would just say we don't know why children and women are less likely to get severe illness with COVID-19. It is a clue for something about the virus. But as we reopen, we want to prioritize societal benefit. For example, daycares. If we keep out from daycare kids who have underlying condition and staff who are older, who have underlying conditions at risk, that may be a way of starting to reopen. But we also have to consider if those kids get infection and the staff get infected and come home, and they are living with their grandparents, are they at risk there, and we don't know.

But I do think that there is a valid argument to be made for a sooner reopening of areas with younger people because of the lower risk, but you have to do it in a way that minimizes risk and recognizes the vulnerable population that need to be protected as well as the risk of onward transition.

Mr. COLE. Thank you very much.

Thank you, Madam Chair.

Ms. DELAURO. Thank you. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chair, and thank you again for all of this.

I wanted to just start with a broad question. If you could name a country that you think is doing a good job and if they have a national plan.

Ms. RIVERS. Singapore has done a very good job, and they do have a national plan.

Ms. CLARK. Any others come to mind?

Dr. FRIEDEN. There are many countries that are—

Ms. CLARK. Do any of them not have a national plan? Do any countries who have successfully have done this said we are going to do this regionally or by city?

Dr. FRIEDEN. I think there is a varying degree of centralization and decentralization in different countries. So even Germany, which has a very effective response, has a very decentralized form of government. So there is strong national guidance but regional implementation of that guidance, as far as I understand it.

Ms. CLARK. Yeah. But they certainly have a more unified healthcare system for delivery.

Dr. FRIEDEN. Yes.

Ms. CLARK. As we look at testing essential workers, I think it is easier to think about healthcare workers, but how do we—how do you start to look at one area that I am very interested in to follow up on the ranking member's question is childcare. Childcare is critical to reopening our economy. We are not going to have success if we don't have a childcare system which has been so underfunded and teetering at the brink.

Would you see sort of employer-based testing? Is that how we would—you know, with a childcare center, maybe smaller, would you test every teacher within those essential? Would you be looking at auto manufacturing plants? Would you test everyone coming onto the floor, or would you do something more like what Dr. Gottlieb suggested, testing everybody who shows up at a doctor's office, whether that is for a sprained ankle or for symptoms of coronavirus?

Dr. FRIEDEN. I will make a brief comment. I completely agree that daycare is, childcare is particularly important, and we have highlighted that in the materials from resolve To Save Lives in day one, that this may be an area that can open sooner as long as we do it safer which means if there is a kid with an underlying condition, they shouldn't go in. If there is a staff with an underlying condition, they shouldn't go in. We should use hand sanitizer frequently.

I think the potential of mass testing is just that. It is a potential. In order to do that kind of testing, you are talking about tens of millions of tests a day. And exactly as Dr. Rivers said, we don't know whether that will be feasible, but I don't think it is realistic to wait to reopen some of the most critical aspects of society until there is that kind of capacity.

Ms. RIVERS. I agree with that. And again, coming back to not having clarity about what kind of capacity we can expect, but I also think we need to understand more about the logistics of how that would work. If you had a point of care test that could be right here that can only test five people an hour, how would that work if you have an entire daycare center that need to be tested? I think there are probably ways around that, but it hasn't been worked out, and so my point is I don't think that we should have rely on having that capacity. I think we will have to be prepared to move forward without it.

Ms. CLARK. So how would you see getting these—you know, getting the testing done for the 1 percent that I understand will vary in region in the country will vary. How do you see that going forward? Do you see something like Dr. Gottlieb suggested where it would be people who come into doctors' offices so that you are getting a random sample?

Ms. RIVERS. Starting with people who have symptoms, and the nice thing about contact tracing and once you get in the network, and once you are connected to people who are infected and the people who might get infected because they have been exposed, you can continue to follow the network outward. And so you don't have to be concerned about checking here, there, and everywhere because you start to get a handle on transmission in the community.

Ms. CLARK. So this sort of brings us back to where we started, that to even open something essential like childcare that we are going to need to open quickly and support as we are looking at tremendous, you know, instability in the a critical underpinning of our economy, we can't begin to do that until we have robust testing and tracing and quarantining.

Dr. FRIEDEN. The sooner we establish the box it in strategy of test, isolate, contact trace, and quarantine, the sooner and safer we can reemerge.

Ms. CLARK. Thank you.

Ms. DELAURO. Congressman Harris.

Mr. HARRIS. Thank you. So let me just ask a little about the box it in strategy. So Dr. Frieden, how many people do you think there are asymptomatic for every one that we have a diagnosed because, you know, we talk about the numbers of cases, but we should be very specific.

We mean the number of cases confirmed by testing and, of course, what is your impression? How many cases are there that aren't confirmed by testing, the asymptomatic?

Dr. FRIEDEN. Well, there are two different questions there. One is how many people were symptomatic and not tested and then how many people are asymptomatic and not tested. So the number of infections we have documented is a small fraction of the total.

Mr. HARRIS. And what fraction do you think that is?

Dr. FRIEDEN. It depends on the area of the country and the level of the testing.

Mr. HARRIS. So it could be kind of high, right? So how do you box in something when you are not recommending testing asymptomatic people, but you know there are asymptomatic people out there?

And again, it comes to my question. Why wouldn't we just have very intensive education processes so that every American follows social distancing, wearing a mask, and you know, hand hygiene. So we kind of hammer this in because these are the principles, and get a test if you are symptomatic.

Dr. FRIEDEN. So I think that is correct. I think we can do both, and we have to do both because this is a very infectious virus, and it is very deadly for certain people.

Mr. HARRIS. But the criteria for reopening include the need—and I have seen this where it has been suggested don't reopen until you have contact testing in place.

Dr. FRIEDEN. What we can say is you will be safer if you are able to open with contact tracing in place.

Mr. HARRIS. We are safer if we are not born. We are safer from death if we are not born, right? I mean, the bottom line is there is some element of risk. And I bring this back to, you know, stay at home might work in New York because if you leave your home

in New York, you are going to get on a train. You are going to get on subway. You are going to get in a crowded street. But if you are in parts of my district, you are going to leave home, get in your car or truck, drive to a store that has almost no customers in it, conduct your business, and go back home because that is normally the way you live.

So why would you insist that or why is there insistence that stay at home—the broad blanket statement it is effective because I am not sure it adds anything more in the instance I just gave you in a rural area. So why do we have a kind of one-size-fits-all approach when we can be much more nuanced about it.

Dr. FRIEDEN. I think the concept of physical distancing is an important one. And in the scenario you outlined, if the individual goes to the store and, for example, calls in advance, picks up the order at the front, that is a very low risk interaction. If you go out and work outdoors, that is a very low risk interaction.

Mr. HARRIS. Right. So I would suggest, you know, I visited, you know, a couple of the stay-at-home things that just don't make sense to me. Recreational boating is prohibited in my State. So a family that stays at home, eats at home, they don't wear masks at home, they can't go out and get on their boat and go out in the outdoors. Golf courses, as you know, outdoor. There are guidelines in place that would absolutely physically separate you from other people. Are these things that, again, nuanced approaches that, you know, stay at home is, you know, one size fits all. Everybody has got to stay at home no matter what it is you are going outside to do.

Can't we get more nuanced given the data we have and knowing how social distancing, wearing a mask, hand hygiene will likely be the major way to stop spread of this in some circumstances?

Dr. FRIEDEN. I think that is generally correct. One other factor to consider is environmental contamination. COVID is spreading like a super SARs, and we know that SARs spread through elevator buttons, door handles, and other ways, so we have to also think about reengineering some of our environment so we have no touch doors, and we reduce the number of contaminated surfaces and clean them more reliably. This is about adjusting to a new normal. And the sooner we do that, the sooner we can get our economies back without unduly stressing our health and healthcare systems.

Mr. HARRIS. Sure. Just two additional things. One is kind of novel ideas that are coming forward. One is the ability to test because, you know, nasal swabs are a problem, but my understanding there are tests now being licensed that work on sputum, so just salivary tests. And what do you think the effect of that will be on availability of testing?

The other are the new antivirals that are being spoken about. Obviously Remdesivir, you know, made by Gilead which took money from the money they made from Hepatitis C drugs and, you know, reinvested in helping us cure this as well as the monoclonal antibody discovery in Israel reported, I think 2 or 3 days ago. Will these change the playing field?

Dr. FRIEDEN. I think we have to see. We are learning more about this every single day, and the more we learn, the more we can do.

Mr. HARRIS. And is sputum testing, is it likely that it will work, that you can actually test if you are, you know, sensitive enough assay for virus so you don't need a nasal swab?

Dr. FRIEDEN. I would need to see the data on it.

Mr. HARRIS. Okay. Thank you.

I yield back.

Ms. DELAUR. Congresswoman Bustos.

Mrs. BUSTOS. Thank you, Madam Chair.

I am wondering if you can share with us the patient experience. A patient who has COVID-19 goes to the hospital. How long is it taking there? What is the treatment? And then what does the hospital bill look like, if you could maybe talk through that?

Dr. FRIEDEN. One thing is that for many patients, it doesn't require hospitalization. And in areas of the country like New York City where there are overwhelming numbers of patients, what has been said for the past couple of months is if you are just mildly ill, stay home.

Mrs. BUSTOS. Right.

Dr. FRIEDEN. Because you are going to come in, you are going to use up scarce resources. If you don't have it, you might get infected. If you do have it, you might infect someone else, and if you have it, you will just be told go home. That may not be the right answer. The answer may be if you can't be safely cared for at home because you may infect your grandmother or someone who has got cancer, come into this facility, and we will care for you until you are no longer infectious. And that is something that we need to think going forward.

But for someone who comes into the hospital, what we are seeing is very low levels of oxygen in the blood, and that is a big concern. So oxygenation is a major component of care. It is probably the most important part of supportive care of someone with COVID. And doctors in intensive care units are figuring out ways to support oxygenation without intubation and use of ventilators. That is a new finding in intensive care and reduces the number of ventilators we thought would be needed.

Mrs. BUSTOS. What is that care if you don't need the ventilator?

Dr. FRIEDEN. There are a variety of ways to position patients or give oxygen through other means that don't require insertion of a breathing tube, and may be effective.

Mrs. BUSTOS. Okay.

Dr. FRIEDEN. And then general supportive care for the individual, making sure that they are well cared for. We have seen very severely ill patients in cities that have been hard hit having a very low survival rate partly because they are so severely ill, partly because systems are somewhat overwhelmed.

We are learning more about how to care for patients all the time. There is potentially good news with Remdesivir, the antiviral. It appeared to shorten the time to recovery in a well done study that hasn't yet been released, but the data has been shared. It had—

Mrs. BUSTOS. Can you talk a little bit about that, reduce it by?

Dr. FRIEDEN. From 15 days to 11 days.

Mrs. BUSTOS. Okay.

Dr. FRIEDEN. And it reduced mortality rate by about 30 percent, although that difference wasn't statistically significant given the

size of the sample. So a trend, a nonsignificant trend toward a lower death rate.

Mrs. BUSTOS. Okay. I am guessing if you are hospitalized this is going to result in probably thousands of dollars in hospital bills.

Dr. FRIEDEN. Intensive care is extremely expensive.

Mrs. BUSTOS. And do we have any hard numbers associated with what an average stay is going to look like for patients?

Ms. RIVERS. No. I am sorry.

Mrs. BUSTOS. Okay. All right. And part of this—I want to make an editorial comment in that Congressman Lloyd Doggett, Congressman Susan Wild, and I have a bill that would call for the opening up of the reenrollment for the Affordable Care Act Right Now when we have 30 million uninsured Americans, and in the State of Illinois, we have 800,000 uninsured Americans. So I actually partially wanted you to go through that.

I mean, we know this is going to be very costly. I mean, we know it by, you know, the economic recovery bills that we are looking at. But I just think it is critically important. The Trump administration has pushed back on opening reenrollment. Ours calls for an 8-week period where people can get in, be reenrolled in the Affordable Care Act.

And I just think—and Dr. Frieden, you have been obviously in the Obama administration very involved in the Affordable Care Act, but I think that is important to note. I mean, what you just talked through is a long process. Glad that we are seeing some encouraging news out of the treatment in the hospitals.

I want to ask you also about behavioral health. If you can talk a little bit about that from a public health perspective, what we are seeing as far as what is happening with behavioral health, what we need to prepare for going forward, and just what we can do as members of the labor Health And Human Services Subcommittee of Appropriations as we look at that. Maybe we will start with you, Dr. Rivers.

Ms. RIVERS. Yes. I think this is an important area. Going back to our previous discussions about the secondary consequences of this pandemic and the support and treatment and continuity of care that people have had, I think behavioral health is one area that is chronically underserved and undersupported. And I think it is very possible that in the context of this pandemic that those disparities will intensify.

Dr. FRIEDEN. I would just outline four areas of concern. The first is interruption of needed care, either ongoing care or need for new care in a behavioral health area. Second is substance abuse and chemical dependency, the need for treatment and the potential increased need for treatment and care.

The acute trauma of grieving and losing family members or family members severely ill. And also the responders, first responders and healthcare workers. I was health commissioner in New York City after 9/11, and we studied the impact of the World Trade Center attacks, and we found that as severe as the respiratory impacts were of people caught in the dust cloud, in terms of the amount of disability, post traumatic stress disorder, depression, and anxiety caused even more disability.

So we have to take care of our responders during this time and limit their hours to the extent possible and provide good care and support.

Mrs. BUSTOS. Okay. Very good. Thank you to both of you.

I yield back.

Ms. DELAUR. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

You know, on that last part with regard to mental health and the impact it is having not just on our first responders, although they are constantly in our hearts and minds because they are the ones that are taking it in 24/7, one of the things I think with regard to, you know, Congressman Harris' comments about kind of a nuanced approach to reopening. I just recently called on the Federal Government to reopen.

So Washington State, we have been dialing—we dialed back. We are starting to dial back open, and the governor has reopened State parks, or at least he is doing them in a phased approach so people are able to leave their house, go to a safe place that has a lot of space and distance, but it has an impact on social. You have family, kids, you are all in the house together. It lets them release a little bit. I just recently asked that the Feds Reopen the Federal land in our area because they closed it off in cooperation with the State when it made the shutdown order. So now I think it is time to start opening those things off—up.

Mrs. BUSTOS. I would like to know on the recreational side what types of things you see as nothing is 100 percent safe, let's go ahead and throw that out there, but could help balance out the mental health piece. You know, I have been thinking and being very concerned about domestic violence and violence with regard to children, you know. The reports have gone way down because they are not in school, and the school—you know, educators aren't able to see things and make calls. It is not that they are not happening. So could you please speak to the health piece with regard to reopening some of these things?

Ms. RIVERS. I agree that outdoor areas are low risk for transmission and that they play a really important role in mental health and overall well being, and so I do support the reopening of those outdoor areas.

Dr. FRIEDEN. Complete agreement. I would encourage, actually, that. The only thing is you want to be careful about is where do people go after they go outdoors? Do they congregate in a bar inside, and are there any things like doorknobs or spaces that just can be easily reengineered to be safer, but absolutely.

Ms. HERRERA BEUTLER. Well, in addition, I think, as the public is more educated, I don't see anybody who—I mean, most people are carrying around hand sanitizer, right. You use it before you touch—before you eat, so you take your own lunch, you go sit out there. You are going to gather up all your garbage. You are going to put your hand sanitizer on before you eat. I mean, people—I think we need to begin to show the American people that we are seeing and hearing their stress and not just the folks who are in the middle of fight but those who are in rural areas, those who are held back, you know. We are almost a victim of our success in certain ways that we haven't had—and I am so grateful. I mean, we

have worked very hard to not allow our local health systems in my district to be overwhelmed.

But because that isn't happening, people aren't seeing the immediacy of the crisis, and we have to respond to them in that. And so I think that nuance, especially come from our public health experts, is going to help us. I think it will help in the long term with regard to adherence, but it will gain some trust.

The other thing I wanted to bring up and ask about was nursing homes. Obviously, that is a hot spot, and they continue to be a significant portion of our COVID patients and COVID deaths including, I think, it is not just in my area, it is nationwide. A high number of those patients who travel three times a week to dialysis are nursing home residents, and this figure could increase during the pandemic. What special protections can we be looking at for these individuals, for them and for the staff? A lot of how these viruses have been spread originally could have been visitors, but now they are really outside—it is healthcare providers and/or their staff.

Ms. RIVERS. We have talked here a lot about testing and when we should test and where we should test. For me, this is a really appropriate opportunity to do that universal testing. I think that all staff who are working in care settings should have access to tests and should be tested regularly for that exact purpose. We know that nursing home residents are at very high risk of severe illness. The virus spreads very easily in those settings, and so I think that is the perfect opportunity to intervene.

Dr. FRIEDEN. I just completely agree. I am deeply concerned about nursing homes. In fact, exactly 2 months ago, I said that nursing homes were ground zero for COVID-19 in the U.S. And as I said in my opening statement, unless urgent action is taken, there will be at least 100,000 deaths in nursing homes in this country.

And that means taking a comprehensive approach, making sure there is leadership in the nursing home at every level, every unit, every shift, making sure we take a hierarchy of controls, including source controls, administrative engineering, and personal controls, cohorting staff and patients, coming up with novel ways to try to keep staff and patients safe.

Some nursing homes are paying staff extra to stay there so they are not exposing others. That is a very costly and difficult thing to do. If, if, if it turns out that antibodies reflect immunity, maybe we can have people who have immunity care for others in nursing homes. We have to do something so that we don't have that kind of terrible devastation.

Ms. HERRERA BEUTLER. Thank you.

I yield back, Madam Chair.

Ms. DELAURO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you. Liberated.

Thank you both. This has been a tremendous learning experience for me. I wanted to ask you a couple of questions about our sense of connectivity to the rest of the world.

What do you think, for instance, is the true impact of the decision that our President made to withhold funding to the World Health Organization? What do you think that that has in terms of a short-term, mid-term, or even long-term negative implication?

Dr. FRIEDEN. We are in the midst of the most severe public health pandemic in a century. WHO is our global health organization, and we need to support it and make it stronger. I think we can look with time to see do we need a different approach? Do we need a supplemental approach? What are ways that it could be more effective? I think every organization will need to look back and see how it could have been more effective, but the WHO has a critical role to play, and we hope it will be able to play that with ever increasing effectiveness in the weeks, months, and years to come.

Mrs. WATSON COLEMAN. I don't know if you wanted to weigh in, Dr. Rivers.

Ms. RIVERS. I will just add that we know from this experience and from everything we know about infectious diseases that a threat anywhere in the world is also a threat to the United States, and so I would also like to point out that it is in our national interest to make sure that the rest of the world is able to respond effectively, and WHO is the tool that we have to do that and to ensure that.

Mrs. WATSON COLEMAN. Thank you.

Another question I have in support of all my colleagues that have spoken to the need for a national plan, cohesiveness, and how we approach it, how we deal with it through all the various phases, and how we can create hopefully more dependability by having a national plan.

What is your reaction to the proposal to shut down the task force, the coronavirus task force? Is it an okay thing? Is it problematic? What should we be thinking about that?

Dr. FRIEDEN. I would say it depends what comes next. At Resolve to Save Lives, an initiative of the global health organization of vital strategies, we advise governments all over the world in how to prepare for and respond to an epidemic. And one of the essential components of an effective response is a clear what is called incident management system where there is an incident manager in charge. There is transparent information. The incident manager reports up to the highest authority and raises the policy decisions that need to be made which are then made and implemented through the incident management system. That is the best practice in how to handle an emergency like this. So whatever structure is there, I would hope it would follow that best practice.

Mrs. WATSON COLEMAN. I think that that has been one of our challenges is that we have had so many people on the same base at the same time staking out little pieces and sometimes colliding with one another as they are trying to get to home plate. And so to me, it is very important that we have a cohesive plan of action, one voice, and an agreement among all of the agencies that would be inputting into that.

My other question has to do with the minority communities, the black community, the Native Americans, the Hispanic, and the very poor communities. A lot of their access to healthcare has been diminished regardless of the healthcare facilities, the FQHCs and stuff not operating to par, if at all. What do we need to do ensure that they are not deprived of either the therapies or the vaccine

once it becomes available to the degree that the infection has disproportionately impacted those communities?

Dr. FRIEDEN. We have seen three problems. One, larger proportion of essential workers in some underrepresented communities. Two, higher proportion of diabetes, controlled diabetes, and other underlying health conditions. And three, lesser access to healthcare services. If and when we have a vaccine, it needs to be provided to those who need it most first. That would be healthcare workers and other essential workers and as it is rolled out to everyone, everyone in society, because that will protect all of us.

Ms. RIVERS. I agree with Dr. Frieden. And I would just add that although we do not have a safe and effective vaccine yet, that is the kind of thinking and planning that we can and should be doing now so that we can really take our time to identify the best way forward.

Mrs. WATSON COLEMAN. Thank you.

And, finally, I just want to say that I was really impressed with the discussion that you both approached at some point about looking forward and being prepared for disease X that is going to come along.

I think that we are very fortunate. No, we are not. We are not fortunate with what we are experiencing right now, although I suspect it could be worse, but this is pretty doggone bad. And we have the smartest country in the whole wide world, as far as I am concerned, the most amazing country in the whole wide world, and we ought to be better positioned should there become and when there becomes another incident of this nature, anything close to it.

Thank you. I yield back.

Ms. DELAURO. Thank you.

With the agreement of the ranking member, what I would like to do is, as I mentioned, that we have members who could not be here, and I know that there are three members on our side of the aisle who had a question which I would like to pose on their behalf. And I don't think that there are any further questions. Is that correct, Tom?

Mr. COLE. Correct.

Ms. DELAURO. Thank you. So let me—and I will try to give you the sense of the question.

Ms. DELAURO. Congressman Mark Pocan of Wisconsin, his question is: In order to safely reopen our communities, experts like Dr. Gottlieb have recommended being able to consistently test 1 percent of our population every week, 50,000. That means in Wisconsin 50,000 tests per week. Do you feel that the Federal Government should play a role in helping States secure testing supplies so they can safely reopen? What should the Federal Government do to ensure our communities have testing and the contact tracing capacity they need to safely address the pandemic? Are the guidelines from CDC on who should be prioritized accurate in your view? Are they missing anyone, such as essential workers, folks working at factories still, or our first responders? And I would add to that list—and I am sure Mark wouldn't mind because one of the questions I wanted to ask is about our folks who are in the meat and poultry processing plants. And the President is designating meat

and poultry processing plants as essential infrastructure that must stay open.

Now, I don't know about everyone here, but I have been to both a poultry processing place and a meat processing place. You just watch how those people are standing right next to each other as either chickens or beef just go by. And so how do we deal with them as well? So let me lay that one out.

Ms. RIVERS. Yes, I do think the Federal Government should play a role in obtaining testing supplies for the States. What we don't want is a situation where all 50 States are having to devise their own strategies and bidding against each other, and we really need a central coordinating function in order to make that run smoothly.

And I think the same largely goes for contact tracing in that the Federal Government plays an important role in issuing guidance and supporting State and local health departments in doing this work. But our public health in the United States really does happen at the State and local level, and so I do think it is appropriate that those functions be carried out at those levels.

The CDC testing priorities largely revolve around people who are hospitalized first and foremost with COVID-like symptoms, those with symptoms who don't require hospitalization, healthcare workers, and I do think those are appropriate testing priorities, given our limited resources. But that is not to say that people in these essential roles, like those working in manufacturing and meat packing facilities, should not become essential. It is just a matter of getting our testing capacity to the point that we are able to support that.

Dr. FRIEDEN. I would agree with all of that and just request that—we had issued a brief on exactly this question, just two pages, on who should be tested—

Ms. DELAUBRO. Should be tested.

Dr. FRIEDEN [continuing]. How many are in each group, and what the level of prioritization is, and if we can enter that into the record—

Ms. DELAUBRO. Yes, we would like to have that.

Dr. FRIEDEN [continuing]. It is generally in close agreement with the CDC recommendation.

Ms. DELAUBRO. Right. And you also have, besides the meat and poultry processing plants, prisons have become now a place that we really need to look to. Thank you.

On behalf of our colleague Lucille Roybal-Allard, this is about CDC authority, and she talks about you, Dr. Frieden: You have been the—CDC has been an authoritative voice in the country to prevent the spread of infectious disease. Back in January and February, we were learning about the novel coronavirus. CDC leadership, particularly Dr. Messonnier, Dr. Redfield, were present several days a week and testified in hearings providing guidance. However, once the stay-at-home efforts began, CDC became disturbingly absent in their visibility, silent in their recommendations. Let me just paraphrase, do you consider it problematic that the task force contained one CDC representative and, for the most part, the briefings over the last 2 months, Dr. Redfield was not invited to be part of the presentation? Given your own experience, is it normal that CDC not be more directive in response to the out-

breaks in meat processing plants, Federal directives that these plants stay open even when they do not have protocols in place to protect workers? Should CDC be mandating the use of face masks in public venues, insisting that face masks be made available to all individuals entering stores and other public places? What role should CDC be playing in addressing this tragic epidemic of COVID in our nursing homes? It is all about the CDC, Dr. Frieden, about what you know.

Dr. FRIEDEN. First, to say that CDC has 20,000 health professionals who dedicate their lives to protecting Americans. The National Center for Immunization and Respiratory Disease has more than 700 FTE staff who are experts in this area. They have spent decades working on the public health control of respiratory viruses. Dr. Anne Schuchat, the principal deputy director, was the former director of that center, in addition to being the principal deputy of CDC. Dr. Messonnier is the current director of that center. Others in that center are deeply experienced and deeply committed to this. And many parts of CDC also have deep expertise in infection control, for example, in nursing home care.

CDC does not have the authority to mandate. CDC provides guidance. But I will say that, even as I am an infectious disease specialist, I have spent 30 years on infectious disease control. I have run two large public health agencies. I would not take action without detailed input from the experts at CDC because they are the world's top experts in this, and I will feel safer when we are hearing from them regularly.

But I would also say that the American people have voted with their clicks because, by this date, CDC's website has had something like 1.4 billion clicks, and it is still the best place to go for information, advice, guidance, and recommendations, to keep you, your family, your workplace, your school, your daycare, safer.

Ms. DELAUBRO. And essentially what that would mean, though, is that CDC cannot mandate, we understand that, but certainly I can imagine, in your town, with regard to these meat and poultry processing plants, that you worked closely with OSHA and with the USDA on these issues, as well as State health departments, to make these—but you were, in effect, leading the way is the point, that CDC took a major role in this effort, and that is with the guidelines as well, which is why I asked the question, are we—you can't mandate this, but are we implementing everywhere in this country the CDC guidelines with response to testing? And I think the answer to that is no. But in any case.

I don't know if you want to comment on the CDC piece, Dr. Rivers.

Ms. RIVERS. No, thank you.

Ms. DELAUBRO. Right, thank you. Okay. And Congresswoman Lois Frankel of Florida—again, this is similar to earlier—testing is the key. There is inconsistency on how much testing needs to be done, hundreds of thousands, and we are currently testing less than 200. Give us again the benchmark for the number of tests we should be doing in this country.

Ms. RIVERS. Estimates start at 3.5 million per week and go up from there.

Ms. DELAURO. Okay. Her next question, do we have the capacity to provide this?

Ms. RIVERS. Not yet.

Ms. DELAURO. What will we have to do to achieve the capacity?

Ms. RIVERS. The steps aren't clear to me, but I think that should be a priority.

Ms. DELAURO. Who should determine the steps?

Ms. RIVERS. The Federal Government.

Ms. DELAURO. Okay. She has—she asks: Based on your knowledge of the timeline of the response, she talked about November, U.S. intelligence officials began warning a virus sweeping through Wuhan region of China, took more than 70 days from the first confirmed case in the U.S. for the administration to take serious action. Based on your knowledge of the timeline of the response, was there anything more that could have been done to contain the spread? And also she points out that, in May of 2018, the administration disbanded the White House Pandemic-Response Team, later received a report warning that the U.S. is not prepared to respond to a severe influenza-like pandemic. Do you have an opinion as to whether disbanding the pandemic response team was appropriate, and that is, was there anything more that could have been done? Okay.

Dr. FRIEDEN. This is exactly why we need a health defense operations appropriation so that, whatever the status of the budget, Americans can be safer because we have a stable source of funding to protect us from health threats at home or abroad.

Ms. DELAURO. Dr. Rivers.

Ms. RIVERS. Just thinking about the first question, it is always true in public health that we prefer prevention, and it is easier to stay ahead of something than it is to regain control. We have a lesson here in front of us now, though, as we are really in the midst of our pandemic, that we need to be forward-looking.

Ms. DELAURO. Forward-looking, right, yeah. Okay. Let me just say—okay. I am going to ask Congressman Cole if he has some closing comments, and then I will close.

Mr. COLE. Thank you very much, Madam Chair, and I want to thank both our witnesses. It has been exceptionally helpful testimony and very forthright and compelling answers, and I appreciate you both.

I want to thank you, Madam Chair, for holding this hearing, as I did at the beginning. I think it is a very important hearing to hold, and you ask a lot of your members because this is the only reason why we are in town, and I am very pleased with all the members of the committee that were able to come here and certainly very understanding of the ones that were not but certainly took time to submit questions.

I thought I might win the prize for coming furthest, but my friend Jaime Herrera Beutler, once more, showed me up. I think it is exceptional that you came with young children to come for this hearing, and I think all of you need to be commended, but I want to point out my friend who came the furthest for what she did.

There is a lot of good information in this hearing, and I think it really shows the reason why we need to be meeting as regularly as possible, particularly on this issue.

I want to thank again both of you, but, Dr. Frieden, this idea of a health defense fund, so to speak, comparable to OCO, I think really bears considerable merit. The chair and I have talked about something like this, have talked about the accounts that you would want to have that we are not trying to open up the budget or crack the budget caps, but, look, the defense budget in January 1, 1942, was a lot different than it was in December 1, 1941. I mean, you have an intervening event, a Pearl Harbor type event. You have to relook at what you have planned and see if—what is necessary to go forward, and I think, you know, honestly spending billions to save trillions is a no-brainer to me, and I think that is where we are at. We can never go through what we have gone through here before in terms of the disruption in the lives of the American people and in terms of the catastrophic cost imposed on the Federal Treasury. This is really the classic, you know, “stitch in time saves nine” kind of argument here, and I think it is incontestable.

I think it is also clear that this is not—and Dr. Frieden and I have talked about this before—this is not a one-and-done supplemental type of problem. We are going to have to look at adjusting baselines going forward in light of the information that we have, and not all those are in this committee. When I talked about this to our chairman, we, of course, focused on the CDC, the NIH, the Strategic Stockpile, the Infectious Disease Fund. But as she quickly pointed out, you know, the food inspection network and the FDA, neither of which are under our direct jurisdiction, are also areas that you would want to look at and include. So it is—and I know I have talked to our ranking member about this and to our staff about looking across all the budget categories that might fit in and have some appropriate response to be in a system like Dr. Frieden recommended.

I note too by just having this discussion, Madam Chair, it has already popped up on Politico. So it shows the virtue of being at work and doing your business because I think it will stimulate a discussion farther beyond here. And I think it is a very important discussion for us to have. We are going to be caught up, we should be caught up, and we are focused on dealing with the immediate problem that the coronavirus—and I have been very proud of the Congress. Yeah, we have our differences of opinion, and there is some partisan elbows thrown here and there along the way, fair enough, but four supplementals in a row with essentially no partisan dissent, I think, is a pretty good indication that people are very, very serious about this and are anxious to work together on this and can work together on this.

But while we respond to the immediate—and we are going to be responding to it for some time—you know, I think we ought to build on the work that this committee has been engaged in for a number of years, in a bipartisan way, and a bicameral way, because it couldn't have happened without help from our good friends in the Senate, and move toward, you know, some sort of more realistic and systemic—systematic, I should say, program, and systemic changes to accommodate those. So, again, we build up the kind of capability and sustain it over time that we are going to need. I think that is going to be the real judge, the real test as to whether or not we have learned the lessons.

I am not very—I am very understanding, honestly, of people caught up in a crisis that we probably couldn't envision literally 16, 17 weeks ago. So, you know, there will be valuable lessons to learn, but, again, we have not had a lot of time to deal with this, and so we are not going to get everything right.

Where I would be more critical is if we lost the opportunity to make the basic changes we all know that we need to make and the basic investments that we need to make, and both of have you laid those out for us to consider today.

So, again, thank you, Madam Chair, for what I thought was a very thoughtful and productive hearing. I thank all of my colleagues. I thought every one of them had good and important points to make and questions to ask, and I look forward to working with you, Madam Chair, and all our colleagues on this committee and the full Appropriations Committee, to see that we draw the lessons and make the investments the American people need us to make going forward so that, while we are going to deal with this, not just in the short term but probably, as both Dr. Rivers and Dr. Frieden indicated, in the intermediate term. This isn't going away by the end of this year. It is not going away by the end of next year. It is going to be with us for a considerable time until we can develop the therapeutics and ultimately the vaccine to deal with it. But it has taught us an important lesson that we ought to learn about the biosphere in general in terms of the number of challenges. We have had quite a few in the last few years, everything from SARS to Zika to MERS to Ebola, and now this. That ought to tell us this is just a fact of life we are going to have to deal with, and we are going to have to deal with it more effectively than we had.

And this hearing that you engineered, Madam Chair, has made that very apparent, and I think it is very helpful to the Congress and beyond that, to the American people. So, with that, I thank you and I yield back.

Ms. DELAURO. Thank you very, very much. Really this was—the thought process on this was, especially with this subcommittee, that we are at the center of the programming. The portfolio includes so many of the issues that we face in this pandemic, and so I want to thank both of you for your willingness to be here this morning. I don't know what kind of difficulty that was in your own concerns or changing your lives, but also your own concerns about your health and your safety. And in particular, thank you to my colleagues who have come from all over to be here today. And, you know, Jaime traveled the farthest here, so—

Ms. HERRERA BEUTLER [continuing]. That—

Ms. DELAURO [continuing]. Right. I wish I could think about what—here is a bottle of hand sanitizer.

Ms. HERRERA BEUTLER. If I bring back a bottle of hand sanitizer, Madam Chair, I am in trouble.

Ms. DELAURO. But it is a testament to the interest, and every single member on the committee that we spoke with wanted to be here and, for one reason or another, could not. And that is why, at the opening of my remarks, I talked about these conversations are so critical to the health, the safety, and the economic health and safety of the country, and we ought to be discussing those now

in real time as we are putting together the public policy, the commitment of serious resources, which is what we are doing and will continue to try to do since we are working through now to think about where we go with the CARES 2 package.

A couple of the, you know, things that we have talked about, I would just say to my colleague, Dr. Harris, I wrote down, you know, the education piece of this, very, very important. But then I watch the news and I see the beaches, and I see people who are bright people, smart people, and it doesn't make any difference. And then I see—honestly, I see people at various places around the country storming the Bastille, if you will, storming into city halls, storming here and saying, you know—no, you know, that is not what we—this is not what we should be doing, as, even with the education that is out there at the moment, and with the scope of the number of cases, and with the scope of deaths, I mean, that in and of itself should make you pause to think about what your own behavior ought to be in this kind of a crisis. With the issue of—I also said at the outset of my comments is, that I was or I am angry. Why—and you have helped a lot here, with, can we get our arms around the testing and the Federal Government and its role as its role in laying that out for the States, in that collaborative effort, in taking on the responsibility because I see it at the Federal level. There was a—after the New Orleans, with Katrina, a writer who is name was Michael Ignatieff. He wrote a piece that it was when the levees broke. He spoke about government as—and citizens, as there being a covenant, and that, when you reach a place where the circumstances in your life or in your environment are overwhelming, where the challenges are so overwhelming that you cannot do something about it, that is the role of the Federal Government, to step in, to take charge, to make sure that we can build those bridges, those pillars, that can allow for us to move forward. And he talked about, when the levees broke, the covenant broke at that time. Well, I think we have a very similar situation here. The levees broke. And the Federal Government is not at the center of the determination of how we gain control and go forward.

You all have written very substantial plans. We asked about plans. Is there a national plan, et cetera. The roadmap to reopening lays out very specifically the kinds of things we ought to do with phase 1, phase 2, phase 3, and the fourth phase is how we rebuild.

Dr. Frieden, you have laid out a roadmap of the agencies that can move us forward, where we go in a forward way. You know, there are going to be people looking backward. We want, on this committee, to look forward, the kinds of things that we can do to make sure that we can prevent this. And I am asking you again, I look at—box it in: test, isolate, find, and treat, and quarantine. This is a roadmap.

And at the Federal level, what we ought to be doing is speaking with one voice and giving simple directions to our States, to the agencies of our States, and most of all, to gain or to regain the confidence of the American people and letting them know that how difficult this road is because, again, as I said earlier, they are looking for the truth, no matter how hard it is. That is what I have always found. You tell people straight. Give them the sense that, while we

do not have all the answers, we do have a focus and a direction forward to safeguard themselves, their families, their health, their loved ones, and to safeguard their economic future and their economic security for the future.

So I can't thank you enough for doing this. And I want you—you have written it out. You have laid it out. We need to work very closely with you. You need to keep speaking about this with the kind of standing that you all have. We believe in doctors and researchers and scientists. We believe in data. That is the foundation on which we will need to build, to regain control of this scourge, which is what it is. So I know you are not afraid, but don't be afraid to speak out. You have people who will listen, want to work with you, have you help us get to where we want to go.

And, with that, this hearing is concluded. Thank you very, very much.

THURSDAY, JUNE 4, 2020.

COVID-19 RESPONSE

WITNESS

DR. ROBERT REDFIELD, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

Ms. DELAURO. This hearing will come to order.

First, I would like to welcome our witness, Dr. Robert Redfield, director of the Centers for Disease Control and Prevention. And we thank you for being here this morning, Dr. Redfield, to discuss the CDC and the ongoing response to COVID-19.

I also want to welcome the subcommittee members, Ranking Member Congressman Thomas Cole and our full committee chair, Nita Lowey. I want to thank you to the subcommittee members who are here in person as well as subcommittee members who are participating by secure video teleconference.

Before I move to my opening statement and because this is our first Labor, HHS, and Education Appropriations Subcommittee hearing, with some members participating remotely, I would like to begin by offering a brief explanation of how it will work in order to benefit both members and the public.

This hearing room has been configured to maintain the recommended 6-foot social distancing between members, witnesses, and other individuals in the room necessary to operate the hearing, which we have kept to a minimum. Some members have opted to use secure video teleconferencing which allows them to participate remotely.

For those on video conference, once you start speaking, there will be a slight delay before you are displayed on the main screen. Speaking into the microphone activates the camera, displaying the speaker on the main screen. Do not start your remarks if you do not immediately see the screen switch over. If the screen does not change after several seconds, please make sure you are not muted. To minimize background noise and ensure the correct speaker is being displayed, we ask that the members who are participating by video remain on mute until it is your turn to ask questions. Please remember to mute yourself at the conclusion of your question. Should you seek additional time, please unmute yourself so that I may recognize you.

I want to remind all members and witnesses that the 5-minute clock still applies. If there is a technology issue, we will move to the next member until the issue is resolved and you will retain the balance of your time.

For members using the video option, you will notice a clock on the bottom of your screen that will show how much time is remaining. At 1 minute remaining, the clock will turn to yellow. At 30 sec-

onds remaining, I will gently tap the gavel to remind members that their time is almost expired. When your time has expired, the clock will turn red and I will move to recognize the next member.

In terms of the speaking order, we will follow our traditional order, beginning with opening statements from the chair and ranking member and then the full committee chair and ranking member. We will then hear from our witness, Dr. Redfield, and then we will proceed to questions.

Members present at the time the hearing is called to order will be recognized in order of seniority, and finally, members not present at the time the hearing is called to order.

Now I would like to move to my opening statement.

Before I make opening remarks, I want to reflect on today. This afternoon, there is a memorial service for George Floyd. For the last few months around the pandemic, we have been talking about how to get back to normal. However, what we can hear in the chants for justice and the cries for equality is that going back is not good enough. This tectonic moment exposes so many wrongs, deep inequality, and racial wrongs. And that as we fight the COVID-19 virus before us now, we must also fight the virus of injustice.

Good morning. Welcome to the Labor, Health and Human Services, and Education Appropriations Subcommittee. This is our second hearing to oversee the Federal response to the coronavirus, and it is bipartisan. Let me commend my colleagues on both sides of the aisle, including the ranking member, Congressman Tom Cole. With us this morning is Dr. Robert Redfield, director of the Centers for Disease Control and Prevention, the CDC.

Thank you, Dr. Redfield, for joining us today.

Our Nation is in turmoil. The coronavirus is the biggest public health crisis we have experienced in at least a century. And to be blunt, the Federal response has been inconsistent and incoherent. A major focus of today's hearing is getting a better understanding of what has gone right and what has gone wrong these past 5 months. We need to learn from mistakes, not repeat them. We cannot stop the risk from this virus overnight, but in the months to come, we can spare the American people from unnecessary misery, illness, and death.

In a typical public health emergency and historically, the response would be led by the CDC, our Nation's foremost public health agency based on science and public health expertise. I am alarmed that this administration has sidelined the CDC in our response to the pandemic and chosen political expediency over public health. As a result, the U.S. has had the worst response to coronavirus of any country in the world, and it is particularly egregious because our public health system should have been better prepared than almost any other in the world.

Over the last 3 years, on a bipartisan basis, this subcommittee has increased annual funding for the CDC by approximately \$1.1 billion, an increase of 17 percent since 2017. That included the first year of a new Public Health Data Modernization Initiative, which will transform how the CDC collects, uses, and analyzes public health data. We also created an Infectious Diseases Rapid Response Reserve Fund to enable the CDC to respond to outbreaks

quickly to protect public health. Ranking Member Cole and I have worked closely together, understanding the challenges, to create that reserve fund, and it was critical to funding early response activities at the outset of this pandemic. Since March, the Congress has provided \$7.5 billion in emergency supplemental funding directly to the CDC, and I might add, in bipartisan fashion.

But instead of public health expertise driving our response to the pandemic, it appears CDC has been sidelined for political interests. That is dangerous. The stakes are too high. There are projections that, going forward, 30,000 and more could die each month. That would mean another 100,000 dead over the summer months.

Yesterday, The New York Times released a powerful and well-researched exposé of the consequences of the lapse in the work of CDC. The piece opened, the quote: Long considered the world's premier public health agency, the Centers for Disease Control and Prevention has fallen short in its response to the most urgent public health emergency in its 74-year history.

From the moment this pandemic reached our shores, President Trump and his administration's response has been woefully inadequate, abdicating all responsibility. There was never any coordinated plan to address the pandemic, and under this dangerous lack of leadership, our Nation surpasses 100,000 deaths from COVID-19, the most of any country in the world.

When it comes to crucial details like acquiring tests and supplies, setting goals for how much of the population should be tested, facilitating contact tracing and isolation efforts, and ensuring communities that have been hit the hardest are given the support they need, there is no national coordinated strategy. Our Federal response cannot be defended from a public health perspective. Other nations around the world, from Germany to South Korea, have found ways to keep people in their country safe. It appears as if the United States is just admitting defeat.

Is that acceptable, or simply accepting the preventable deaths of hundreds of thousands of Americans to COVID-19? If the administration is asking us to accept that, in my view, the answer is a decisive no. For us to keep our people safe, our response needs to be led by the scientists and the public health experts at CDC. Our response needs to be based on reliable public health principles, not political appointees in the White House. It is our expectation that public health expertise must be at the forefront of our national response.

We need answers to vital questions. Why has the administration accepted the world's worst outcome and the level of preventable death that would have been unconscionable a few months ago? How is our country going to reopen when there is not a coordinated nationwide effort to test, contact trace, and isolate cases? Why are States disregarding CDC's guidelines for reopening business and for social activities? Why are CDC's guidelines not at the forefront? Why did CDC's guidelines on reopening come after States started to reopen or were already reopened?

We are asking the CDC to lead the way and uphold its mission. And I quote that mission: As the Nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish our mission, CDC conducts critical science and provides

health information that protects our Nation against expensive and dangerous health threats and responds when these arise. That is the highest mission, and it is the right mission.

So let me say affirmatively that this committee supports the scientists and the public health officials at the CDC, like Dr. Nancy Messonnier and others who are trying to provide science-based guidance to the country.

What went wrong? Why has the CDC been left behind when there was an early declaration of a public health emergency by HHS on January 31, when Dr. Messonnier said it is not a question of if this will happen but when this will happen? She further said disruptions to everyday life may be severe, but people might want to start thinking about that now.

CDC produced high-quality, in-depth publications. You need to take note of this. The CDC's morbidity and mortality weekly reports, the MMWRs. CDC experts have published evidence about universal testing at skilled nursing facilities to interrupt transmission of COVID-19, as well as critically important work about super-spreading events, which are responsible for transmitting the majority of cases of COVID-19.

They identified the cause of some of the super-spreading events, the larger events. The exposure at a choir practice where 61 people led to 32 confirmed and 20 probable cases, attendees at a church in Arkansas, workers in meat and poultry processing facilities.

We cannot have a CDC that fails to publish high-quality, specific technical guidance. We cannot have a CDC that has reports shelved, edited, not scientifically driven, or redrafted to suit political purposes. We cannot have a CDC that provides spotty data collection and reporting. We cannot have a CDC that fails at transparency.

We need Federal leadership that is guided by public health by that expertise, real time, rigorous, and transparent. We need CDC and we need its scientists and its public health experts leading the way for all of us. And I am angry that their experience and commitment have been pushed aside for a political agenda. That must change, and I believe the Congress has to change it, and we have to redirect the current course to set us on the path forward.

So I look forward to this important conversation, and appreciate, Dr. Redfield, your being here, and I appreciate the same for all of my colleagues.

And now I would like to recognize the ranking member of the subcommittee, Congressman Tom Cole, for any opening remarks that he would like to make.

Mr. COLE. Thank you very much, Madam Chair. And I want to begin by thanking you for holding this hearing in the middle of a difficult time, and you are to be commended for, certainly, Dr. Redfield, being here. And I want to associate my remarks—or myself with your remarks about the tragic death of Mr. Floyd and, frankly, the healthcare disparities that this tragic pandemic has shown a bright light on, that this committee has worked on for many years, and I know concern Dr. Redfield, just as they concern everybody here, and that is going to be clearly a major task for our committee going forward, as it has been in the past, but probably with a higher sense of urgency.

Good morning, Dr. Redfield. And I want to thank you, again, for coming to testify before us today. First, I would like to thank you for your public service. The director of the CDC is no easy job, but leading your agency through a once-in-a-century event compounds the challenge. You have led that agency with a steady hand in uncertain times, and I want to thank you personally for your leadership.

I am going to depart from my remarks a little bit here because I think sometimes when we are in the middle of something, it is hard to keep it in context, but our performance has not been the worst in the world, depending on how you want to measure performance.

Quite frankly, I am sitting here looking at literally today's latest statistics, and if you wanted to measure it by the basis of fatalities per million population, then the performance of the United Kingdom has been worse, the performance of Italy has been worse, the performance of France has been worse, performance of Spain has been worse, the performance of Belgium has been worse, performance of the Netherlands has been worse.

Those are all pretty advanced countries with pretty sophisticated healthcare systems. I don't think you can really take the Chinese numbers, quite frankly, upon face value.

And then beyond that, and I say this with no criticism of the countries involved, but I do worry a lot about India and Pakistan, that part of the world. I worry a lot about Sub-Saharan Africa. I think when this is all done—I worry a lot about our friends in Latin America. I think when this is all said and done, we are going to see the numbers are probably worse in those places than they are in the United States just simply because we have a more sophisticated healthcare system.

So I have no problem with being critical or putting a flashlight on anything. I think we learn lessons that way, but, you know, in America, we always tend to think we are either the best or the worst at everything. And in this case, we may not be the best, but I think we are better than most and we are certainly not the worst. The numbers just simply don't bear that out.

I hope today we can focus on future steps that we can take together to ensure a sense of safety as our Nation returns to work and school. After more than 2 months of staying inside, the American people need the guidance of the CDC more than ever to help us navigate the path ahead. Efforts to reopen our country and reignite our economic engines should be approached with caution and designed on each States' unique circumstances based on sound data.

This pandemic has caused unprecedented disruptions to our families, communities, and economy. And it will continue to do so for some time. The strain on our supply chains and the devastating economic impact to hard-working Americans have created challenges that will take months and, in some cases, years to address. However, I am encouraged to see State and local economies slowly and cautiously beginning to reopen.

I also welcome the renewed focus on the need for U.S.-based capacity and resilient supply chains. I look forward to working with my colleagues across the aisle to address these challenges.

I also want to acknowledge the robust, bipartisan congressional response. In a deeply partisan climate, I am pleased to see Congress and the Trump administration work together across party lines to deliver critical resources for the American public in supplemental funding and support programs like the highly successful Paycheck Protection Program. We set aside our differences and quickly delivered legislative action to address the pandemic, passing record sums in record time. When the consensus is clear, Congress is as capable as ever for decisive action.

The fight against COVID-19 is far from over. I hope the spirit of bipartisan cooperation can continue as we assess our past efforts and determine what more may be needed.

While the Federal Government has provided some short-term relief to help individuals, households, businesses, and communities stay afloat during this period of extreme social distancing, our economies need to get moving again and Americans need to get back to work. However, any such efforts to reopen must continue to keep the health and safety of Americans at the top of mind and not undo previous progress in slowing the spread of this coronavirus.

This will indeed be a delicate balancing act. Until there are working treatments, effective therapeutics, and ultimately a vaccine to control COVID-19, the risk and the danger of the disease remains. Fortunately, I see real progress in all of those areas.

Returning to more regular functions and operations requires gradual action, completed in phases and based on data. President Trump and the coronavirus task force established phased-in and data-based recommendations and criteria for States on reopening efforts. The administration recognized now is not the time for a one-size-fits-all model for each State. They are leaving key decisions to each governor to make as appropriate for the circumstances of their communities based on their needs, their supplies, and local capacity. As the States develop their plans, the administration is fortifying the supply chain for testing supplies and ensuring each State has access to the supplies needed for reopening, often shipping testing supplies directly to each State.

Finally, it is critically important that the Federal Government learns from this crisis and actively prepares to face down another pandemic in the future. While I am proud that Congress has generously invested in worthy tools and response resources to strengthen our readiness in recent years, it must be an even higher priority in the days ahead. Though the United States was prepared to face an emergency, you can never be fully prepared for what you don't know is coming.

In the future, we must not just prepare for the emergency at hand, but leave our Nation better prepared for the emergencies ahead. Sustained, predictable, robust funding for research, preparedness, and U.S.-based capacity are vital components to this approach and something that this committee in a bipartisan fashion has worked on well over several years.

I want to thank the chair, again, for holding this important hearing at this critical time. And I yield back the balance of my time.

Ms. DELAURO. I want to thank my colleague. And just take a moment to say that the member that gets the award for traveling the

farthest, once again, is our colleague, Congresswoman Herrera Beutler. Thank you so much for being here.

And with that, I would like to recognize for an opening statement the chair of the full Appropriations Committee, Congresswoman Nita Lowey.

The CHAIRWOMAN. Thank you, Chair DeLauro. I am assuming this is working and you can all hear my voice. Is that correct, Madam Chair?

Ms. DELAUBRO. We can. Loud and clear.

The CHAIRWOMAN. Okay. Okay. Well, I do want to really thank you, my friend, Chair DeLauro, and my friend Ranking Member Tom Cole for bringing us together. It is a pleasure for me to join you remotely.

And, Dr. Redfield, welcome back before the subcommittee.

As the Nation faces the greatest public health crisis of the past century, Americans have never needed the CDC more than we do right now, and that is why I am so troubled.

The President has pushed away the science when it did not suit him time and time again. The President pushed aside medical experts, including the CDC's expert on respiratory diseases, Dr. Nancy Messonnier, because her legitimate warning rattled the stock market. The President encouraged the use of hydroxychloroquine, even though studies have shown that coronavirus patients receiving this drug were more likely to die. He even raised ingesting disinfectants like Lysol and Clorox, causing manufacturers to warn of the danger, and leading to a spike in calls to poison control centers throughout the country. This is not normal, my friends. This is dangerous.

We have lost more than 100,000 souls, nowhere more than in my own home State of New York. And in the absence of a strong Federal role, New York has been a leader in testing to contain COVID-19, but this virus does not recognize State boundaries.

To succeed against the coronavirus, our Federal public health officials must take charge, combat disinformation, and get this right. With many States beginning to reopen, the CDC must remain vigilant to combat the continued increasing cases, as well as the expected second wave this fall. The President's preference of the patchwork for 15 different States fighting COVID-19 on their own will not stop these levels of destruction and will lead to more suffering and death.

We need a national strategy on testing and tracing, and, my friends, we need it now. We don't need a Democratic plan. We don't need a Republican plan. We need a United States plan and we need it now, and we stand ready to support the CDC.

In recent months, this committee has provided \$7.5 billion in emergency supplemental funding to CDC to respond to this public health crisis, and the House-passed Heroes Act would provide an additional \$2.1 billion. And we will do everything we can working together, Democrat and Republican. We have the responsibility to protect the public. I only wish the President would do the same.

Thank you, Madam Chair.

Ms. DELAUBRO. I thank the gentlelady.

And now, Dr. Redfield, again, thank you for being here. And thank you again for your public service and for—that is not only in the United States, but all over the globe as well.

You understand that your full testimony will be entered into the record, and you are now recognized for 5 minutes.

Dr. REDFIELD. Thank you very much, Chairwoman DeLauro, Ranking Member Cole, distinguished members of the committee. I thank you also for the opportunity to testify before you and, again, thank you for your long-term support of CDC.

The COVID–19 pandemic is the most significant public health challenge to face our Nation in more than a century. And as we sit here today, this novel virus is weaving its way through our social consciousness, our outward expression, and our grief. I am deeply saddened personally by the many thousands of lives that have been lost to COVID–19 in the United States and around the world, and I fully recognize the anguish that our Nation is experiencing now.

Today I call on the American people to remain vigilant in our collective obligation to protect the vulnerable, to protect your community, your grandparents, your loved ones who may be at risk for severe COVID complications. And we must lessen the impact on African Americans, Hispanics, Latino, American Indian, and Alaska Natives who are being disproportionately affected by this disease.

This Nation is not only hearing a wake-up call; rather, we are hearing a clamoring for equity and healing, for a positive permanent change to health and social disparities that persist in our Nation.

As communities make plans to cautiously reopen, this means that we need to continue to embrace the now familiar social distancing, hand washing, and face coverings. These actions will allow us to move forward and contain the outbreak, along with readily and available testing, comprehensive contact tracing, timely isolation of known cases, and self-quarantine to break the chains of transmission.

CDC is providing communities with public health tools and information to confront this novel virus. Personally, I can't tell you how proud I am of the men and women and the dedicated public health professionals at CDC and how grateful I am for their service and their family sacrifice. CDC has deployed over 5,000 personnel to the COVID–19 response. Field teams are on the ground providing local health officials with expertise in epidemiology, surveillance, infection prevention and control, lab science, and community mitigation. We have published more than 1,500 specialized information and guidance documents so far, and the COVID website has been consulted more than 1.3 billion times. CDC has responded to more than 20,000 inquiries for doctors and clinicians, and we have hosted calls that have reached over half a million more.

With your support, CDC has been able to award nearly \$12 billion to States, territories, Tribes, and localities. These funds are being used to enhance diagnostics, healthcare worker safety, and the other important public health measures that I previously mentioned.

Through our partnerships with CMS and the Indian Health Service and HRSA, we are deploying teams to the needs of population

at the highest risk, specifically those living in nursing homes, shelters, and correctional facilities.

This outbreak has shone a bright light on the true heroes of the response. They are the public health and the healthcare professionals, the first responders, and the critical infrastructures workers. But, unfortunately, this pandemic has also highlighted the shortcomings of our public health system that has been underresourced for decades.

Never has it been more clear that our Nation's public health IT infrastructure requires modernization to support and collect reportable, reliable, comprehensive, and timely data. When we confront any disease threat, CDC and public health departments must make real-time decisions based on real-time data. Data forms the roadmap and it informs policy. Data is the backbone of any disease threat response.

As a virologist and a physician, I know the importance of strong clinical laboratories. We must equip our public health laboratories with advanced technology and the ability to adopt new platforms required in emergency response. We must exponentially grow the necessary workforce to address COVID and future public health threats. Sustained investment in our public health system of this Nation is an investment not only in health and prosperity for today, but for the future generations tomorrow.

Preparedness will be critical when influenza and COVID hits the doorsteps of our hospitals and healthcare providers this winter. I want to encourage all Americans to be prepared to embrace flu vaccination with confidence for the families, themselves, and communities. This single act will save lives. As a person of faith and good conscience, I ask all of you to see the possible. We must resolve, we can and we must lessen the health disparities in this Nation.

I leave you with a reminder from our mutual friend, the dear—the late dear Congressman Cummings when he used to say the cost of doing nothing isn't nothing. As CDC director and a grandfather, I ask you to continue to work with me to build the public health system our Nation not only needs but that it deserves. Now is the time.

And I want to thank you for this opportunity, and I look forward to your questions.

Ms. DELAURO. Thank you very much, Dr. Redfield.

Let me begin. Many Americans today are worried that politics and not public health facts or the CDC are driving our Nation's coronavirus decision. March 13, President Trump declared a national emergency. Our Nation had 556 new cases and 7 deaths. Four days later, he urged the American people to follow stay-at-home guidance. He said, we are asking everyone to work at home, if possible, postpone unnecessary travel, limit social gatherings to no more than 10 people.

Let me show you this chart.

On June 2, as this chart shows, there were over 20,000 new cases, and we have had more than 1,000 new deaths. And President Trump is telling the American people that we are reopening the economy and everything is okay.

Our policies don't seem to make any sense. When we had fewer than 1,000 new cases, we went into a national emergency. Now we have 20,000 or more new cases a day, yet we are opening up.

Based on those inconsistent responses, I have come to a conclusion. In March, we made decisions based on public health expertise, but now we are basing decisions or making these decisions based on the interests of politicians in the White House. I question these facts, and I have several questions, so I am going to try to move quickly.

This chart shows the crisis isn't over. Instead, it appears the White House is trying to convince the Americans to just accept more risk and death.

You run what has been the world's preeminent global disease detection and control center. How does this make sense from a public health perspective? I am going to ask you to be succinct, Dr. Redfield, because there are a few more questions and there are a whole lot of folks who want to ask questions.

Dr. REDFIELD. I thank you for your questions and comments. I would say that as we have experienced this coronavirus pandemic, we are learning every day. I think probably the most critical thing that we have learned is to understand who is most vulnerable to this infection. Clearly, we have seen that with the nursing homes, the elderly. We have seen it, obviously, in African Americans, Hispanics, and American Indians and Native Alaskans, and really design our policies to protect those vulnerable individuals.

I think that is one of the fundamental lessons that we have learned in the last several months. And I think that is really central to the policies that we have going forward is to continue to protect the vulnerable.

Ms. DELAURO. So yes or no, does it make sense for us to be doing what we are doing, when we are looking at 20,000-plus cases on June 2 and over a thousand deaths? And so it leads me to believe that we are not following what is based on public health expertise but, rather, making decisions based on what are more political interests.

Let me ask you these questions, and this is a yes or no, Dr. Redfield. Do we have a vaccine yet?

Dr. REDFIELD. We have candidate vaccines under development.

Ms. DELAURO. But we don't have one yet?

Dr. REDFIELD. We don't have one for deployment at this point.

Ms. DELAURO. Are we close to achieving herd immunity across the United States? Yes or no.

Dr. REDFIELD. No.

Ms. DELAURO. Is there any evidence the virus has become less contagious or is becoming tired of infecting us? Yes or no.

Dr. REDFIELD. No.

Ms. DELAURO. Okay. Are all the States meeting the basic tests that the White House guidance laid out for reopening: downward trajectory, documented cases within a 14-day period, downward trajectory of positive tests within the 14-day period?

Dr. REDFIELD. Chairwoman, of course, these were guidances that we put out. And to answer your question directly, not all the States have met those criteria.

Ms. DELAURO. Okay. My understanding is that we have had—well, a number of States.

Let me just ask you one concrete example. Let me show you this photograph. This is the Lake of Ozarks. Yeah. I had the same visceral response, Dr. Redfield. Look at this. Look at these folks. This is unbelievable. And you have got this happening in the State of Missouri. The White House guidance says that States need to have the ability to trace the contacts of COVID and results. The State of Missouri where this has happened does not have the capacity to do contact tracing.

Is the CDC tracing everyone who was there? Yes or no, Dr. Redfield.

Dr. REDFIELD. It would be the State, and we would assist them. And the answer is that we haven't been asked to assist them for that.

Ms. DELAURO. So we are not contact tracing, even though we have the—we have identified the person?

Dr. REDFIELD. I can't answer for the State what they are doing, but I will say, because of Congress' support, we are building enhanced capacity across this country to do contact tracing and get that capacity fully operationalized by the fall of this year when we are going to need it to maintain containment as we get into the fall and winter of 2020.

Ms. DELAURO. Let me have you look at this photograph. This is—we saw the Ozark photo. This is the photo from last week's SpaceX launch. People gathered on the bridge. Would you put yourself in these types of situations?

Dr. REDFIELD. I think the really important thing of all of this, as you pointed out, is that not just to the individuals, but to the risk that they are putting the individuals they go home to.

Ms. DELAURO. And that is what is happening. That is what is happening.

Let me just—I will try to close with this. Two and a half months ago, the President started the process of shutting down the economy, fewer than a thousand new cases a day. Since then, administration's failure to respond competently, squandered the opportunity to bring the virus under control, protect the health of the American families. We are being told it is safe to reopen. Over 20,000 new cases, over a thousand deaths. We do not have testing, tracing resources that we need to prevent more deaths. It is no wonder the world's leading medical journal, *The Lancet*, just this past week calls the Federal response inconsistent and incoherent, but the President wants us to get used to this and to pretend it is business as usual.

Let me just say this to you, Dr. Redfield, with all the—I have such admiration for the work that you and CDC do, but if you and the CDC are driving this bus, you are taking us in a dangerous direction. From everything I can tell, the CDC isn't in the role you have had in the past. Not only aren't you driving the bus, but the President seems to have left you at the curb. That is wrong for CDC, but it is deadly for our country.

I recognize my colleague, Congressman Cole.

Mr. COLE. Thank you very much. I have got a different question, but let me start with this. Are other countries in the world, based on mortality rates, doing less well than the United States?

Dr. REDFIELD. There are countries, as you pointed out in your opening statement, that are not doing as well as the United States.

Mr. COLE. And are those countries reopening for business?

Dr. REDFIELD. There are countries that are reopening.

Mr. COLE. Now, at some point, we put 40 million Americans out of work, literally, in a matter of the last few weeks, and we have done what we can as a Congress in a bipartisan basis, with support of the administration, to help those people. We think we are making a lot of progress on both therapeutics and vaccine, but people do have to go to work. You do have to have a functional economy at some point.

And, you know, again, when we did the shutdown, a lot of this was to try to make sure we didn't overwhelm our own healthcare system. Could you give us some view as to whether or not we are anywhere close to that or how is that worked out in retrospect?

Dr. REDFIELD. Thank you. Thank you, Congressman. I think that was fundamental. I think there was enormous concern that I and others had that this pandemic could have overwhelmed our healthcare system, particularly in some of our major metropolitan areas, such as New York and Connecticut area and the northeast area, northern New Jersey. And so there was—and we saw that actually happen in Italy. It overwhelmed that. We saw that in Wuhan, China, that they overwhelmed the health system.

And so when it did overwhelm the health system, not only the mortality rate for the COVID was up, but the mortality rate in general for being in the hospital was up. So that was the greatest concern. That is where you saw the attempt to expand healthcare capacity.

It is—we were able to get through that and—in the sense with some augmentation, but in general, in most jurisdictions, we were able to get through that. And I think that is the scene you have changed. And it isn't just health versus the economy. And I think, you know, it really is health versus health.

I mean, I mentioned that 85 percent of the children have now missed their immunizations. Around the world, 120 million kids have missed the immunization of the measles. There is going to be more deaths from measles in children than there is going to be from flu. So it is trying to find that balance as we come back and be able to make sure that we can begin to operationalize, not only our employment, but our health system.

When you think of all the cancer screenings that have been missed that are going to have consequences, so I do think it is important to get back, you know, not only our economy back, but our health system back, but to do it strategically and prudently.

As I said, we have learned a lot. The key to us right now is to protect the vulnerable and to focus our energies on that. This pathogen doesn't, in general, cause a lot of disease in young individuals, but, boy, it can be deadly in those with chronic medical conditions and the elderly.

Mr. COLE. Let me ask you this. I want to go to a topic that we have discussed many times before and I sort of want to pat this

committee on the back, because the last 5 years, we have increased funding for NIH by 39 percent, for CDC by 24 percent, strategic stockpile by 34 percent, set up the Infectious Disease Rapid Response Fund, as my good friend, the chair, noted. In other words, we have done quite a bit, and yet we were still overwhelmed by what happened.

And we are responding right now in a crisis mode with supplementals. I am really concerned about what we do going forward. And the administration's original budget obviously was put together with no idea that this was going to occur, so that budget no longer is really applicable, in my view.

I want to ask you, looking forward, and you referenced this in your remarks, what kind of budget do we need in terms of sustained commitment? What areas do we need to focus on?

Because, again, I know we are going to keep passing supplementals. I don't think that is the real answer here. I think we need this really focused deal. Dr. Frieden, your predecessor, came here, talked about a equivalent of what we call an OCO account. It is an off-budget account for the military that allows, in extraordinary circumstances, to finance military activity not be limited by the budget.

My friend, the chair, and I have talked together about we have a budget agreement, but maybe CDC, NIH, FDA, food inspection, strategic stockpile, maybe a few accounts ought to be selected to get outside of that agreement and just do what we need to do. Because we are going to be dealing with this.

So I would really welcome your thoughts as to what kind of investments we need to make going forward and how do you sustain those investments. Because I don't like one-and-done supplementals here. I don't think that is going to ultimately—it is going to help us in a crisis, but it is not going to get us where we need to go.

Dr. REDFIELD. Yeah. First, I just want to thank the chair and yourself and the committee for the consistent enhancement of our capacity. You know from the very beginning, within the first month of me being CDC director, my assessment was that the public health core capabilities—the core capabilities of public health that we need both the CDC and throughout this country in States, local, Tribal, territorial, is inadequate. And that we really need to be overprepared, not underprepared. And when you asked me what kept me up at night, I would say pandemic flu, because we are just not prepared.

I think this is highlighted, even with all the improvements, which I treasure. The data modernization that the chair put forward, fundamental. You know, the reason we are having trouble with the issue in healthcare disparity and understanding how this virus is affecting the African American is because we don't have the data, and getting that data modernization is fundamental.

You know I feel the same way about laboratory resilience and multiple platforms. The workforce that we just talked about. We are going to need 30 to 100,000 new contact tracers and we are going to need them before September. The rapid response fund that you all have put into place, which is critical and continue to sup-

port. And, of course, the global health security, which I think is the big elephant in the room.

You think we weren't prepared for this; wait until we have a real global threat for our health security. And I echo your concern. I think it is a much greater probability than we have a real defense threat. And so I think we do have to build that into the long-term base budget and figure out, you all—to work to figure out how to get that done.

I think that the public health infrastructure of this Nation, which you all know, a significant portion of it goes to State, local, Tribal, territorial. We fund 50 to 70 percent of all the public health infrastructure in your own State and communities. That needs to be augmented.

And truthfully, I meant what I said at the end, with my friend, Congressman Cummings, the cost of nothing isn't nothing. The time is now to do it and get that investment.

Mr. COLE. Thank you, Madam Chair. Difficult without the clock, but I apologize for that. Thank you.

Ms. DELAURO. No, I understand. Everyone is here today.

Mr. COLE. Absolutely. I have got it. Thank you.

Ms. DELAURO. We now recognize the chair of the full committee, Congresswoman Lowey.

The CHAIRWOMAN. Thank you very much, Madam Chair. And, Dr. Redfield, it is good to hear from you today.

New York's ability to scale up testing has been extraordinary, and we are now testing about 50,000 residents each day, with more to come. We need every State, however, to take these steps to have a true picture of where infection rates are rising and mitigate the damage. But most States are not even close to New York's capabilities.

Can you tell me, why hasn't the CDC established testing benchmarks for each State to meet? And maybe I will have you answer that and then, with all due respect, the virus doesn't recognize State lines. We cannot fully protect the population of one State if other States aren't holding up their end of the bargain. So a Federal response is needed to truly protect the public.

I don't understand why CDC isn't taking a leadership role in establishing testing benchmarks for each State to meet.

Dr. REDFIELD. Thank you very much, Chairwoman, for your question. And also, thank you for the recent resources that you provided to HHS, of which 10,250,000 came to CDC and has already been distributed to the States to be able to do just that.

We have worked with each of the States to develop their independent plan and benchmarks, and those plans are now under review. They were due on the 31st of May through June. And then from June 15, they are due for the rest of the year, from July to December. It is really going to be important. I will say that you are blessed with the Wadsworth lab, one of the best State labs in the Nation.

As I talked about core capabilities, the number 2 was laboratory resilience. I am personally saddened that there is a handful of State labs that have the capability to do what needs to be done. Again, as part of this core capability investment, I want all State labs to be able to do that. I got to work with Howard Zucker very

early as New York State lab stepped up to develop their own test, as you know. And they were the first to develop the test, not on the what I call the slow platform that we have for flu, but they put it on a rapid throughput platform and really led the way.

So I agree with you. We are in the process of doing those plans with each of the States because of the resources from you all in Congress. But I would add that I think it is a critical time for us now to invest heavily in State labs so that they have the resilience to do exactly what your colleagues in New York have been able to do. We could do that in each of the 50 States of this Nation.

The CHAIRWOMAN. Well, thank you very much. And I just have a little time left, and I want to say that this committee had the benefit of being briefed early on by Dr. Nancy Messonnier, the director of the National Center for Immunization and Respiratory Diseases at CDC. And on February 26, she said: Ultimately, we expect we will see community spread in this country. It is not so much a question of this will happen anymore but, rather, more a question of exactly when this will happen and how many people in this country will have severe illness.

Is Dr. Messonnier's explanation correct?

Dr. REDFIELD. Yes. I mean, I just also want to add that Dr. Messonnier is one of the outstanding lead scientists at CDC. She continues to run our center for immunization and respiratory diseases. And, as you know, she was the first leader of our IM response to this outbreak when it was grounded in her center.

The CHAIRWOMAN. Well, I just want to comment in the limited time I have left. Was she sidelined for telling the truth? It has been widely reported that President Trump wanted to fire Dr. Messonnier after her comments, fire her for telling the truth because of the impact on the stock market. Instead, he removed her from any public facing role.

What does this say to the public health professionals at CDC who may be fearful of retribution for doing their jobs?

Dr. REDFIELD. I just want to stress that Dr. Messonnier remains one of our outstanding leaders. She continues to run our center for immunization and respiratory disease. She is a great scientific ally of mine and other leaders.

In addition, I just want to point out, she is our lead on the project Warp Speed, in developing the vaccine and taking the leadership for CDC on that task force. So she has not been sidelined, and she continues to use her expertise to lead one of the most important agencies that we have at CDC.

The CHAIRWOMAN. I want to thank you, Dr. Redfield. We have known each other a long time, and I am glad that you are there and I am glad that Dr. Messonnier continues to be a key part of this project.

Thank you very much, Madam Chair.

Ms. DELAUBO. Thank you.

Dr. REDFIELD. Thank you, Chairwoman.

Ms. DELAUBO. Congressman Harris.

Mr. HARRIS. Thank you very much. And thank you, Dr. Redfield, for being here.

First off, I want to draw the distinction between March and June. In March, because the chairman brought up—well, it doesn't

make any sense. We had very few cases in March, we have a lot of cases now, but, in fact, China had a lot of cases by then, and we really didn't know a lot about the disease by then. We know much more about it now, and I would suggest that if we really want scientifically based actions, we should actually use data. And we have a lot more data now.

For instance, I remember sitting at a hearing in this committee where the death rate was speculated to be 3 to 4 percent. And last month, the death rate, I think the CDC quote best estimate is .26 percent. So a lot has changed in the past time, and to say that this is politics is ridiculous. This is actually science. It is actually looking at data and dealing with science.

Now, Dr. Redfield, I don't have a lot of time, but you are well aware of the effect of unemployment on health, I hope. The landmark study in 2009, Quarterly Journal of Economics, looking at the unemployment rate following the oil crisis in Pennsylvania in the 1980s, showed that the death rate among men unemployed doubled in the year following their unemployment. And when they tracked it for 20 years, there was an effect that lasted 20 years with an average loss of longevity of 1 to 1½ years for unemployed people. That is a pretty serious health effect.

So I am going to ask you, because we are in the midst of reopening in Maryland, and one of the things that, in my district, is very important is the tourism industry and the restaurant industry. And our governor has decided, in accordance with CDC guidelines, because we have the phasing document. Our governor has decided we are ready for phase 2. I look at the—at the document that CDC has about scaling up operations for restaurants and bars. It is step 2, where you have indoor dining, and our governor has decided for some reason you can do outdoor dining, you can't do indoor dining in restaurants.

So I am going to ask you a very simple question. In fact, since our governor decided phase 2 gating has already—criteria has already been satisfied, is there anything in CDC guidance that would say indoor seating is not appropriate maintaining social distancing? I mean, could the governor say, well, the CDC guidance is holding me back, once phase 2 gating has been exceeded?

Dr. REDFIELD. No, you wouldn't find that in there. Again, as you pointed out, the critical thing is to have these things. CDC, we are not an opinion organization. It has got to be science based. And I think the principle of the science that we have right now on social distancing is that 6-feet, 2-meter distancing, and that is the key.

Mr. HARRIS. Should be adequate. Thank you very much. That is what I thought. And, again, you know, you want to talk about things based on politics. Some of these delayed reopenings are based purely on politics, because there, as suggest, there really isn't a whole lot of scientific evidence that at this point would delay some of these reopenings consistent with CDC guidelines of social distancing.

Now, I do have a question about masks because, you know, there is now a cult of masks. That is what I will refer to it as because, you know, we get criticized. Oh, my gosh. I am afraid to get a picture taken of me without a mask somewhere because someone will say, well, how can you possibly—you are a doctor, how can you not

wear a mask? But, in fact, we don't know a whole lot about what—whether a mask is better or worse than a cloth face covering or is better or worse than a face shield.

But I am going to ask you something very specific about restaurant opening guidance, because the CDC document says that restaurant workers should wear cloth masks and not surgical masks. I mean, it specifically says wear cloth masks not surgical masks. But my understanding is the surgical mask is probably a little bit more protective of the other person in the room than a cloth mask. So is there evidence behind that? I mean, is it just that we want to reserve surgical masks for other situations? Is there science behind that saying a cloth mask is better than a face mask? And face shields aren't even mentioned in the guidance.

Dr. REDFIELD. Yeah. Not in terms of better. Clearly, there is science behind the potential benefit, if I am infected, of wearing a face covering in changing the amount of infectious virus that can go across a 6-foot space or 3-foot space, and we have good data to show that. But I think you hit the answer yourself is the real issue is to preserve the medical surgical masks for the medical surgical first responder community. That is the intent there, not that there is any evidence that one is better than the other.

Mr. HARRIS. That is what I imagined. And, again, you know, getting back to science, because there is a lot of critique when, you know, first people were told don't wear a face mask, then they are told wear a face mask. We had a big discussion, you know, is it surgical masks, face masks, face shields, what is it? I mean, the bottom line is, you should protect the other person that you are coming near—

Dr. REDFIELD. That is right.

Mr. HARRIS [continuing]. In case you are an asymptomatic or presymptomatic carrier?

Dr. REDFIELD. That is right. That is the purpose.

Mr. HARRIS. Thank you very much.

I yield back, Madam Chair.

Ms. DELAURO. Thank you.

Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you, Madam Chair. And, Dr. Redfield, thank you for being with us today.

I would like to follow up on the issue of masks. In early April the CDC reversed its initial guidance from masks being optional to advising the public to wear cloth masks in public places at all times. In spite of this advisory, U.S. culture has continued to be a barrier to a universal acceptance of these recommendations. Mask wearing importantly has become very politicized, and those who oppose their use argue that mandating masks is interfering with individual freedoms.

A recent study by a group of Cornell University scientists showed that when quarantines are lifted, if 80 percent of the population wears masks with social distancing, the virus could be eliminated. Unfortunately, today only 15 States require the wearing of masks in communal places and the President continues to flaunt his opposition to this public health recommendation.

Based on the science, why did you initially recommend the masks as optional and what fears do you now have regarding the spread

of the virus if States and individuals can't be incentivized to wear masks in public, including during these massive protests that we have recently witnessed throughout our country?

Dr. REDFIELD. Thank you very much.

I think fundamental to this was the recognition of the importance of asymptomatic infection or presymptomatic infection. When this outbreak originally happened, the CDC had the original 12 cases in the first of January, February, we did about 800 contacts through our contact follow-up. Two of those individuals were confirmed to be positive both symptomatic and both spouses.

So we had the view from our Chinese colleagues and their experience and our early experience that this was a symptomatic disease, like most respiratory viral diseases were. But what we rapidly started to learn is there is significant asymptomatic infection and—or what we will call presymptomatic infection, and we have learned that the amount of virus that is shed in individuals that are asymptomatic is just as high as that in symptomatic.

And when that knowledge base came, we realized that we had an important public health tool that we needed to take advantage of, and that is if people were asymptomatic or presymptomatically infected, if they were wearing a face covering, that they would have less ability to transmit to others, and that is why we embrace this important public health tool. And I will say that I—and we continue to see this as a critical public health tool, as I said in my opening statement, that we ask the American public to be vigilant about utilizing particularly as a major mechanism that we have to protect the vulnerable.

Ms. ROYBAL-ALLARD. And can you also elaborate on what your concerns are then when you see these mass of protest, when you see as things are opening, when you see people on the beaches and in public places who are not wearing masks, what is your concern of what the possible outcome of that will be in terms of the spread of the disease?

Dr. REDFIELD. Yeah. Obviously, we are very concerned that our public health message isn't resonating. We continue to try to figure out how to penetrate the message with different groups. The pictures that the chairwoman showed me are great examples of serious problems, you know, and I can say that we will continue to try to message as well we can. We are going to encourage people that have the ability to request or require a mask when they are in their environment to continue to do that.

We do think this is an important public health tool, and we are going to continue to try and figure out how to get more and more people to embrace it.

I was just remarking when I will go home in the Baltimore area, I don't see anybody without a mask, but a lot of times when I walk through Washington, D.C., I see a lot of people without a mask. So there is different cultural approach to it, but we think it is an important public health message, and we are going to continue to stress it. I think it is going to be key.

These social distancing strategies that we have learned are something we need to perfect because we are going to need them to be our major defense again in October, November, and December.

Ms. ROYBAL-ALLARD. Well, I hope that you can start with convincing our President to be a champion of advocating for masks to prevent the further spread of the virus.

I yield back.

Ms. DELAURO. Thank you.
Congressman Moolenaar.

Can you unmute and then start from the outset here.

Mr. MOOLENAAR. Okay. Thank you, Madam Chair. I appreciate the opportunity. And, Dr. Redfield, we appreciate your presence with us today, and I want to thank you, the 5,000 members of your team that are helping during this health crisis and also just for the sacrifice that they and their families are making to help protect the vulnerable.

And I wanted to talk with you, one of the areas that you brought up as a concern was the IT infrastructure. One of my priorities on this committee has been to provide funding for the CDC's public health data modernization initiative, and I think this pandemic has really demonstrated the importance of that. In fact, some of the early reporting said that the CDC's response was hampered by an antiquated data system and a fractured public health reporting system across the United States.

And I wondered if you could speak to the early response as well as what you have done since that time, and as we go forward, what do we need to do to really invest in this data modernization?

Dr. REDFIELD. Thank you. And, again, I want to thank the chair and this committee.

You, I think, heard those discussions that I had I think in the first weeks of my directorship, and we talked about the core capabilities, and the one that I said was the most, most, most important was data. We need data. We need it in real-time. We need it actionable.

And I mentioned that I had had a briefing the first month that I was on with the opioid deaths, and when they finished—this was in April of 2018. When they finished, I asked my CDC experts what the data was through, and they said March 2015. And I said, "is that the most recent data we have?" And they said, "Yes." And I said, "I didn't know I was becoming a medical historian." And I shared that comment with the chair and the co-chair and others, and we are appreciative.

We have a long way to go, though. It is not just the data system at the CDC. It is the data system throughout this Nation. And in some States, they have decentralized public health data collection. I have States that are still collecting data on pen and pencil. And so this data modernization that you all started, I do believe to get us over the goal line, it is going to require a substantial enhancement of that investment. We are talking about building a comprehensive data system for the public health system of this Nation.

But when that is accomplished, it is going to be a gold mine. You know, we are able to do syndromic surveillance now, and that 2-year lag that I had, 3-year lag I had for opioid deaths, we now can solve in 48 hours. We saw it with the EVALI syndrome that we had with the e-cigarettes, how rapidly we were able to detect that because we could use syndromic surveillance.

So I want to just encourage you to continue to accelerate the ability for us to modernize this Nation's system and get it done once and for all. It is going to have enormous health benefits for us across the Nation to be able to respond to that which we don't know we are going to need to respond to.

Even in my short time, we have had EVALI. We have had unexplained hemorrhagic deaths from contaminated marijuana. We have now, obviously, had this. All of these things—we have the acute flaccid paralysis in children. All of these things would be enhanced so much if we had a real-time actionable data system across this Nation.

Mr. MOOLENAAR. Thank you, Doctor.

I want to also follow up with you along the lines of the data collection and talk with you about the skilled nursing facilities. It is no secret that nursing homes and long-term care facilities have been among the hardest hit during this pandemic, and data from CMS suggests that 26,000 nursing home residents have died from COVID-19 and more than 60,000 have fallen ill. However, only 80 percent of nursing homes have reported data to the CDC, so these numbers are only going to increase.

Two questions. How has the CDC been working with CMS to ensure greater compliance on reporting of infections and deaths at nursing homes? And then also when do you expect that we could get this data reporting as close as possible to a hundred percent?

Dr. REDFIELD. Thank you, Congressman. This is a major priority. CMS and ourselves, our group, are working very closely together. This is really one of the key priorities to successfully combat the impact of this pandemic on nursing homes. And as you mentioned, we have the ability now to have these nursing homes required to report all of their infections to us and deaths and for us to get those into CMS and for CMS to face them forward so the American public knows what nursing homes are doing well and what nursing homes aren't doing well and we know which ones we need to go in and help them even more with infection control.

I am hopeful that we will have this completed over the weeks ahead. This is a priority. It is a requirement now by CMS that these nursing homes do report. You know, it was just a couple of weeks ago we were under 20 percent and then recently 60 and now 80 and I think actually I heard numbers today that might be 90. So I think we are going to get this done, hopefully before the beginning of July, it is a priority, get it done this month.

Mr. MOOLENAAR. Thank you.

And I yield back.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Thank you for holding this hearing, it is very, very timely.

First let me just say I think you know and I think everyone recognizes we have a pandemic upon a pandemic in the African American community. And so today I just want to take a moment to offer my condolences to the Floyd family as we mourn and grieve his loss and hope that justice is served in his memory. And that goes right into the disproportionate rates of African Americans and people of color who are dying from COVID-19.

Now, Dr. Redfield, the PPP and Healthcare Enhancement Act, which became law April 25, mandated that the CDC provide us with a report on COVID-19 data based on race, ethnicity, socio-economic data within 15 days. Now—within 21 days; excuse me.

We received this report on May 15th and, of course, you signed this report. It was 2½ pages long. It contained no new insights, and what it did was just link to websites of data that was outdated, and it was very limited on testing and demographics. In short, the CDC and the Trump administration did not complete the assignment at all.

And so, Dr. Redfield, first of all, what is your plan for how you are going to target resources and a Federal response to Black and Brown communities which are disproportionately being hit? And as you said, the impact is greater, disproportionately with people of color.

How are you going to coordinate a Federal response if you don't have the data? You said that you would provide this. I actually called on May 18, to some of your deputies and asked for some of this data as relates to where African Americans are being disproportionately hit, and I was told that the CDC did not have the data to illustrate these disparities and must make assumptions.

So I want to know, how are we going to get the actual data and the report quickly so we can target the Federal response?

And then, secondly, I co-chair the Asian Pacific American Caucus's health task force, and I am concerned about the fact that the data as it relates to the AAPI community is not disaggregated, which makes this challenging to properly allocate resources and to ensure positive health outcomes. Actually, in one of your reports, you had the AAPI community designated as other.

And so what are you going to do in terms of collecting data as it relates to the AAPI community, as it relates to cases and mortality? And how are you going to make sure we get the report, your next report, which I think is due on June 14, that tells us where we need to target these resources based on race, ethnicity, and socioeconomic status?

Dr. REDFIELD. Congresswoman Lee, I want to thank you for your question, and first I personally want to apologize for the inadequacy of our response. It wasn't intentional. Unfortunately, it is just reflective of what I tried to say is that we didn't have the data that we needed to be able to answer that in a responsive way. That data comes in to us obviously from the State and local, tribal health departments. But that response was not adequate, and I apologize. And, unfortunately, it was under my signature, so I take responsibility; but we are correcting it. I think there is going to be an announcement today, that because of what you all have done with the CARES Act, it is now going to be a requirement for all laboratory tests to be reported to CDC to include the type of test, the zip code of the test, the ethnic and racial demographics, the age and the sex.

And as I said before in my opening speech, the data is the road map. It is fundamentally the key first step that we need to do to address the health disparities that you so correctly have highlighted.

And I think many of you know I spent 22 years practicing medicine in urban Baltimore. I understand firsthand the disparities of healthcare in this Nation. This is why Congressman Cummings and I became close friends. I have every intent to get that data so that we can begin to understand.

Clearly, increasing access to knowledge of infection in vulnerable communities is critical, getting testing more available in there. I do think with the—

Ms. LEE. So, Dr. Redfield, so what report are you going to release today so that we can have—so we know in advance what we can expect?

Dr. REDFIELD. Yeah. It is not a report, Congresswoman. It is a requirement that the reporting to CDC now is going to include ethnic, race, age, and demographics, and zip code. So we are going to be able to generate exactly what you have been requesting very specifically so we will know exactly where this virus is occurring—

Ms. LEE. Dr. Redfield, okay, so the next report to Congress is June 15. Will we have that data based on the CARES Act requirement?

Dr. REDFIELD. All I know is that whatever data I have—and I am pushing to get it in the way that meets yours, and my goal. I am not going to be able to promise it is going to be perfect on the 14, but it is going to be a lot further along than it was in the last one, and I think we are going to get this solved, if not by the 14, by the next one.

So you are going to—

Ms. LEE. And I know my time is up, but just let me ask you, will the AAPI data be disaggregated? We need that because otherwise we won't have a true picture of where to target resources.

Dr. REDFIELD. Yeah, we are going to try to make sure this data is forward facing, down to the zip code level, Congresswoman.

Ms. LEE. No. I am asking you the disaggregation of data based on the AAPI, the Asian American Pacific Islander community. For example, are you going to say in the Chinese American community, this is the data; in the Filipino community, this is the data; in the Japanese American community, this is the data; in the—you know, disaggregating the Asian Pacific—

Dr. REDFIELD. Okay. That I will have to look into, but I will take your concern and recommendation that we work to see how to accomplish that.

Ms. LEE. Thank you very much.

Thank you, Madam Chair.

Ms. DELAURO. Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair. And thank you, Dr. Redfield, for being here.

I have a difficult question for you, but I think it is really important to really understand what we can do to not be in this place again. And I value so much your work and your many sleepless nights and the work of your agency because I know they have been on the front lines.

I was reading an article—there is a—I saw an article from The Wall Street Journal I think in April, and I saw one from The Times today about CDC and testing. One of the things that was quoted

said, former officials in the CDC said the CDC's culture locks some of the agency's employees into a fixed way of thinking helping to produce its first and most consequential failure in the crisis, its inability early on to provide state laboratories around the country with effective diagnostic tests.

Then if I kind of fast forward over to where—and I am not trying to say who is—I am not trying to take a figure down, despite what everybody is probably thinking. I want to understand this.

I understand that when the public health emergency was declared on January 31, it meant that State labs had to—or any lab had to get permission then to get approval to do our own testing.

Basically it was about a month later before tests started really flowing. We know early on kind of the control of the situation was aggregated. They wanted—whoever made the decision that it was aggregated and CDC was going to produce the first tests and send them out to the States.

What we now know is those tests didn't work. They were sent to Washington State; Washington State had to send them back. And ultimately what I feel like happened was, you know, we have to have diagnostic testing ability, and we had to ramp that up quickly in order to stop infection.

Now we are at the place of limiting new infections for reopening, and we have broken through some of the barriers. Thank goodness, the private companies were able to step up. We broke down some of that bureaucracy, and they were able to step in and fill in holes. I know in my community in Southwest Washington, my local health—I mean, I have spent months trying to get testing capability for private labs. I know that because of relationships, for example, within the Vancouver Clinic in Southwest Washington, they were able to use their relationships to get their testing capability going. Everybody was—it was kind of like everybody was doing their own thing to make it move forward and we were trying to break down the bureaucracy.

The Wall Street Journal says—this was back in April—that an FDA official flew to the CDC headquarters in Atlanta, visited the lab that had prepared the tests, and the lab was, quote, a mess, and it became clear that the tests had likely been contaminated, said one person familiar with the matter. The CDC then disputed that the lab was a mess and pulled back its test, and there has been an investigation, and we haven't—I haven't seen the investigation results yet.

I know that your heart and your soul is to protect and to promote the public health of people in this country. There is no question about it. You have a long and distinguished career, which we are grateful for.

In recognizing these problems, my question is—and I keep hearing we just need to put more money into public health, we just need—and I agree, I want a real-time active data system, but this committee, in a bipartisan fashion, has increased funding for CDC, strategic national stockpile. We have instituted a rapid response team. We say yes to public health requests, we really have.

And yet here, when it all counted, some people in some places made decisions that all of this was going to be kind of constricted by the Federal Government, the Federal Government was going to

be the one that innovated and then distributed it. And I don't know if all of the money in the world can fix what some have called a culture where, quote—again, this is The New York Times—The culture at the CDC is risk-averse, perfectionist, and ill suited to improve—improvising in a quickly evolving crisis.

So when I read that, I don't think ill of the CDC. I think you guys are doing what you are doing in your lane. But wouldn't this better be—wouldn't we all better be served if the doors of collaboration opened at the very beginning and it wasn't public health or private, you know, or private labs, because we have got the challenges with how private labs have done things with regard to Quest and LabCorp; but if we had thrown open the doors and said together we are going to move forward.

And I would ask you, would you consider—I know you want your legacy to be building a robust public health system, but could your legacy also include fixing some of what seems like a siloed approach within the CDC—and that is going to require you to fight upwards I realize, not just downwards; but is that something you would be open to consider in terms of righting the ship so that the next time we are in this place—and I pray to God it is not in the fall, but it could be; but is that something you would consider and perhaps speak to that?

Dr. REDFIELD. I appreciate your comments.

A couple of quick things. First, I do believe, just to level the field here, that the CDC developed within ten days a test from the time the sequence was published, and that test is not a flawed test. It works perfectly. It was available in mid-January to diagnose the original cases in Washington, as you know. And its only limitation was, in order to get that test, you had to send the blood to CDC, and there was never a moment in this Nation when any health department couldn't get that test. They just had that limitation. There is no question there were shortcomings at CDC when—

Ms. HERRERA BEUTLER. I have to push back on that one. My public health departments could not get that test.

Dr. REDFIELD. Well, I am saying if they chose to send it to CDC, they could get the test. That is what I would say, Congresswoman. We always had that capacity.

The shortcoming was then we then tried to manufacture the test so that each health department would have their own. All right. I don't think you are going to see CDC in the manufacturing position anymore. It will be contracted out. And in that time there was a shortcoming. There was a contamination. It is being—there is an inquiry to figure out, you know, what was there and why it happened. But I will say within 5 weeks, it was corrected.

And so for me, within 5 weeks of the sequence, we had the testing now available in the public health labs, which some people may think is a delay. You know, as a virologist, from the time of a new pathogen to having a test and public health allows for it around the country, I think that is still an accomplishment, so—

Ms. HERRERA BEUTLER. But let me add in there, though, that 6 weeks—Madam Chair, I beg your indulgence.

That 6 weeks was the 6 weeks that we had to get ahead of this virus. That 6 weeks—well, you said 5 weeks.

Dr. REDFIELD. Yeah, 5 to 6.

Ms. HERRERA BEUTLER. On January 29th to February 29th, that is when we shut down, and now we are doing—we are digging our small businesses out, we are digging everybody out. I know as a virologist, that is good, but we have to get into the 21st century. We have to change the culture of the organization because that was the 5 weeks we had. That was our lead time.

Dr. REDFIELD. If I could just make one last comment on this?

Ms. HERRERA BEUTLER. Please. Madam Chair, I beg your—

Dr. REDFIELD. I know my time—

Ms. HERRERA BEUTLER. Thank you so much.

Dr. REDFIELD. Can I make one comment?

Ms. HERRERA BEUTLER. Yeah, yes.

Dr. REDFIELD. I know the time is up. I won't go through the other comments because we can talk offline on that; but the issue that really has to happen and one thing that we have to correct is the day CDC got in the lane to make a public health test, the private sector had to be in the lane to make a test for the rest of America.

It wasn't CDC makes the public health lane. It took, unfortunately, you know, weeks and weeks and weeks before the private sector stepped up, all right, and developed what we now have. As you know, we have now done over 17 million tests. The public sector is in the game. The public health is a small part of it, but I think that has to change, too.

Ms. HERRERA BEUTLER. Thank you.

Thank you, Madam Chair.

Ms. DELAURO. Congressman Pocan.

Mr. POCAN. Thank you very much, Madam Chair. Thank you, Dr. Redfield, for being with us.

Dr. Redfield, I have a lot of questions. So if you can be as concise as possible, I would certainly appreciate that.

It was inferred earlier by our ranking member that—and I think you answered the question, but that we don't have the worst amount of cases, the highest amount per capita on the planet; is that correct?

Dr. REDFIELD. Yeah, we are—that is correct.

Mr. POCAN. However, according to your data, CDC data, we have had over 1.8 million cases of coronavirus. That is nearly a third of all of the cases on the planet and by far the most of any country; is that also correct?

Dr. REDFIELD. Of those that have been reported, yes.

Mr. POCAN. Yeah. And also we have had 106,000 deaths by far the most in the world; is that correct?

Dr. REDFIELD. Again, of those that have been reported, yes.

Mr. POCAN. And our death rate is like 320 per 1 million, which is six times the reported global average; is that correct?

Dr. REDFIELD. I would have to double-check that. I don't have that figure in my head, but I have confidence that you have data there; but I would be glad to check that and get back to you.

Mr. POCAN. Sure. Thank you.

In fact, there is only eight countries out of 195 or so countries that exist on the planet that have a worse ratio per capita, Qatar, San Marino, Andorra, Bahrain, Kuwait, Luxembourg, Singapore and Chile. Altogether their populations are 33½ million people,

about a tenth of the United States. So it is not exactly impressive to say that we don't have the worst, but for almost every country, we have the worst amount of cases that are out there.

Do you have to agree, Dr. Redfield, that countries like Germany with a rate of 220 out of a hundred thousand; New Zealand, 31 out of a hundred thousand; in South Korea, 22 out of a hundred thousand have been more successful than the U.S. in controlling the spread of the coronavirus?

Dr. REDFIELD. Yeah. Based on the reported cases that we have, that would be correct.

Mr. POCAN. So I think one of the problems that we have in the United States, unfortunately, Dr. Redfield, is back in mid-April your agency was putting together detailed—recommendations for businesses, child care facilities, restaurants, and others to reopen, and that got sidelined for a month. In fact, I think it finally was on May 20, you released those guidelines, and on May 14, you put out decision trees.

Who made the decision to delay the release of the reopening guidelines?

Dr. REDFIELD. Again, all of these guidelines that we have developed, and as I mentioned—

Mr. POCAN. The question is, who made the decision to delay?

Dr. REDFIELD. Right, and I was just trying to answer, sir, that these guidelines, forming them was a reiterative process. So it wasn't a question of delaying the guidelines. It was a question of completing the process to make sure the guidelines had the input of the different groups—

Mr. POCAN. Who made the decision specifically that they would be released on May 20, rather than anytime sooner?

Dr. REDFIELD. It would have been me, sir.

Mr. POCAN. Okay. And were you at all in consultation with anyone at the White House; and if so, who?

Dr. REDFIELD. No. We were working again through the inter-agency group, so, again, that has multiple agencies that have input when these guidelines cross over. As I mentioned, it is a collaborative inter—

Mr. POCAN. I can tell you that release, though, Dr. Redfield, in States like Wisconsin where our State Supreme Court forced us open and other States were opening, came after all of that happened. It created a lot of chaos, and we had a spike in cases after that.

Let me ask you another question. So we know that chemical agents that are similar to teargas and teargas itself can cause people to cough which can spread COVID-19; is that correct?

Dr. REDFIELD. Definitely coughing can spread respiratory viruses including COVID-19.

Mr. POCAN. And do you agree that teargas and chemical agents like teargas can cause people to cough?

Dr. REDFIELD. That has been my experience.

Mr. POCAN. Have you made any advice to the President or report to any police agencies or the military to not use teargas or chemical agents with the recent protestors because obviously that could cause an increase in COVID-19 due to the coughing?

Dr. REDFIELD. I think you raised an important point. We have advocated strongly the ability to have face coverings and masks available to protestors so they can at least have those coverings. But you do raise an important question.

Mr. POCAN. Would you make that recommendation to the President—

Dr. REDFIELD. I will pass on this comment at the next task force meeting, yes.

Mr. POCAN. Okay, I appreciate that.

And with 6 seconds left, I will yield back.

Ms. DELAURO. I thank the gentleman.

Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chairwoman, and thank you, Dr. Redfield.

As you acknowledged in your opening comments, you come before us today in a time of national anguish and turmoil. This pandemic did not create inequities, disparities, or racism, but it has magnified the lethal effects of all of those.

Dr. REDFIELD. So true.

Ms. CLARK. We will only emerge through this public health crisis, this economic crisis, and this moral crisis if we demand that our American ideal of equity truly applies to each and every one of us.

Dr. Redfield, the CDC website contains pages of information on disparate health outcomes for people of color, higher rates of asthma, heart disease, diabetes, to name a few.

I understand from your answers to Congresswoman Lee's questions that tomorrow you will have an announcement or today, later today, about mandatory demographic reporting. But wasn't it imminently predictable that COVID-19 would disproportionately impact black, Latinx, and indigenous communities?

Dr. REDFIELD. You know, Congresswoman, I don't know; but it is clear once we understood that individuals with certain medical conditions were greater at risk, once we, you know, stepped back and understood certain social factors in living conditions would be critical, I think it became rapidly self-evident.

Ms. CLARK. Well, I can tell you it played out very, very quickly evidently in my district.

Dr. REDFIELD. Right.

Ms. CLARK. And I think that is true across this country, and we have to do better.

This plan that you are putting forth, is it a written plan that you will be sharing with us with specific benchmarks on how you are going to collect this data?

Dr. REDFIELD. Again, the announcement that is coming is actually coming from the Secretary of Health. It is not the CDC, but it is the CDC that is going to be getting this.

But you highlight such an important area, and those of you have been able to visit CDC, the whole area of health disparity, the whole area of social determinants of health, the whole area of making purposeful, meaningful progress in this, not just for COVID, but for all of the health outcomes that we have, I did mean what I said when I said the time is now to get a purposeful program to address these inequities.

Ms. CLARK. And I have visited the CDC, and I appreciate your commitment to that; but in this particular case, with this pandemic reaction, there were public outcry and outcry from Members of Congress and pressure to have this information. I am interested in who wrote this plan that is going to be released today. Was that the CDC or someone within HHS?

Dr. REDFIELD. It is in responsiveness, as I understand it, to the CARES Act and HHS will be announcing it. I think—

Ms. CLARK. Do you know who wrote it?

Dr. REDFIELD. It is really just meeting the criteria. It is not a plan in how to respond—

Ms. CLARK. Okay. What I would request is that we get a plan.

Dr. REDFIELD. I agree with you.

Ms. CLARK. So we can make sure we actually collect this data.

Dr. REDFIELD. Yes.

Ms. CLARK. Going back to the other point, we have seen Native Hawaiians and Pacific Islanders have the highest COVID-19 rates of any race group in California, and in many States Asian Americans have a case fatality rate significantly higher than the overall population. I hope you will do more than look into the disaggregating of AAPI information but that you will make it happen.

I also hope that you will add the LGBTQ community. June is pride month. This is a great time to add them to your forms, your surveillance forms, in particular the person under investigation form.

Your website also states that a lack of health insurance is one of the reasons that communities of color face systemic health disparities and in particular have been hard hit by COVID-19.

Is it your professional opinion, then, that dismantling the ACA and the administration's proposed budget cuts of \$1.6 trillion to Medicare and Medicaid could actually harm people and in particular people of color in this country?

Dr. REDFIELD. You know, Congresswoman, the way I can answer this is that, you know, I share with you the deep commitment that all Americans get access to high-quality healthcare and that we effectively address access issues. I do know—

Ms. CLARK. Do you think there is a way to address the disparities of healthcare in this country without expanding rather than reducing access to quality affordable health insurance?

Dr. REDFIELD. I think we clearly have to make sure that all Americans can expand the ability to get access to—high quality healthcare. The manner in which we do that, you know, I am not really here to comment on it, but—

Ms. CLARK. I am not asking you to comment on the manner. I am just saying, is there any way, in your professional opinion, to address these disparities if we do not expand rather than contract access to healthcare in this country?

Dr. REDFIELD. And as I said, I am firmly with you, that we need to continue to expand access to high-quality healthcare in this country for everybody.

Ms. CLARK. Thank you.

I yield back.

Ms. DELAURO. Congresswoman Frankel.

Ms. FRANKEL. Yes. Thank you, Madam Chair. Thank you. I want to thank your staff, Gloria Nlewedim—I hope I said her name right, but she really set us up well for this. And I am finding this meeting actually very enjoyable, even though—and I am sitting at home. That makes it even better. I didn't have to get on one of those planes.

So thank you, Dr. Redfield, for your service to our country. I want to—I have a few questions.

First of all, Dr. Redfield, do you agree that the CDC might have learned more about the virus and the necessary response had we had a greater global presence in the days and months leading up to the COVID outbreak?

Dr. REDFIELD. You know, Congresswoman, I think we would have benefitted enormously from having a greater presence, particularly in our CDC office in Beijing.

Ms. FRANKEL. Thank you for that.

In your written testimony, you say that contact tracing is a core infectious disease control strategy and involves case and contact investigation, followed by implementation and intervention. I know you testified at the Senate that contact tracing is going to be the difference of succeeding and containing this outbreak.

So, first of all, I just have a few questions in regards to contact tracing. One of your former predecessors, Tom Friedman, has suggested a work force of at least 300,000 people in the country to effectively contact trace. I would like you to comment on that.

And then a few other things. How should a community determine the right number of contact traces they need to respond to the pandemic?

Dr. REDFIELD. Thank you very much.

You know, I have spoken to Tom about this. I know his number, he estimated 300,000. I mentioned that I have estimated between 30 and 100 thousand. It is sizeable. I think we won't really know until we work State by State. We have met with all 50 States and jurisdictions and some of the metropolitan areas or cities that we have also to work with them to figure that out.

I am happy that many of the States have started to really expand. A number of them have already added a thousand, 1,500 contact tracers. We are working with them. CDC has made available through our foundation the ability for States, we will allow them to hire people to help augment the epidemiologists and the leadership group that they need, and then we are looking at them with the resources we gave them. We are hopeful that the America Corp will be another source, but we really have to get this built, and we have to get it built between now and September and get these public health work forces up.

And in some States, it may be 500; in other States it may be 5,000. We are in the process of doing that State by State by State to help them understand what is that work force that they need.

Ms. FRANKEL. What exactly are you doing to build the contact tracing—the work force?

Dr. REDFIELD. So what we are doing is really a couple. We have over 600 CDC people now embedded throughout the country, but through our foundation, our CDC foundation, is there to hire for

the States additional personnel, and we can augment that substantially. That process is ongoing.

In addition, obviously, we have dispersed the resources that you all have given us to the States to encourage them, and some States have already, I know, hired on their own over a thousand individuals that are being trained as contact tracers, to work under the supervision of the people that they hired through our foundation. And we are going to continue to do that.

And, lastly, I am hopeful that the America Corp will also, in each of the States, be having a public health work force that will provide more long-term augmentation of this public health work force. So we are working State by State by State to see them augment, and as I mentioned, some States have already augmented over a thousand.

You know, finding that magic number, I don't know. I do think in some States it is going to be over 5,000 people, maybe 10,000. In other States it is going to be, you know, 300 to 500 people that they need.

But it is fundamental that we have a fully operational contact tracing workforce that can—every single case, every single cluster can do comprehensive contact tracing within 24 to 36 hours, 48 hours at the latest, get it completed, get it isolated so that we can stay in containment mode as we get into the fall and winter of 2020.

Ms. FRANKEL. Thank you.

And, Madam Chair, if I may just follow up with one more thought on this on contact tracing is, you know, we are watching all of these peaceful demonstrations, and I know a lot of people are very close together.

So I would just like your—what are you advising the States if the number of cases overwhelm contact tracing abilities?

Dr. REDFIELD. Yeah. I think the first thing I would like to see is those individuals that have partaken in these peaceful protests or have been out protesting, particularly if they are in metropolitan areas that really haven't controlled the outbreak to the extent we want—Minneapolis happens to be one, who is still having significant transmission. D.C. is another one. We really want those individuals to highly consider being evaluated and get tested and, obviously, go from there.

Because I do think there is a potential, unfortunately, for this to be a seeding event, and the way to minimize that is to have each individual to recognize it is to the advantage of them to protect their loved ones to, hey, I was out, I need to go get tested, you know, and in 3, 5, 7 days go get tested and make sure you are not infected.

Ms. FRANKEL. I don't think you answered that question, but—you know, the question was, what are you advising States if they are overwhelmed and they don't have the contact tracers?

Dr. REDFIELD. Yeah. I want to work with the States so they don't get to that place. I agree with Tom Friedman, we need to build that work force. They need to work with us now to make sure they are overprepared. This is not an area that you need to skimp and be underprepared. This is a time to be overprepared. And if you hire extra contact tracers, then you can use them to help with our

HIV elimination program or vaccination program or maternal child health program; but this is not a time to be understaffed.

Ms. FRANKEL. Thank you, Madam Chair. I yield back.

Ms. DELAURO. Congresswoman Bustos.

Mrs. BUSTOS. Hello, everybody. Thank you very much, Dr. Redfield, appreciate your time today. And thank you, Madam Chair, for putting this together.

Back to Congresswoman Frankel's point just a second ago, my entire screen disappeared right when I went to go and unmute, so I think we are all learning this together.

But, Dr. Redfield, like many of my colleagues, and I know Congresswoman Clark brought this up just a little bit ago, Congresswoman Lee did also, I am very, very concerned by how COVID-19 is impacting our communities of color. And so I would like to start there with my line of questioning with you.

So I am from the State of Illinois, and African Americans represent roughly about 15 percent of the population but nearly 30 percent of the COVID-19 deaths. Hispanics represent about 17 percent of the population in Illinois and 31 percent of the people diagnosed with COVID-19. All right. So that puts it into perspective.

I am going to drill down to my own congressional district, which I live in downstate Illinois, and want to look at specifically my congressional district. Winnebago County, which is the farthest northeast county in my congressional district, African Americans make up 13 percent of the population there and 25 percent of the COVID-19 cases.

In Peoria County, which is the farthest southeast part of my congressional district, African Americans make up 18 percent of the population and 36 percent of the COVID-19 cases.

Rock Island County, which is where I live, where I am sitting right now, the Mississippi River is to my left here, Hispanics make up 13 percent of the population and 22 percent of the COVID-19 cases.

So, Dr. Redfield, given these facts, I want to ask you about how social determinants of health can fuel such statistics.

And just further, in the southern part of the city of Peoria, African Americans face serious food desert issues. I heard a story of a resident there who literally would have to stop at 16 stops while riding the bus to be able to get to a grocery store, and that is the only way that that person had access to fresh produce.

So my question is this, Dr. Redfield. Can limited access to healthy food increase poor health outcomes and lead to issues like diabetes and obesity? Do such conditions put people at higher risk if they contract COVID-19?

Dr. REDFIELD. Thank you very much Congresswoman.

You know, you have hit on a critical issue, something I would love to work with Congress. The social determinants of health, you know, as a laboratory scientist, you know, I kind of shrug my shoulders and say I don't know if that is going to be really relevant, but obviously data is the key, and I happen to be data driven. And I have seen overwhelming compelling data that show that social determinants of health and childhood actually do determine long-term health outcomes.

I would like to work with Congress to develop the mechanism for this Nation to understand long term which ones are the most important. I have talked about trying to set up a Framingham-like study over the next 20 years that really allow us to nail down firmly is it the grocery store, is it the fresh area, is it violence in the home, what are critical social determinants of health.

But the answer to your question directly, there is no question. There is no question that the social determinants of health as pertain to access to quality food have enormous public health outcomes.

Mrs. BUSTOS. So let's drill down a little bit, and part of this, my line of questioning, Dr. Redfield, is I want to make the point—and I think we are on the same page here and I hope my colleagues are as well; but further, there is a 2018 Rockford Regional Health Council report that says two out of five black residents are below the 100 percent federal poverty level in the Rockford region. Again, that is the farthest northeast region of my district.

Dr. Redfield, can you also talk about how poverty can lead to negative health outcomes, and can poverty levels put a person at greater risk of contracting COVID-19?

Dr. REDFIELD. Again, I don't think there is any question. What I would like us to be able to—or not me, but hopefully my grandchildren or maybe in the next 5 years, 10 years, 15 years, I would like us to really understand exactly which social determinants of health are the most influential and get these things corrected.

We don't have to wait for an answer to start correcting them because some of them are just obviously intuitive, but I do think this is one of the public health issues of our time, the social determinants of health.

Mrs. BUSTOS. Thank you, Dr. Redfield.

In my 5 remaining seconds, what I would like to point out is I have bill called The Social Determinants of Health Accelerator Act. I just want to draw that to the attention of my colleagues and also, Dr. Redfield, to your attention.

I am really hoping that this is something that not only will have a debate around it, but also pass at this congressional session.

Thank you very much.

And I yield back.

Dr. REDFIELD. Thank you.

Ms. DELAUBRE. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Madam Chair. Thank you very much for this hearing, and thank you, Dr. Redfield, for all of your testimony thus far.

I want to follow up on a couple of questions that have already been posed to you. With regard to the report that is going to come out that is supposed to break down certain of the demographics of where the disease is, how it has hit and how it has affected certain populations.

Will that information that is coming out in the report on the 15th include the number of positive cases by race, ethnicity, et cetera, the number of hospitalizations by race, ethnicity, et cetera, the number and the percentage of deaths under those categories? Will it be broken down to that finite degree?

Dr. REDFIELD. Yeah, just to clarify again, Congresswoman, this is the beginning of finally getting the data that we really need to do all that you just asked. So there is now—

Mrs. WATSON COLEMAN. So that is a no?

Dr. REDFIELD. No. It is not a no. I am just saying this is the beginning of having the data to get the report in the manner that you ask.

The first step is to get the data. That is really what the announcement is later today, that that data is coming to us, and that gives us—enables us to give those reports in that granular detail that you requested.

Mrs. WATSON COLEMAN. So will that granular detail be in the report that is coming out on the 15th, or are we going to wait for a later report? Just want to know.

Dr. REDFIELD. Yeah. I am going to—

Mrs. WATSON COLEMAN. There will be a report?

Dr. REDFIELD. I am going to give you all the data that I have at that time. I will continue—

Mrs. WATSON COLEMAN. You are not answering the question.

Dr. REDFIELD. Well, I am going to give you the data that I have, and that is really all I can do—

Mrs. WATSON COLEMAN. Thank you. I am reclaiming my time, Doctor.

When will testing be available to anybody who wants it and thinks they need it? Do you have any idea?

Dr. REDFIELD. I think the key on this testing is for it to be a decision between the individual and their healthcare provider to get the testing.

Mrs. WATSON COLEMAN. Yeah. I am simply asking, is there any impediment to anybody getting tested who wants to be tested if they have a doctor and the doctor says, yeah? Is there any impediment? Is there testing capacity that exists to meet that need?

Dr. REDFIELD. There should not be an impediment, Congresswoman.

Mrs. WATSON COLEMAN. If you don't have a relationship with a doctor and you are just an uninsured individual, how do you get tested?

Dr. REDFIELD. So there is a variety of different testing sites that have been set up, and I know, I think over two-thirds, 70 percent, have been set up in areas that are considered socially disadvantaged. Those testing sites are there and available for the American public.

Mrs. WATSON COLEMAN. Okay. So if we are going to consider reopening up our economy, is there any science that informs us as to what percentage of the population needs to be tested and their information traced, if necessary, before we know that we are really in a healthy mode as opposed to a lulling off of a curve simply because of the few numbers that we are testing?

Is there a percentage of the population—I know each State would be different in terms of the number, but is there a percentage of the population?

Dr. REDFIELD. That is an excellent question. What we have is estimates from the WHO and others that the threshold of being ade-

quate in your testing is when one out of every ten tests that you do is positive. So when we—

Mrs. WATSON COLEMAN. But does—okay. But that is based on how many you are testing. I am asking you, what is the percentage of the population that should be tested?

Dr. REDFIELD. Yeah, I don't know the answer to that question at this moment in time.

Mrs. WATSON COLEMAN. Okay. Are there people in the science field who think they have got a handle on that? And, if so, would you find out for us and share that information with us?

Dr. REDFIELD. Yes, Congresswoman.

Mrs. WATSON COLEMAN. Okay. Thank you.

Earlier on in response to Representative DeLauro's question, you made some comment that if this were a global health threat. Is this not a global health threat, this pandemic?

Dr. REDFIELD. Yes, it is a global health threat. You must have misunderstood—

Mrs. WATSON COLEMAN. Okay. Thank you.

Then should we not be connected to the World Health Organization? Have you any position on that and have you given the President your wisdom, your advice on that?

Dr. REDFIELD. The WHO continues to be a close colleague of ours in the public health efforts. We are currently working on a number of outbreaks, as you know, around the world, Polio, Ebola—

Mrs. WATSON COLEMAN. But it is not—

Dr. REDFIELD. So we continue to have a close collaboration with the WHO.

Mrs. WATSON COLEMAN. Thank you. It doesn't seem to be a priority of the President's.

I am going to ask you a question about the Ozarks, the wonderful time they had on Memorial Day and the launching of this space shuttle. Even though those States may not have asked for your help, because of the possibilities of additional infection or a higher rate of infection because those people were so densely integrated into whatever they were doing, is there a role for the CDC to be proactive in reaching out to them to see if we can get a handle on what possibly could be a problem before it becomes a big problem? And, if so, what would that be?

Dr. REDFIELD. Yeah, I agree with you Congresswoman. We do routinely reach out to the different State health officials and offer our assistance. And in those circumstances, I have 38 teams now out assisting different States and territories with the different outbreaks, particularly in the area that you mentioned, contact tracing, and we will continue to emphasize that obviously to our colleagues in Missouri and Florida that we are prepared to provide the assistance if they would request us to come in and help.

Mrs. WATSON COLEMAN. Thank you.

Chairwoman, just one last thought. You know, given your vast experience and your interest in this area, was it not obvious to the CDC that the African American community would be disproportionately negatively impacted by this COVID from the very beginning?

Dr. REDFIELD. Again, Congresswoman, I think we have worked and will continue to work to try and identify and help respond to

develop interventions that can minimize the impact of this in the African American community, and we have.

The challenge that we had that we have acknowledged is we haven't gotten the data that we needed so that we could give the American public the analysis. And, again, we are going to continue to commit to get that data so that we can do that.

Mrs. WATSON COLEMAN. Thank you, Doctor. Thank you, Dr. Redfield. I guess you have to go where the action is.

Thank you. I yield back.

Ms. DELAUBRO. Thank you.

We are going to begin a second round, but it can be only 2 minutes. Dr. Redfield has a hard stop at 1:30. I want to accommodate people, but we can only go 2 minutes. I will try to be as lenient as I can because this is a critical, critical hearing and people have excellent questions that they need to get answered.

So with that, let me start. And what I want to do is to talk about vaccinations and an influenza vaccine campaign.

Dr. Redfield, you said in April the need for an enhanced vaccination effort this fall for seasonal flu. As you noted, we were going to have—we are going to have a flu epidemic and the coronavirus epidemic at the same time, which will put tremendous strain on the hospital system.

Yes or no, do you still stand by your April 21, questions—your answer?

Dr. REDFIELD. Yeah, I think we are going to have a difficult time.

Ms. DELAUBRO. Okay. Given that we have to be prepared to deal with that effort, we are also going to be having companies around the world racing for a vaccine.

There is funding, that means for infrastructure, medical supplies, workforce, and a bunch of unknowns which have to do with storage requirements, cold chain supply, et cetera.

Explain that aspect of a massive vaccination campaign. What is already in the works? What activities? What is the funding capabilities? If you can't deal with all the funding now, I want a budget because it will impact our negotiations when we are dealing with the Senate on the Heroes Bill?

Dr. REDFIELD. And, Chairwoman, is that in reference to influenza or COVID?

Ms. DELAUBRO. I want to know about vaccine, but I also wanted you to answer the question on influenza and what we need to do with regards to that.

Dr. REDFIELD. So the COVID vaccine effort, Operation Warp Speed, which is run by the Secretary of Defense, the Secretary of Health, that is moving very rapidly. I can just leave it at that. It is moving quickly. It is my expectation that we will have one or more vaccine available before the end of the year for COVID, which will be a great—

Ms. DELAUBRO. The infrastructure, the infrastructure for putting this together and a budget for putting this together, we need it now.

Dr. REDFIELD. Well, we will be able to work with HHS and get that back to you, okay?

Ms. DELAUBRO. Okay.

Dr. REDFIELD. I do want to emphasize the importance of flu vaccine, and Nancy Messonnier is leading that effort. I mention to really get our Nation accelerated, as you know, only about 47 percent of the American public take advantage of flu vaccine. We are really hoping that the American public will see that the flu vaccine is one major way they can help this Nation can get through this fall.

Ms. DELAURO. And that is going to be a further strain on this system with this virus.

Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair.

Since my friend from Wisconsin had some questions about my numbers, let me just add some. Death rate in the United States, 333.9 per million; United Kingdom, 597.5; Italy, 556; France, 433; Spain, 580; Belgium, 835.9; the Netherlands, 347.6; Sweden, 446; Ireland, 341.8. Those are all advanced countries with first-rate healthcare and, frankly, likely to produce numbers that we can trust.

Personally, for the record, I don't trust numbers coming out of Russia, China, or Iraq. And I think a lot of the rest of the world, frankly, just doesn't have the infrastructure to give us, if they don't have the testing capability or anything else.

I will say there are some real stars that I do trust. Japan, 7.1; New Zealand, 4.5; and Taiwan, .3; Hong Kong, .5. I just say that to say there are places clearly have done this better than us and we have lessons to learn from, but I want to be clear that we are not the worst in the world. And this data is very interesting to compare because it is not the same data from the same source. So there is a lot of apples and oranges in comparison.

Let me move to something near and dear to my heart of this committee because I just have a few seconds left. Recent data from the University of California said the Tribal nations were States—the five States with the highest infection rates in the country would all be Tribal nations. Let me repeat that. On a per capita basis, five Tribes have more coronavirus cases than the State of New York. The Tribe with the highest rate, the Mississippi Band of Choctaw Indians, an infection rate more than doubled.

Given that challenge in that community, could you tell us just quickly some of the things—I know you are working on this hard—that you are doing to help Tribal nations deal with this?

Dr. REDFIELD. Yeah, it is really important, Congressman. I mean, clearly, the Native American community has been disproportionately hit. We have been able to award, as you know from what you have granted to CDC, almost \$60 million to the Tribes, with the total hopefully soon to be \$205 million to Indian Country to help give them the financial support.

I think, more importantly, we have also provided a number of rapid response teams into Indian Country to basically provide technical assistance, because they have had some of the more significant outbreaks, as you know. Help them with contact tracing and community mitigation, as well as some of the unique challenges they have had in dealing with—particularly with water security. And we will continue to augment the ability of the Indian Health Service to support these Tribal nations in terms of providing both

technical assistance and resources because they are disproportionately affected.

Mr. COLE. Chair, you have been more than generous with time. Thank you.

Ms. DELAURO. Congresswoman Roybal-Allard.

Congresswoman, can you unmute?

Ms. ROYBAL-ALLARD. Yes. Can you hear me now?

Ms. DELAURO. Fine. I can hear you now.

Ms. ROYBAL-ALLARD. Okay. Dr. Redfield, first of all, let me acknowledge that, under the leadership of both Congresswoman Rosa DeLauro and Congressman Cole has been mentioned, that efforts have been made to address the serious shortfall in CDC funding; but nevertheless, there still remains chronic deficits in local and State health department resources as well as CDC still has an antiquated infrastructure.

There has been discussion during the subcommittee that you have received billions of dollars to address the COVID-19, and also it is anticipated that you will be seeking more money under The Heroes Act. Can you explain to this committee, what is the difference between what this supplemental funding pays for and the base funding that you actually need to address the shortcomings in CDC's infrastructure and core capabilities?

And then quickly after that, if you could just, please, give your opinion with regards to what your predecessor Tom Frieden said about the need to create a health defense operations budget designation that would exempt certain health security budget lines from the Budget Control Act, spending caps, so that we don't have the same situation where CDC gets money through supplemental during a public health crisis and then we go back to the erosion of funding CDC.

Dr. REDFIELD. Thank you very much, Congresswoman. A majority of the funds that we have received from the supplemental, we have really pushed out to the State, local, Tribal, and territory health departments to really give them the immediate response capability and at CDC to support the more than 5,000 people that we have now moved out to help support this response. So it has really been directed at immediate response activities, as well as building that capacity in the States that we mentioned for rapid ready testing, contact tracing, and isolation and quarantine. I mean, the issue is many States don't have the capability to effectively isolate people that don't have adequate housing. This stuff has to all be built.

The real challenge, as has been alluded to by the chair and Congressman Cole as well as yourself, is how do we get this into the long-term base funding so that we can make sustainable progress in these core capabilities. And I will just say that I don't know the best way to accomplish that, but it is going to be very, very important.

I think the comment also that you have worked with the Emergency Response Fund, the ability to have emergency funding when things happen around the world is important.

Ms. DELAURO. Thank you.

Congressman Harris.

Mr. HARRIS. Thank you very much.

So if I am correct, despite reopening and greatly increasing number of tests so you can actually confirm more cases, we are down about 40 percent from our peak. Is that right? The peak numbers? It was about 32,000. Now it is down to about 20,000?

Dr. REDFIELD. Yeah. We average about 20,000 new cases a day.

Mr. HARRIS. So we are down about 40 percent, again, despite reopening and despite more testing. So that is evidence that, I guess, that we really are on a decline and now is the time to think about reopening, because we can't really stay shut down forever.

Now, you brought up a point in response to a previous question and that is, you know, if CDC is expected to be the foremost public health authority in the world, it actually needs cooperation from other health authorities in the world. Could you describe the co-operation between Chinese authorities and the CDC in January when we really needed information about this epidemic that was going to become a pandemic?

Dr. REDFIELD. Well, as you know, Congressman, we have a CDC office in Beijing. It is limited in its staffing, although I had augmented it by another technical expert. I had been in regular discussions with my counterpart George Gao, who is the Chinese CDC director, over the New Year. And we did have discussions about what was then an unidentified pulmonary illness.

We did request the invitation to come in and assist them directly. And then particularly after the coronavirus, we reiterated that, formally requested, that I—at the levels above him to grant that request. Unfortunately, we haven't been able to have that scientific interaction that we had requested.

Mr. HARRIS. And is that because you think they also consider CDC the world's leading expert in public health or was it maybe for political reasons? You can't—I know you can't—it was a rhetorical question.

And I assume that the release, for instance, of the genetic information on the virus was held back until it was actually reported outside public channels.

Look, the bottom line is, you can't do your job if we don't get co-operation. We didn't get cooperation from the Chinese.

I yield back, Madam Chair.

Ms. DELAURO. I thank the gentleman very much.

Let me just see. Okay. Congresswoman Lee.

Ms. LEE. Thank you for meeting next week with the Black, Hispanic, Asian-Pacific American, and Native American Members of Congress next week. It is going to be a very important meeting, and we thank you so much for that.

Secondly, let me just say one thing as it relates to what Congresswoman Bustos talked about as it relates to social determinants. I am really surprised to hear your response, Dr. Redfield, because we have a roadmap—the National Medical Association, I know all of the African American doctors, the Asia-Pacific American, the Hispanic community, in terms of the medical profession, we have the roadmap on how to deal with social determinants of healthcare. Actually, surgeon general David Thatcher, way back in the day, came forward with that. So I was really surprised and also disappointed at your response.

It takes a political will of this administration to address it, and so we need to discuss that with you further because we can't wait. We know what the social determinants are and we have a roadmap that has been completed for many years on exactly how to address that.

Let me ask you about contact tracers. Because of the sensitive nature of this work, we want to make sure that contact tracers are from the community, trained, and provide this very sensitive type of work. Can you comment on a protocol or the importance of having not people coming into our communities doing this in minority communities, but the trusted messengers being trained, how they would be trained to provide this type of work?

Dr. REDFIELD. Yeah. Thank you for both. I will be very quick. First, I am very familiar with the Thatcher report and I have high regard for it, and I think it was a critical turning point. I was just trying to raise the idea of getting scientific proof for which one is influenced, but not waiting. And I look forward to working with you on that.

Secondly, on the contact tracing. I couldn't agree with you more. It is the same thing you and I discussed about the Indian HIV in America. We need to build trusted members of the community to be the community workers to get this work done. We don't need outsiders coming into communities to do this work. So we do have significant training programs, and I do think these need to be—you know, we have to expand the community base of trusted individuals in the community to do this work. I couldn't agree with you more.

Ms. LEE. Thank you very much.

Thank you, Madam Chair.

Ms. DELAURO. Congressman Pocan.

Mr. POCAN. Thank you very much, Madam Chair.

So let me ask you, Dr. Redfield, a little question about supplies. We have had a problem in Wisconsin getting supplies from the Federal Government. FEMA originally, months ago, said they would get us reagents. Then I think around April 8 the policy changed and said we would get them from CDC from the IRR. In April, we got less than 1 percent of the reagents that we requested as a State. Last month, of all the information we requested, we got less than 18 percent.

I find it confusing that of all the PPE and other supplies that we are supposed to be getting, FEMA gets us some of it, although, as I just said, one out of every five items that we actually need, but that we have to go to another agency to get reagents. And from CDC, we could only get reagents for public labs, which is a couple labs in the State, and we have 60 labs that are actually doing COVID tests.

Can you just address that real quickly? Because we need more reagents and we need them for our hospitals and clinics in the State and we are not able to get them right now from FEMA and we are not able to get them from the CDC.

Dr. REDFIELD. Well, clearly, the CDC and IRR, which is long-standing that we support our public health labs, is that mechanism for the public health labs.

Congressman, you need to look to see—I know we have been transitioning to the private sector to be providing for the nonpublic health enterprises, but let me look directly into your request and see if I can get better clarity and get back to you and your staff.

Mr. POCAN. Okay. No, I appreciate that.

And then in the 30 seconds I have left, Mr. Harris said that cases are going down; however, Scott Gottlieb this morning in the last hour tweeted out that we are slowly expanding the number of cases, according to a Morgan Stanley report, and that is part of because there is still this no consistent standards for people reopening.

Can you address, what did we do wrong that we are eighth—or ninth worst in the country only behind Bahrain and Qatar?

Dr. REDFIELD. Well, you know, I do believe we have enhanced our response. You know, as I mentioned, I think we have now tested almost 17 million people. I don't want to get into the numbers of tests because I don't think that is the real issue. It is how testing is used and what is the consequence. But we have, after the slow start that we had in getting the private sector engaged, we continue to build—that is not to say we are at the end of the day. We still need to expand the ready access of testing across this Nation. You know, it is not where it ultimately needs to be.

But I will say that each day, each week, we continue to make progress for that expansion, and we will continue to do that. I will look into the specifics of your question, though, related to where additional laboratory reagents are coming from for your State.

Mr. POCAN. Thank you.

I yield.

Ms. DELAURO. I yield to Congressman Graves. And since Congressman Graves did not get his 5 minutes in in the first round, he is recognized for 5 minutes.

Congressman Graves.

Mr. GRAVES. Thank you, Madam Chair. And thank you, Dr. Redfield. I come to you from Georgia, the home of the CDC, and thank you for your service over these challenging last several months. I know it has been difficult, but we are grateful for your work.

I wanted to just change just a little bit to antibody and antibody testing, and if you could maybe share with us a little bit about what we can expect from FDA approvals, if they are any FDA approvals, the testing kits, and if you could just give us a little feedback, little insight into that, what we can expect there.

Dr. REDFIELD. Thank you very much for your question, Congressman. There are a series of antibody tests that, initially, the FDA allowed the EUA to come out and a lot of tests got on the market and then they had to show that they really were valid. A number of them has been pulled back, but there are a series of antibody tests. And I can get you the names of them that are really a quality test approved by EUA by the FDA.

The real issue is what does antibody mean? And right now, we don't really know exactly what antibody means. If you have a valid antibody, it means that you have been infected at one point in time with the virus. We don't know how long that antibody will last. But we don't know the critical question is, when does the antibody test

mean you are immune to the virus? And that is what we are still trying to find.

It does help us as CDC to understand the full extent of the infection in our Nation. You know, our current estimates is about 5 percent of the American public got infected during this initial experience. That does mean that about 95 percent are still susceptible, just for us to understand what might be coming. Some cities it is much different, like New York, obviously, and the New York metropolitan area, but that is the key. Right now it is a surveillance tool that we have. Whether it has clinical implications or not, we still don't know.

Mr. GRAVES. Thank you. I am hoping that list of who you might recommend would be approved vendors. It seems like there is a lot of potential for fraud—

Dr. REDFIELD. Yeah.

Mr. GRAVES [continuing]. From a lot of vendors out there.

Dr. REDFIELD. I am sorry—

Mr. GRAVES. And then maybe you could share with us also, how do you think—what about the accuracy and reliability of the testing as well?

Dr. REDFIELD. Yeah. I think your point is critical, and I can have my staff get you the actual list of the testing that we know we do not recommend and that the FDA is asking to get off the market. And then there is another group that have really performed well, and I can make sure you get that. Ortho is one of the main ones that we have been using for antibody testing. And so I can get you that and make sure your office has it.

Mr. GRAVES. Okay, great. Thank you.

As we are talking about testing and the COVID-19 testing and the testing sites, is there any value to at the same time testing for antibodies? I know a lot of individuals go to get tested because they are concerned they may currently have the virus, but is there any value in testing for both simultaneously? And then on top of that, do you believe that the antibody testing is something that should be paid for by the government, as we have previously as the COVID-19 testing is?

Dr. REDFIELD. Yeah. The challenge that I have there is just trying to understand what the clinical utility of antibody testing is. And CMS will—and they will all pay for it if it is for a specific clinical indication. And my understanding is they currently pay for it with the clinical indication being that you have been previously infected by this virus. So that is the one part.

I was going to say something else, but I am having an adult moment with the first part of your question.

Mr. GRAVES. It was about should the antibody test be conducted simultaneously along with the COVID-19 test when an individual goes to be tested. Is there—

Dr. REDFIELD. I think the one area that it has a major clinical relevance is in the children. You have seen about this hyperinflammatory syndrome that we are seeing in children. Luckily, it is very rare, but it really occurs post a COVID infection and it does help understand that that is really the causation. So we do use antibody testing in trying to define the case definition in children that have this new rare inflammatory system.

But I think the answer to your question, just to be honest and transparent is I don't know.

Mr. GRAVES. Well, thank you.

And so to just sort of sum up on antibody testing, we really don't know what it means right now if somebody tests positive? It sounds like we don't know. Is it a protectant or not, or how long might it last, and those results have yet to be determined. Is that——

Dr. REDFIELD. That is correct. And it is one of the critical things I think we are going to learn between now and January.

Mr. GRAVES. Great. Thank you, again.

And thank you, Madam Chair, for letting me jump in real late here today.

Ms. DELAUBRO. Congresswoman Clark.

Ms. CLARK. Thank you so much.

I want to go back for 1 minute to the disparities in outcomes and ask if the CDC has made any effort to ensure that public test sites are installed in communities of color. Is that going to be a focus?

Dr. REDFIELD. Yeah. And that really was orchestrated by the assistant secretary of Health, and I don't have the exact number, but I can tell you that 60 to 70 percent of them were put into areas that had—were basically in areas that had social disadvantaged sites. But I can get you the exact number, because there was a direct intent to open these sites when the Federal Government opened these testing sites that you know and the testing sites that are being developed with CVS. But I can get that exact information to you. But it is substantial, and the answer is yes.

Ms. CLARK. Okay. Because there have been some recent investigations saying that these are showing up in more—in wealthier and whiter communities, and we want to make sure that we are putting our scarce resources where they are most needed and that we also remember that not everybody has a car for a drive-up site.

Dr. REDFIELD. I agree. I agree. Very important.

Ms. CLARK. I want to go back to what my colleague mentioned briefly, which is the World Health Organization. Back on April 15, you said that we have a long history of working together in multiple outbreaks throughout the world, and I am heartened to hear you say today that you are continuing that relationship.

Do you stand by your comments in April? Do you feel this is an important partner for us at this time of a global pandemic?

Dr. REDFIELD. Yes. And, actually, in the last couple days, I was telling the chairwoman before this hearing start, unfortunately, we have a new Ebola outbreak now in the western Congo, and we jumped right in with WHO and the Ministry of Health to begin to confront that Ebola outbreak.

Ms. CLARK. If this administration completely severed our ties and demanded that you did as well, are you worried about our impact to develop our access of vaccination?

Dr. REDFIELD. You know, I don't want to get hypothetical. I feel confident that the public health partnership that we have, although it may be modified in some way in a political level, I don't think it is going to be modified in terms of our public health efforts.

Ms. CLARK. Thank you.

Ms. DELAUBRO. Congresswoman Frankel.

Ms. FRANKEL. Thank you, Madam Chair.

Dr. Redfield, I have a softball question for you. Older adults represent a high-risk group for COVID-19 as higher—with a higher hospitalization, mortality rates, and CDC correctly is telling them to stay home. But we also now see that this isolation is exacerbating loneliness, stress, mental health challenges, making it more difficult to obtain food, for prescriptions, be physically active.

So my question to you is, would CDC benefit from an increased collaboration across agencies during the pandemic, as well as the pandemic—beyond the pandemic to meet the public health needs of older Americans?

Dr. REDFIELD. I think you raise really critical—critical, critical questions. As you said, many older Americans who have stayed at home have been—also have negative consequences of isolation, lack of human connectedness, obviously other issues into maintaining critical activities of life. They have also necessarily maybe not gotten the preventive medical care for the chronic illnesses that they need.

You know, we are committed to continue to work and figure out how to maximize the health and well-being of these Americans. And any way that we can assist, I know this is an important issue for you, and we are prepared to learn and assist to help improve that. This is—the critical target group, unfortunately, for this particular virus is those of us—and I am in the group. You know, I am over—I am 68—older Americans.

Ms. FRANKEL. Thank you.

Madam Chair, just to remind you, I know we have talked about this, that I filed—actually, we filed a bipartisan legislation that would establish a national COVID-19 resource center for older Americans within HHS and establish a healthy aging grant program at the CDC.

Dr. REDFIELD. Good.

Ms. FRANKEL. I thank you. And I yield back.

Dr. REDFIELD. Thank you.

Ms. DELAURO. Congresswoman Bustos.

Mrs. BUSTOS. Thank you, Madam Chair.

Dr. Redfield, prisons across the country have seen large outbreaks of COVID-19. Unfortunately, our communities, our prison staff, our inmates are being put at additional risk because the Bureau of Prisons continues to transfer inmates without first testing them for COVID-19. This is in part because the CDC guidelines do not recommend testing inmates before they are transferred, even from facilities with COVID-19 cases.

So your guidance notes, and this is a quote: If a transfer is absolutely necessary, perform verbal screening and a temperature check, end quote. So as a result of this, a few weeks ago, the Bureau of Prisons transferred 19 inmates from the Chicago prison, where there are cases of COVID-19, to the Thomson prison in my congressional district, where there were zero cases. And they did this without first testing all inmates.

So, now, two of those inmates have tested positive for COVID-19 at our prison in Thomson, Illinois, which, by the way, there are no hospitals in the county where that is located. And so for those inmates that have tested positive for COVID-19, we have got that, and then for weeks, because of all of this going around, I have been

pushing the Bureau of Prisons to test all inmates before they are transferred. So what they have told my office is that they cannot test inmates before transfers because they don't have adequate testing supplies.

So couple questions. What is the CDC doing to increase testing capacity at the Bureau of Prisons? And should inmates be tested for COVID-19 before they are transferred, especially from facilities with cases of COVID-19? And I am hoping you will end this by saying you will update your guidance, but those are my two questions.

Dr. REDFIELD. Thank you, Congresswoman. You raise a very, very important critical issue. Obviously, I think we all know that we are learning as we go along. One of the areas that we have prioritized for surveillance and when we talked about the \$10 billion to go out for each of the States to come out with their testing strategy, the priorities that we have given them, one of the priorities we have given them is a comprehensive surveillance strategy. All nursing home residents to be tested and then weekly testing for the workers in the nursing home to develop their prison guidelines. And, again, that is being debated back and forth right now, but I think there is a strong sense of, again, getting everybody tested in the prison and obviously new people coming in.

I can't tell you where that is going to land, but we are highly discussing that now and obviously encouraging States to use these new testing resources to accomplish that. And obviously the same goes for homeless in shelters and homeless settings. These are critical areas that—and in certain industries like meat-packing plants and where we have congregate living. So we are on board with you that we need expanded testing in these circumstances, particularly highlight—

Ms. DELAURO. We have to wrap up, so—

Mrs. BUSTOS. Okay. All right. I yield back. I would love to know a little bit more, but we can talk offline.

I yield back, Madam Chair.

Ms. DELAURO. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chairman.

Dr. Redfield, I want to explain something to you what my concern is about opening up our various States, and I asked you that question about what is the safe percentage of people that need to be tested as a function of the population. Because some States may be testing more than other States and some States may have more relevant data as to what the situation really is because they are testing more; whereas, the State next to you may be testing only a fraction of the people that it needs to test.

Is there not any kind of guidance on what percentage of the population needs to be tested to make sure that we are at optimum opportunity to open up?

Dr. REDFIELD. I think you raise an important point. I know the first threshold was at least 2 percent. I know we have some States that are over 10 percent. I think you have raised this earlier and you have raised it, again. I think this is an area that we are going to go back and have our subject matter experts really discuss because it is clear that we benefit from this guidance.

Mrs. WATSON COLEMAN. Okay. Thank you.

And lastly, I just want to point out that when the ACA was passed about 10 years ago, there was a section under 4302 where the CDC had a responsibility to develop a form to collect information and then add the demographic data requirements that both Congresswoman Lee and my other colleagues have asked for and that I have asked for. So it is not really creating something brand-new; it is something that really have already been in operation.

And so does that mean that your form is out of compliance with the requirements of the ACA in a law that was passed 10 years ago?

Dr. REDFIELD. No. Our form that we do for case reporting has that information. Where the challenge has been is that the reporting of the actual laboratory test results. You know, historically that is not something that was necessarily independently reported to CDC. We would get case report forms, and that data we do have good racial, ethnics, and sex distribution. We know where it is coming from.

But we are also now getting reporting of all the test results. It is just a test result, and they come—they come in non-name linked without that information. And the difference is now every test result, every positive test result, every negative test result is going to have those fields that we discussed. And I think it is going to be very helpful for us to get even additional sets of information based on testing.

Mrs. WATSON COLEMAN. Thank you, Doctor.

I yield back.

Ms. DELAURO. Thank you.

Let me yield now to Congressman Cole for closing remarks.

Mr. COLE. Thank you very much, Madam Chair. First, I want to thank you for holding this hearing. It is very informative, and I want to thank all the members on both sides. I thought the participation and the questions were truly good.

Dr. Redfield, I also obviously want to thank you for being here. You have one of the most important jobs in the United States, but probably one of the toughest too. And I appreciate you giving our committee this much time. And I want to publicly also thank the President's chief of staff who helped make that possible, Mr. Meadows. I know our chair talked with him directly, and he couldn't have been more helpful in making it possible for you to be here. So we are grateful for that.

We covered a lot of ground today and I thought, again, it was very good. And I think, appropriately so, a lot of the focus is clearly, you know, driven by coronavirus, clearly on the massive supplementals where we have devoted much more money to this than your normal entire budget would be—

Dr. REDFIELD. Right.

Mr. COLE [continuing]. Because we have entrusted a lot of money there. I think you have done a tremendous job, honestly, moving this through the chain at CDC and getting it out into the country, into your State and local and Tribal partners, to deploy these resources really well. And I want to thank you for that, acknowledge the hard work of your staff.

But I also want to close by saying, while I am really confident that the Congress will continue to work on these supplementals,

like I suspect the chairman, I am worried about the long-term funding here and capacity. And you certainly talked about that in your opening remarks and in your testimony. I don't want to lose sight of that.

This committee and, frankly, the Congress are dealing with a budget agreement that, again, was done in good faith. I am not critical of anybody for it, but it doesn't apply now. I mean, just as I told somebody the other day, look, the defense budget was one thing on December 1, 1941. It was something very different in January 1, 1942. There is an intervening event called Pearl Harbor. This is a biomedical Pearl Harbor, and we need to recognize that and we need to not just deal with this thing but build the capacity.

The phrase I have used is not popular with some of my friends, but I think it is right: It is a smart thing to spend billions to save trillions. We know what the cost of this event has been to our economy and our country. We need—and I hope our leadership on both sides—I know I will be working with my friend, the chairman, on this. We need to have the adequate permanent investments.

What Ebola and some of the other incidents have taught us, these supplementals, again, can be helpful, but then the capacity starts to erode when the supplemental money runs out. We need that long-term thinking, because we know we will be dealing with this in the fall and for the foreseeable future. We also have just gotten one heck of a lesson from the biosphere about how dangerous it is and how, even when we think we have done pretty well, it wasn't nearly good enough.

So I just pledge to my friend, the chair, we will be working with you to try and make sure that you have the resources, that this committee has the resources to invest to give the American people the protection that they deserve and they require, and to work with our friends around the world because when we do this for ourselves, frankly, we also work with others and appropriately so.

This is a global pandemic. There are no isolated countries. We are going to need to work together, and I just thank you for your leadership in that area, Dr. Redfield. You have been a visionary on this for a long time. We talked about this many times before we were dealing with this crisis, so thanks for being ahead of the curve on that.

Again, Madam Chair, thank you very much for the hearing.

Ms. DELAURO. I thank the gentleman and—the gentleman and my friend, and it is good to partner with you on these efforts. And thank you, Dr. Redfield, for being here today.

Let me just make one comment. I know that Representative Harris said that we have been successful in reducing our cases by 40 percent from a peak of 32,000 a day to 20,000 per day. So we are ready to reopen. And I just reiterate that it wasn't that what we talked about in March and we declared a national emergency when we had 556 cases. Virtually all other developed countries have cut their cases by about 90 percent or more before they reopened.

The Federal position seems to be—our government's position seems to be that we can't do what other countries do, so we just have to live with 20,000 new cases per day. That puts us all in danger, in my view.

I agree with my colleague, Congressman Cole, that we need to have long-term funding and capacity, but I will just say this to you, Dr. Redfield, because you made a comment that it was Dr. Messonnier who had some lead role when the response to this pandemic was grounded in your center at the CDC. That is no longer the case.

You are no longer at the center, the point of the spear on this issue. It really has gone to FEMA. It has gone to the White House. I will be very honest with you. I want to build your capacity. I want to get you the data. I want you to be science driven, but by God, I do not want your science and your health experts challenged by people who do not know and understand either science or public health.

And I might just add that we have talked about this at this hearing—your guidance, changes, delays, the duplication. We didn't get to that. The National Healthcare Safety Network by HHS shows a message from this administration, in my view, that CDC is being undermined. The administration violates every rule in your 450-page manual all of the time.

Talk about Lysol. Talk about Lysol. We need credible messages. We need credible guidance. We need to hear more directly from CDC's experts. And the CDC media briefings, I hope you will just—one more comment from you and one more thing to say, but your briefings stopped. You had daily briefings and they stopped. And those briefings need to continue, and I hope—let me just say this to you, will you continue those daily briefings? That is a yes-or-no answer, Dr. Redfield.

Dr. REDFIELD. We had them weekly. Just so you know, we did our weekly briefings, and we do have our briefings back. You know, I did one last Friday. Right now, they were going to be every other week. I am working to get them every week.

Ms. DELAURO. We need to have those briefings back online.

I just want to comment on yesterday, the publication the Nature, they published a study that analyzed the economic impacts of lockdown and reopenings. The conclusion was that to protect our economy, we need to focus on public health. And we are not doing that. I make a reference to these photographs that I showed earlier on. We are not doing it.

Reopening before the virus is under control will put our economic recovery at risk. And until we get that and it is loud and clear from the science community, from the public health community, we are not going to succeed economically, in my view.

You talked about testing. The number of tests every day and knowing that and the public knowing that is important, because we need to know who is testing, where they are being tested, and where they are not.

I just say, I am in awe of science, Dr. Redfield. I don't have scientific knowledge. Dr. Harris does, and there are others, but most of us do not. What we do here is to provide the resources that allow you and your colleagues at the CDC to do what you do. So we are reliant on that science.

Let me just say to you, don't be afraid. Stand up. Talk about what your scientists do and give us that direction, and I will tell you that we will provide the resources that you need to do your job.

Without that and without driven, there will be a great reluctance. I will speak for myself on my part to go further if it is not a partnership in going forward.

Thank you for your service. Thank you for what you do, as I said, domestically and internationally. I know that is where your heart and soul lies in the science. Let us hear from all of you on that.

Thank you and this hearing is over, closed, whatever the proper word is for it. It is adjourned. It is adjourned. Thank you.

[The following questions and answers were submitted for the record:]

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
Centers for Disease Control and Prevention COVID-19 Response
(6.4.20)

Questions for the Record

Submitted by Congresswoman Lois Frankel

COVID-19 Outbreak in Congregate Settings/Nursing Homes

Approximately 15,600 U.S. nursing homes provide essential health care for more than 1.3 million Americans. However, the combination of close living quarters and older resident populations make these seniors particularly vulnerable to COVID-19. At least 20,000 nursing home residents have died from COVID-19.

- **Question: What is CDC doing to support outbreak responses in nursing homes and other congregate settings?**

RESPONSE: CDC continues to update published detailed guidance on how long-term care facilities (LTCFs) can best protect their residents from the virus that causes COVID-19. Part of this guidance includes recommendations for core practices for a strong infection prevention and control (IPC) program, which is critical to protect both residents and healthcare personnel (HCP). The core practices include source control, planning and implementing a structured testing regimen for residents, staff, and visitors, and making adequate hygiene supplies and personal protective equipment available—which should remain in place even as LTCFs resume normal activities, regardless of phase. CDC also recently updated existing guidance for testing in nursing homes and associated healthcare personnel.

In addition to guidance for LTCFs and other healthcare facilities, CDC continues to update published guidance for shared or congregate housing, including detailed guidance for specific types of facilities such as assisted living facilities, retirement and independent living communities, homeless shelters, community-and faith-based organizations, colleges and universities, and households with suspected or confirmed COVID-19.

CDC is working with the Centers for Medicare & Medicaid Services (CMS) to leverage existing data systems and reporting requirements to improve COVID-19 surveillance and response across the healthcare spectrum. In conjunction with the CMS release of new regulatory requirements for nursing homes, as announced on April 19, 2020, CDC released a new standardized reporting tool that allows nursing homes to provide data to CDC's National Healthcare Safety Network (NHSN) as part of COVID-19 surveillance and response.

CDC's NHSN collects key indicators including: confirmed and suspected COVID-19 cases and deaths among residents and staff, ventilators in use, and shortages of healthcare personnel and personal protective equipment (PPE). These indicators provide a better understanding of the burden of disease in nursing homes and enhances the nation's ability to combat COVID-19 in high risk healthcare settings. Specifically, this information is used to strengthen COVID-19 surveillance locally and nationally; monitor trends in infection rates; and help local, state, and federal health authorities get help to nursing homes faster. Without the nursing home data, the nation would have no actionable, standardized information about the burden or needs of nursing homes in the pandemic. Prior to July 15, 2020, CDC's NHSN also had COVID-19 Modules for Acute Care, Long-Term Acute Care, Inpatient Rehabilitation, and Inpatient Psychiatric facilities. Effective July 15, 2020, hospitals began reporting COVID-19 capacity, staffing, and supply-related data to HHS.

As of July 13, NHSN is receiving reports from 15,299 of the nation's CMS certified nursing homes (99% of 15,395 total) as well as reports from approximately 1000 assisted living facilities and facilities for persons with developmental disabilities. CDC provides the nursing home data to CMS and this data is publicly available on CMS' website. CDC also has deployed 49 teams to 30 states with outbreaks in nursing homes, assisted living facilities, dialysis facilities, group homes, homeless shelters, correctional facilities, and acute care hospitals in order to help identify practices that can be implemented to control the outbreak and prevent future occurrences.

CDC also developed a novel approach to broaden the reach of public health infection prevention and control expertise via remote assessment of nursing home preparedness called Tele-ICAR. The purpose of Tele-ICAR assessments is to help nursing homes prepare for COVID-19 cases by quickly identifying and addressing IPC gaps. CDC has trained health departments on this novel approach and have been assisting state and local health departments in conducting at least 736 nursing home Tele-ICAR assessments across 19 jurisdictions as of early July.

With COVID-19 supplemental funding, CDC is creating a new national training program through the State-based healthcare-associated infection- Antibiotic Resistance (HAI-AR) Programs called the First Line Training Initiative. This national program will leverage

existing partner networks and the state-based HAI-AR programs funded through CDC to deliver immediate outreach and training to frontline healthcare providers including: nursing homes, long-term care facilities, and dialysis facilities. This outreach will train approximately 6 million U.S. frontline healthcare providers on IPC practices to stop the spread of COVID-19 in healthcare facilities and keep our healthcare workforce safe.

- The IPC training will address the reality of current PPE shortages and will also prevent the spread of other HAI infections to patients and healthcare workers.
- This training program will also be able to update CDC IPC guidance, based on lessons-learned and new scientific knowledge of COVID-19.

Influenza

Health experts have noted how a potential second wave of COVID-19 cases may hit the country right as children and college students are returning to work in the fall and coincide with the next flu season—potentially overwhelming our health system.

- **Question: What is CDC doing to ensure we can track, identify, and differentiate between the virus strains?**

RESPONSE: CDC developed a new laboratory test, approved in July, that detects and differentiates between three viruses including: two types of influenza viruses (A and B) and SARS-CoV-2, the virus that causes COVID-19, using a single sample from an individual. Testing for all three viruses simultaneously will allow public health laboratories to continue surveillance for influenza while testing for SARS-CoV-2. This will save public health laboratories both time and resources, including testing materials that are in short supply. Another benefit of the new test is that laboratories will be better able to find co-infections of influenza and SARS-CoV-2, which is important for doctors to diagnose and treat people properly following current [NIH's COVID-19 Treatment Guidelines](#) or the [Infectious Diseases Society of America COVID-19 Treatment Guidelines](#). CDC received emergency use authorization (EUA) for this combined laboratory test from the U.S. Food and Drug Administration (FDA) on July 2, 2020. This assay will be accessible to public health laboratories, and the technical information will be available if commercial laboratories choose to use it to develop proprietary tests. CDC expects that private sector laboratory test developers may be creating similar multiplex assays to meet clinician needs during influenza season.

The U.S. influenza surveillance system is a collaborative effort between CDC and its many partners in state, local, and territorial health departments, public health and clinical laboratories, vital statistics offices, healthcare providers, clinics, and emergency departments. CDC collects, compiles and analyzes information on influenza activity year-round in the U.S. FluView, a weekly influenza surveillance report, and FluView Interactive, an online

application which allows for more in-depth exploration of influenza surveillance data, are updated each week.

CDC relies on timely and accurate public health surveillance data to guide public health action and inform the nationwide response to COVID-19. This crisis has highlighted the need to continue efforts to modernize the public health data systems that CDC and states rely on for accurate data.

In addition, CDC laboratories have been applying sequencing technologies to SARS-CoV-2 and have made the data available through domestic and global databases. CDC is leading the SARS-CoV-2 Sequencing for Public Health Emergency Response, Epidemiology and Surveillance (SPHERES), a new national genomics consortium to coordinate SARS-CoV-2 sequencing across the United States to do large-scale, rapid genomic sequencing of the virus. These advanced molecular detection and sequencing activities are being ramped up at the state and local levels to give us a clearer picture of how the virus outbreak is evolving and how cases are connected.

- **Question: How can we ensure that public health labs, schools, and employers have sufficient screening tools to prevent a potential crisis?**

RESPONSE: Mitigation and containment of COVID-19 are key public health strategies, and CDC will continue to work with communities across the US to monitor the impacts closely, contain the spread where possible, and adjust mitigation strategies to fit local conditions and circumstances. Strategies are implemented at the state and local level, because every locale is different and individual jurisdictions have the authority and local awareness to protect their communities. CDC's role is to provide guidance/recommendations, information, and expertise to inform those decisions and support the states as needed. In addition, CDC has provided states additional resources to address COVID-19, including \$140 Million in supplemental funding to support influenza vaccination programs and to enhance capacity to support staffing, communications campaigns, pandemic preparedness, and mass vaccination. CDC has also provided \$10.25 billion in emergency funding to jurisdictions to support surveillance, epidemiology, laboratory capacity expansion, contact tracing, data surveillance and analytics infrastructure modernization; disseminating testing information; and workforce support necessary to expand and improve COVID-19 testing.

CDC is providing additional resources for state health departments on our website – which is updated daily – with guidance on conducting contact tracing, training the workforce, community mitigation strategies, etc.

In addition, as of July 12, 2020 CDC has deployed 79 teams to work in state, tribal, local and territorial health agencies to assist on the frontlines with acute outbreaks among special populations (such as meat packing plants, correctional facilities and long-term care facilities) as well as enhance capacity and support a coordinated response to COVID-19.

Planning activities emphasize the need to serve vulnerable populations and include focused efforts for long-term care facilities, federally qualified health centers, and Tribal Nations, among others.

The Federal Government is committed to ensuring that states can meet their testing objectives to reach 2% of their total population. Supplemental funding from the Federal Emergency Management Agency supports four areas:

- Specimen collection and transport supplies - Supplying 100% of swabs needed and transport media a sterile liquid used to transport specimen from the point of collection to the testing facility (in a 75% ratio)
- Laboratory testing supplies by working with manufacturers to help states procure or redistribute reagents and supplies to meet local needs.
- Personnel
- Guidance and technical assistance

SARS-CoV-2 Sequencing for Public Health Emergency Response, Epidemiology, and Surveillance (SPHERES)

The CDC recently launched a national viral genomics consortium called SPHERES to better map SARS-CoV-2 transmission and expand the use of whole genome sequencing (WGS) of the COVID-19 virus. This sequencing information can help us determine the origin and spread of various strains of the virus, but less than 1% of samples have been sequenced to date.

- **Question:** What can we do to help incentivize labs to sequence more of these samples?

RESPONSE: Genomic sequencing can provide invaluable information on the nature and composition of circulating viruses and help define likely patterns of transmission for contact tracing, infection control, and public health responses. While CDC has greatly expanded sequencing efforts using the SARS-CoV-2 SPHERES consortium as a rapid way to draw on the nation's pool of public health, clinical, academic and commercial sequencing capacity and expertise, only a small fraction of positive cases across the country have been sequenced. CDC is continuing to expand sequencing efforts, both through SPHERES and by leveraging existing capacity at CDC. CDC's efforts to expand sequencing output include 1) plans to expand routine systematic sequencing of samples across all states and territories – with a goal to provide a consistent, representative baseline of circulating viruses in the United States over time; 2) scaled up high-throughput sequencing, which allows for large amounts of sequencing to occur simultaneously, in the CDC's core sequencing laboratory to support outbreak investigations and, state/territory/local public health responses and field teams across the country; 3) expansion of the SPHERES sequencing initiative to augment

public/private sequencing efforts, including direct engagement of sequencing services at national diagnostic laboratories, such as LabCorp and Quest Diagnostics.

As we expand sequencing efforts, CDC and other public health organizations around the world are continuing to assess the impact of comprehensive sequencing programs and determine the right level of sampling needed to both provide actionable public health information and guide state, regional and federal response strategies. Currently, CDC's objective is to ramp up sequencing as much as possible and establish longitudinal baseline surveillance in order to place new sequences into national context.

- **Question: The CARES Act provided \$500 million for “surveillance and data modernization.” Are those funds being used to ensure this program has the resources it needs to address the response?**

RESPONSE: The CARES Act provided \$500 million to CDC to continue the ongoing modernization of public health data systems. With these funds, CDC will leverage data for surveillance, detection, and improving jurisdictions' situational awareness to allow localized, targeted responses and decision making using more real-time data to respond to outbreaks like COVID-19. Data modernization will expand the electronic exchange and integration of information between public health and health care, including electronic health records, which is essential for timely, accurate, and accessible disease surveillance. These funds will support public health's data science, informatics, and IT workforce; expand core data, informatics, and IT capacity; and advance interoperable systems and tools, strengthening coordination and collaboration.

To date, CDC has not used funding from the COVID-19 supplemental appropriations to support SPHERES. Congress's investments in the Advanced Molecular Detection (AMD) program since 2014 enabled the SPHERES coalition to come together very quickly. State health departments are in a position to make use of the data, and because of the partnerships developed with industry and academia over time, both understand how sequence data contributes to public health and how they can help.

Efforts are already underway to establish coordinated national surveillance for SARS-CoV-2 by expanding existing diagnostic testing and extending more comprehensive and systematic viral genomics to all 50 states. For baseline surveillance, CDC plans to leverage existing influenza surveillance mechanisms to establish regular, systematic capture and sequencing of samples at CDC to provide a standard baseline for viral sequences. This will be overlaid with both existing large-scale and distributed sequencing efforts by the SARS-CoV-2 SPHERES consortium and expanded centralized comprehensive sequencing at CDC for cluster investigation, surveillance, and special studies. CDC will leverage existing investments and

architectures by the AMD and Influenza programs and will work with the global community to maximize the use of consensus data standards and open sequence data sharing.

Submitted by Congressman Pocan

LGBTQ Data Collection

General Social Survey data indicate that LGBT people are more likely to work in essential jobs such as food services, health care, and retail. LGBT people are more likely to live in urban areas and in dense housing where they may be more likely to be exposed to the novel coronavirus. We know that LGBT people have certain chronic conditions at higher rates than the general population, such as diabetes, cardiovascular disease, and cancer. And we know that, due to minority stress and stigma, LGBT people use tobacco at higher rates. This all puts LGBT people at higher risk of complications should they develop COVID-19.

- **Question: What is the CDC doing to measure the potentially disproportionate impact of the coronavirus and COVID-19 on LGBT people, and how sexual orientation and gender identity intersect with racial/ethnic disparities?**

RESPONSE: During the past several years, HHS has led the federal Government's effort to enhance data collection in the LGBTQ population and has made significant progress towards improved data collection on sexual orientation and gender identity. Last year, CDC hosted a webinar, [Improving Measurement of Sexual Orientation and Gender Identity in the Federal Statistical System](#), to share challenges and opportunities for improvement in collecting these data. CDC recognizes the importance in responding to the needs of disproportionately affected populations in this response. CDC acknowledges the intersection of sexual orientation, gender identity, and racial/ethnic disparities seen in the COVID-19 pandemic and understands how they pose unique challenges to people who are members of multiple minority communities. CDC and states have experienced obstacles to collecting race/ethnicity during the COVID-19 response, which can hamper prevention efforts. We continue to encourage health departments and other entities that are voluntarily submitting case report data to provide complete demographic information. However, CDC relies on public health surveillance systems that typically capture data from health information systems (e.g., medical records), which in turn do not generally include information on gender identity or sexual orientation. Adding a request for state and local health departments to gather this information might be low yield, because this information is not collected routinely or reliably. Instead, specialized surveys, research, and other new systems designed to answer specific questions might better address this information gap. CDC is continually evaluating the scope of our COVID-19 data collection and will work with our state and local health partners to find ways to better understand the incidence and impact of COVID-19 on LGBTQ individuals.

Long-Term Cellular Immunity in COVID-19 Vaccine

I understand that populations with high rates of diabetes, heart disease, and other comorbidities have a higher risk of severe cases of COVID-19 cases, and may benefit from a specialized vaccine that also stimulates long-term cellular immunity.

- **Question:** What is the CDC doing to support the development of a vaccine targeting long-term cellular immunity? And do you think more attention needs to be paid to the development of vaccines and other prevention strategies that are targeted at communities that are uniquely vulnerable to COVID-19?

RESPONSE: CDC has fully engaged its expertise in public health preparedness and response along with its immunization infrastructure to support Operation Warp Speed in vaccine promotion, distribution, administration, and monitoring.

CDC's Advisory Committee on Immunization Practices has formed a workgroup to assess COVID-19 vaccine candidates. The workgroup is evaluating safety and immunogenicity data for COVID-19 vaccines, particularly in vaccine candidates in Phase I-III clinical trials. They also review the epidemiology of COVID-19 disease to identify potential target populations for vaccination, discuss potential vaccine prioritization plans in the event of insufficient early COVID-19 vaccine supply, and identify areas where additional data are needed to inform COVID-19 vaccine recommendations.

Submitted by Congresswoman Roybal-Allard

Coronavirus Outbreaks in Meat Processing Industry

The meatpacking industry has been particularly hard hit by COVID-19. According to a NY Times report on June 8th, more than 25,000 of its workers have been infected, and more than 90 have died across the United States. In many states workers have been incentivized to come to work sick by oppressive workplace policies, and companies have been slow to act in adopting safety guidelines, especially in enforcing physical distancing and slowing down the line.

- **Question:** What role has CDC's NIOSH played in developing guidelines to address worker safety in these meat packing plants?

RESPONSE: CDC has published guidance to mitigate the risk of outbreaks of COVID-19 in food processing plants co-branded with the Department of Labor, Occupational Safety and Health Administration (OSHA). CDC also independently developed a Meat and Poultry Processing Facility Assessment Toolkit. Because many food production workers are

immigrants and non-English speakers, CDC has produced educational materials in multiple languages. CDC workplace guidance is developed based on the evolving science, what we learn from our field teams, and stakeholder feedback.

In addition to guidance specific to food production facilities, CDC has published [Interim Guidance for Critical Infrastructure Workers Exposed to COVID-19](#), and [COVID-19 Critical Infrastructure Sector Response Planning](#) which are designed to ensure that work in critical infrastructure sectors can continue, while recognizing that critical infrastructure employers have an obligation to manage the continuation of work in a way that best protects the health of their workers and the general public. Additionally, CDC has published [Testing Strategy for Coronavirus \(COVID-19\) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified](#), which presents different testing strategy options for exposed co-workers when public health organizations and employers determine testing is needed to help support existing disease control measures.

- **Question:** How does this differ from what OSHA is tasked with doing, and whose role is it to ensure that these meat packing companies are in compliance with the necessary safety standards to stop the epidemic of COVID in this industry?

RESPONSE: NIOSH is a research agency within CDC focused on the study of worker safety and health, and developing guidance and recommendations for employers and workers to create safe and healthy workplaces. NIOSH is not a regulatory agency and works cooperatively with employers and employees to adapt research findings into workable solutions. Although much of CDC's occupational guidance was developed jointly with OSHA, CDC does not have regulatory authority over food production facilities and cannot require the implementation of its guidance.

Chronic Diseases

As summarized in the Morbidity and Mortality Weekly Report published by CDC on May 8, the majority of patients hospitalized for COVID-19 have been found to have underlying conditions. Additionally, shutdown orders and concern about exposure to COVID-19 have left many impacted by chronic illnesses delaying medical care or pursuing alternative care sites, such as the home.

- **Question:** What can the CDC do to support those with chronic illnesses, especially as states move to lift stay at home orders?

RESPONSE: CDC has determined that individuals with certain underlying medical conditions—which include chronic illnesses—are or may be at higher risk for severe illness from COVID-19 (<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/evidence-table.html>). CDC continues to review and update guidance for community mitigation and critical populations. As states move to reduce or lift stay-at-home

orders, CDC recommends that individuals at higher risk for severe illness take steps to protect themselves. They should consider avoiding activities where taking protective measures may be difficult, such as activities where social distancing cannot be maintained. CDC has issued [guidance](#) on the use and benefits of telehealth strategies to support the delivery of healthcare services in a remote fashion. CDC is also developing a report to show the county-level distribution of the prevalence and number of US adults aged ≥ 18 years with select underlying medical conditions that increase the risk of severe COVID-19-associated illness. The findings from this report can be used by state and local decision makers to help identify populations at higher risk for severe COVID-19 illness in their jurisdictions to guide resource allocation and mitigation strategies. CDC has provided funding to support those with chronic illnesses during the COVID-19 pandemic. For example, CDC awarded funds to the National Association of School Nurses for Collaboration to Support Students with Chronic Health Conditions.

- **Question: What additional resources are needed to minimize the risk that individuals with chronic illnesses will contract COVID-19 while still ensuring that they receive appropriate health care?**

RESPONSE: It is especially important for people at increased risk of severe illness from COVID-19, and those who live with them, to protect themselves from getting COVID-19. People at increased risk of severe illness from COVID-19, and those who live with them, should consider their level of risk before deciding to go out and ensure they are taking steps to protect themselves. Those with an underlying medical condition should continue to follow their treatment plan – continue their medicines, have at least a 30-day supply of prescription and non-prescription medicines – and should call their healthcare provider or nearest community health center or health department with any concerns. CDC also suggests not to delay getting emergency care for underlying medical conditions because of COVID-19.

Other strategies that can be implemented to support individuals with chronic illness include informational campaigns to encourage the use of telehealth and tele-pharmacy visits, delivery of necessary medicines to the home, and increasing drive-through pharmacy availability and use. These strategies can be enhanced by State and local policy and funding efforts (including reimbursement policies) that support telehealth and telepharmacy and other alternative approaches to service delivery as well as the provision of at least 90 days of necessary medications and medical supplies.

More information can be found on our website: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>. The website lists specifics actions people can take based on their medical conditions and other risk factors.

- **Question: What role are voluntary health organizations playing in helping those with chronic illnesses navigate their care during and after the public health emergency, and how can CDC better support this work?**

RESPONSE: During the COVID-19 pandemic, as always, CDC maintains strong relationships with partners including state and local health departments, professional

organizations, national medical organizations, patient safety advocates and organizations, non-governmental organizations, academia, and others. CDC has provided more than \$12 billion to states, territories, and tribal organizations to respond to COVID-19. Many of these partners are working directly with providers and patients to make sure that the most up-to-date information and recommendations are being shared and implemented.

- **Question: What actions can CDC take to better protect individuals with underlying conditions in the event of a resurgence of the coronavirus or other pandemics in the future?**

RESPONSE: CDC is working 24/7 to address the ongoing COVID-19 pandemic and is learning more about the virus and its effects on individuals and populations every day. To prevent the spread of the virus that causes COVID-19, prevent further morbidity and mortality associated with COVID-19, and prevent significant morbidity and mortality from potential pandemics in the future, we must work together to ensure that people have resources to maintain and manage their physical and mental health, including easy access to information, affordable testing, and medical care. We need programs and practices that fit the communities where people live, learn, work, play, and worship. Community- and faith-based organizations, employers, healthcare systems and providers, public health agencies, policy makers, and others all have a part in helping to promote health equity and equal access to healthcare and accurate health information.

As we learn more about the virus that causes COVID-19 and how it affects people and populations, CDC will continue to develop and update multiple resources that provide the public, community- and faith-based organizations, employers, healthcare systems and providers, public health agencies, policy makers, and others actionable ways to reduce the spread and reduce morbidity and mortality from COVID-19.

We know that older adults and people of any age with certain underlying medical conditions (<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>) are at increased risk of developing severe illness from COVID-19, which means they may require hospitalization, intensive care, or a ventilator to help them breathe. CDC is maintaining an evidence-based and up-to-date list of underlying conditions that increase one's risk for developing severe illness and provides recommendations for what people at increased risk can do.

CDC also provides information on the website about how to stay healthy during the COVID-19 pandemic for people with underlying medical conditions:

- Continue your medicines and do not change your treatment plan without talking to your healthcare provider.
- Have at least a 30-day supply of prescription and non-prescription medicines. Talk to a healthcare provider, insurer, and pharmacist about getting an extra supply (i.e., more than 30 days) of prescription medicines, if possible, to reduce your trips to the pharmacy.

- Do not delay getting emergency care for your underlying medical condition because of COVID-19. Emergency departments have contingency infection prevention plans to protect you from getting COVID-19 if you need care.
- Call your healthcare provider if you have any concerns about your underlying medical conditions or if you get sick and think that you may have COVID-19. If you need emergency help, call 911 right away.
- If you don't have a healthcare provider, contact your nearest community health center or health department.

CDC resources also include information for other populations like pregnant people, people experiencing homelessness, people with disabilities, and others who need extra precautions.

Impact of Cigarettes and Vaping on COVID Incidence and Outcomes

Public health officials and medical experts are concerned that individuals with certain underlying conditions such as diabetes, lung disease, heart disease, and tobacco use are at greater risk of worse outcomes from COVID-19. I am especially interested in the role that cigarette and e-cigarette use may play in causing more severe COVID-19 outcomes.

- **Question: Is CDC currently collecting data on whether patients are smokers, former smokers, or e-cigarette users?**

RESPONSE: CDC developed the [COVID-19 Case Report Form](#) to standardize the reporting of key information on COVID-19 cases. This form is publicly available on the CDC website for full use by state and local authorities. The case report form includes a section for reporting underlying health conditions including if the person is a current or former smoker.

- **Question: Are there any specific challenges that CDC is facing in collecting the tobacco use status of COVID-19 patients?**

RESPONSE: CDC is working with state and local health departments to increase completeness of the case report forms. One challenge is that tobacco use is often not collected in a standard way in the medical record, particularly e-cigarette use.

- **Question: When these data are unable to be collected when a patient is first diagnosed, does CDC have a process to retroactively go back and collect these data?**

RESPONSE: CDC does not collect this information directly. State and local health departments report information on cases to CDC through a case report form. CDC continues to work with state and local health departments to increase completeness of the case report forms.

- **Question: What impact has CDC found thus far on the role that cigarette and e-cigarette use may play in COVID-19-related complications?**

RESPONSE: CDC reviews published reports, articles in press, unreviewed pre-prints, and internal data to better understand the underlying medical conditions that put individuals at increased risk for severe illness from COVID-19. The most recent review was based on information available between December 1, 2019 and May 29, 2020. As part of this review CDC found mixed evidence, where multiple studies reached different conclusions about risk associated with smoking. CDC will continue to review the evidence and update the list of underlying medical conditions that increase a person's risk of severe illness from COVID-19.

Development of Vaccine Infrastructure Prior to COVID-19 vaccine

While current efforts focused on testing and contact tracing are essential, the deployment of a safe and effective COVID vaccine is the ultimate key to fully re-opening the American economy. It is likely that this vaccination program will be the greatest public health effort of our generation, and the unprecedented demand for vaccine across the country and across all segments of the population will likely cause intense pressure on already fragile and overworked health care and public health systems.

- **Question:** What is the CDC doing to prepare for a COVID-19 vaccination campaign that would include educating the general public on the vaccine, as well as short, medium and long-term actions necessary to lay the foundation for a smooth and orderly vaccine procurement and distribution process?

RESPONSE: CDC recognizes that effective communication is a critical component of any vaccine program, and CDC is working collaboratively within Operation Warp Speed (<https://www.hhs.gov/about/news/2020/06/16/fact-sheet-explaining-operation-warp-speed.html>) to ensure that consistent and accurate information is at the foundation of the communication plan currently being developed. Understanding that public confidence in vaccines is necessary for vaccine uptake, CDC's strategic framework, Vaccinate with Confidence (<https://www.cdc.gov/vaccines/partners/vaccinate-with-confidence.html>), aims to strengthen public trust in vaccines and prevent vaccine-preventable disease outbreaks. This framework emphasizes three key priorities: protect communities, empower families, stop myths. Within this framework, CDC is working with local partners, using trusted messengers, to establish new partnerships and contain the spread of misinformation. Building confidence requires, in addition to accurate communication of what we know and what we don't know, setting realistic expectations. CDC will continue to build upon the investments of our immunization program as the agency works with the nation's public health system and the private sector to plan and prepare to disseminate a COVID-19 vaccine, when available.

- **Question:** Is CDC working with public health, primary care physicians, pharmacists and other health care providers in the community to develop plans for managing the volume of procurement, storage, and distribution of ancillary supplies that will be

needed for a successful pandemic vaccination effort, including such as personal protective equipment (PPE), syringes and alcohol wipes?

RESPONSE: CDC is helping prepare the nation's public health system and the private sector to disseminate the vaccine to the public when one is available. We are working closely with the interagency on COVID-19 vaccines. Taking into account many uncertainties, we are now working closely with state and local health departments on preparing a detailed but flexible plan, including consideration of critical infrastructure workers, high risk individuals, health equity issues and lessons learned from the 2009 H1N1 pandemic.

HHS (Biomedical Advanced Research and Development Authority and Strategic National Stockpile) leads efforts to purchase needles and syringes for pandemic vaccination program and CDC is working collaboratively to provide technical assistance. There are efforts underway to request that manufacturers produce additional needles and supplies to support pandemic vaccination program. As part of this effort, we are taking care to avoid negatively impacting supplies used for routine and flu vaccination.

- **Question: Advocacy groups have recommended \$3.6 billion in funding through the CDC-Wide Activities account for immediate immunization infrastructure support be included in the next COVID-19 response package. How will funding immunization infrastructure now enable to the CDC to prepare for the COVID-19 vaccination campaign?**

RESPONSE: CDC's Immunization Program plays a fundamental role in achieving national immunization goals and sustaining high vaccination coverage rates to prevent death and disability from vaccine-preventable diseases. CDC provides funding to support public health functions and ensure program effectiveness and scientifically sound immunization policy. A strong public health infrastructure at the national, state, and local levels is vital to sustaining high vaccination coverage levels and low incidence of vaccine-preventable diseases. This support also maintains public health preparedness for response to a vaccine-preventable national emergency, such as a pandemic or an intentional biological attack.

CDC is working closely with Operation Warp Speed (OWS). CDC stands ready to use its expertise in public health preparedness and response along with its immunization infrastructure to support OWS in vaccine promotion, distribution, administration, and monitoring. Congress's recent investments through the Coronavirus Aid, Relief, and Economic Security Act have allowed CDC to provide its immunization awardees \$140 million in supplemental funding to support and enhance their immunization programs. This supplemental funding will be used to support awardee and local health department staffing, communications campaigns, pandemic preparedness, and mass vaccination. In addition to other COVID-19 vaccine response work, awardee activities will include a specific focus on enhancing influenza coverage, especially in historically underserved populations, and enrolling and working with additional vaccinators (e.g., pharmacists, mass vaccinators).

- **Question:** How will CDC work with states to ensure equitable distribution of a vaccine, including making sure that people at higher risk are prioritized?

RESPONSE: CDC has worked for decades with its state and local partners to ensure public health systems are prepared with plans, trained personnel, strategic relationships and partnerships, data systems, and other resources needed for sustaining a successful routine immunization infrastructure, which will help ensure effective distribution can occur once a safe and effective COVID-19 vaccine is available. CDC is working closely with our government partners in response to this pandemic, including with our sister agencies at HHS.

- **Question:** With the flu season and the second wave of COVID-19 are expected to place in the fall, how will CDC manage both campaigns simultaneously?

RESPONSE: As we expect SARS-CoV-2 to continue to circulate in fall, CDC is working to increase seasonal flu vaccination coverage, particularly for populations most at risk. Increasing flu vaccine coverage is an important public health goal, but also serves to reduce the strain on the health care system that will be facing COVID-19 at the same time as seasonal influenza. We remain committed to the goal of increasing flu vaccine uptake, especially in people at higher risk of serious flu and COVID-19 outcomes.

To achieve this, CDC is enhancing communications to target special audiences, including older Americans, people of any age with underlying health conditions, workers in long-term care facilities, other essential workers, African Americans, and Hispanics. Understanding that African American and Hispanic communities have lower rates of flu vaccination and a higher risk for COVID complications, we will enhance our education and communication efforts toward these key communities. We are testing flu vaccine messages to learn what impacts the pandemic may have on the intent to vaccinate, including fears about getting vaccinated in a safe environment. Additionally, this year we are undertaking a project designed to assess the quality of communications with patients regarding vaccinations; areas of focus will include influenza vaccination and African American patients. We will continue to work with our public health and clinical partners to help eliminate barriers to vaccination.

The ongoing COVID-19 pandemic may affect where and how flu vaccines are given. We are working with health departments to develop contingency plans. CDC is also looking at operational considerations such as access to vaccine with potential need for social distancing, and prolonging vaccine uptake from September through December. In addition to these efforts, CDC has purchased \$7.1 million additional doses of flu vaccine directly from vaccine manufacturers to help uninsured and under-insured Americans get their flu vaccines. These vaccines will be provided to state health departments to focus on adults at higher risk. We are taking many considerations into account in our efforts to expand flu vaccine coverage and focusing on specific efforts to address racial and ethnic disparities. Specifically, CDC will be working with the National Association for Community Health Centers to implement evidence-based strategies to increase adult vaccination coverage among underserved priority populations. We will be engaging in expert consultation to develop strategies for addressing racial and ethnic disparities in adult immunization,

soliciting simultaneous individual expert opinion from 15 national leaders in health disparities, health equity, and social determinants of health. The focus will first be on African Americans, with plans to address other populations, such as Hispanics, through similar activities in the future.

CDC is also working with Vaccines for Children (VFC) providers to ensure they are prepared for a potentially increased number of eligible children, due to the economic impact of the pandemic. Children and adults with private insurance should be able to access the flu vaccine at no cost, if they are seen at in-network providers. CDC is also supporting efforts for school-located vaccination clinics to expand access to flu vaccines for all children. Additionally, the Section 317 Immunization program provides some vaccine to be used as a safety net for outbreaks and uninsured adults. On June 4, CDC awarded \$140 million from the Coronavirus Aid, Relief, and Economic Security Act to 64 jurisdictions through CDC's existing immunization cooperative agreement to enable state health departments to launch an initial scale up for influenza season, given the increased risk of COVID-19. Funds will begin to support staffing and preparedness early this summer and focus on ensuring flu coverage for vulnerable populations.

Remote Patient Monitoring in Nursing Homes

COVID-19 has had a disproportionate effect on people who reside or work in long-term care facilities. Within the 80% of nursing homes that have reported coronavirus data to the federal government, nearly 26,000 residents died as of early July.

The main vulnerabilities that we have seen thus far during the COVID-19 pandemic is that nursing homes have inadequate staffing, lack adequate personal protective equipment (PPE), have insufficient infection prevention and control (IPC) infrastructure, and suboptimal implementation of IPC best practices (e.g., inconsistent hand hygiene, improper isolation techniques, and inconsistent cleaning and disinfection). Additionally, the CDC found that a factor that likely has contributed to the vulnerability of nursing homes is staff members who worked while symptomatic and staff members who worked in more than one facility.

- **Question: Would remote patient monitoring that enables the early identification of physiologic changes in patient conditions be useful in nursing homes?**

RESPONSE: CDC recommends that facilities consider implementing FDA-approved novel medical technologies, including remote monitoring devices, as appropriate for their local circumstances and the characteristics of their patient population. Such facilities should communicate with insurers/payers to understand availability of covered telehealth, telemedicine, or remote patient monitoring services.

- **Question: How could this technology be used to minimize cross-contamination and help manage infection control among residents and staff?**

RESPONSE: CDC recognizes the importance of telehealth during the COVID-19 pandemic, both for screening potentially infected individuals and for working with patients needing care for other conditions. CDC has developed guidance for healthcare systems providing non-COVID-19 clinical care, which recommends optimizing telehealth when available and appropriate to minimize the need for in-person services. This is an application of the critically important practice of social distancing to minimize opportunities for transmission of the virus that causes COVID-19.

CDC Order on Border Closure

On March 20, 2020, the CDC issued its order, “Suspending the Introduction of Certain Persons from Countries Where a Communicable Disease Exists.” This CDC order, which has since been extended and amended, authorizes the expulsion of non-citizens arriving at the border without valid documents, including unaccompanied migrant children.

For more than 20 years, federal law has recognized the particular and enduring vulnerability of children who arrive in the United States without parents or legal guardians. In effect, this order deprives unaccompanied children of their ability to seek asylum, as well as deprives them with rights provided to them through the Trafficking Victims Protection Reauthorization Act (TVPRA).

- **Question: Given the protections provided to these children under the TVPRA and the dangers unaccompanied migrant children face upon return to the Mexico and Northern Triangle countries, why were unaccompanied minors not exempt from the CDC order?**

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government’s recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question: ORR currently has the capacity to place these unaccompanied children in non-congregate shelters. Will the CDC look to exempt these unaccompanied children from suspension of entry on one of the Order’s 30-day reviews?**

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government’s recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question: With many reports stating that Mexico is nearing a collapse of their medical infrastructure, is CDC concerned with the return of migrants to a country which is not their country of origin and where most shelters are closed and/or medical**

infrastructure is at capacity? Are there any metrics used for if it is too dangerous for a person to return?

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government's recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question: How did CDC determine that Sections 362 and 365 of the Public Health Service (PHS) Act permit the CDC Director to suspend federal protections for vulnerable children, specifically the TVPRA?**
 - a. Who performed this legal analysis?
 - b. Please provide such analysis to the committee.

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government's recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question: When does the CDC plan to permit a phased reopening of the border?**

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government's recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question: What specific metrics will the CDC be utilizing to make this determination?**

Response: As part of the United States Government response, decisions on federal travel restrictions on the land border are made through an interagency decision-making process that includes other federal partners such as the Department of Homeland Security (DHS) and the Department of State (DOS). HHS and CDC are working closely with these federal partners to mitigate the impact of COVID-19 on the American public to consider necessary adjustments to the response and related guidance as conditions change and as we learn more about this emerging infectious disease. Metrics of evaluation that could be considered in this decision-making process include case incidence rates, sustained transmission, the effectiveness of contract tracing, geographic distribution, state and local control measures, and other information provided by federal partners.

- **Question: Beginning in March 2020, CBP modified the way it tracks publicly available data. Whereas previously, there was a category for "CBP Apprehensions" there is now**

a category for “CBP Encounters” which combines Title 8 apprehensions with Title 42 expulsions. Given this change, it is difficult to determine from CBP data how many children have been expelled pursuant to Title 42. Is the CDC concerned about tracking this information, so that it can have a better understanding of the impact that Title 42 is having?

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government’s recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question:** If so, what steps are you taking to track this information?

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government’s recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

Submitted by Congressman Cole

Pregnancy Outcome Reporting

- **Question:** What efforts is CDC taking to expand the reporting of all complications for all pregnancy outcomes: birth, induced abortion, or natural fetal loss?

RESPONSE: CDC relies on timely public health surveillance data to guide public health action and inform the nationwide response to COVID-19. These data are provided via working relationships with health departments, healthcare providers, and laboratories. U.S. surveillance for COVID-19 cases is routinely conducted using a case report form that is standardized nationally to ensure the same demographic, clinical, and risk factor information is captured consistently via myriad reporting sources. This case report form includes a field to indicate pregnancy status, as well as course of illness and care received. The initial step in case reporting calls for laboratories and healthcare providers to submit case information to their local or state health departments in accordance with jurisdictional requirements. Data from the first five months of COVID-19 case reports reported to CDC were published in the Morbidity and Mortality Weekly Report article, “Characteristics of Women of Reproductive Age with Laboratory-confirmed SARS-CoV-2 infection by Pregnancy Status — United States, January 22–June 7, 2020.” Findings from this report suggest that among women of reproductive age with COVID-19, pregnant women are more likely to be hospitalized and are at increased risk for intensive care unit admission and receipt of mechanical ventilation

compared with non-pregnant women. Their risk for death is similar. Also, with the release of the report, we launched public reporting of laboratory-confirmed SARS-CoV-2 infection among pregnant women on the CDC website. These data are updated weekly and provide the public with cases by selected demographics and outcomes of severity.

Hospitals, healthcare providers, and labs are required to report personally identifiable COVID-19 case data to health departments under state reportable disease laws. However, health departments voluntarily report de-identified case data to CDC under the National Notifiable Diseases Surveillance System. Case data is incomplete in many -- if not most -- jurisdictions, both in terms of the number of cases reported, and in the data reported for each case. Case reporting depends on individuals at the state, territorial, and local levels who have multiple competing demands, limited public health resources, and often antiquated public health information systems. CDC has developed the COVID-19 Pregnancy Module as an optional surveillance component in which health departments can participate, to supplement the data collected from case reporting. The COVID-19 Pregnancy Module collects data on the pregnant individual's obstetric history and pregnancy complications, as well as the outcome of the pregnancy and basic information about the neonate. To further increase our understanding of SARS-CoV-2 infections among pregnant women and their infants, CDC is also expanding its Surveillance for Emerging Threats to Mothers and Babies (SET-NET) activity to include surveillance for COVID-19 in pregnancy. Approximately 30 jurisdictions, representing about 3 million live births, have initiated or expressed interest in initiating voluntary reporting of surveillance data among pregnant women with confirmed SARS-CoV-2 infection.

CDC is also working with partners to study the epidemiology of SARS-CoV-2 infection in pregnancy and infancy in diverse geographic areas. Key objectives these studies aim to address include the following:

- Characterize the clinical epidemiology of COVID-19 in pregnancy and infancy;
- Estimate incidence of COVID-19 in pregnant people (non-medically attended, ambulatory care visits, and hospitalizations);
- Estimate seroprevalence (the percentage of people in a population who have antibodies against an infectious agent) of SARS-CoV-2 infection in pregnant people;
- Assess risk factors for severe COVID-19 in pregnancy;
- Evaluate the potential for transfer of maternal SARS-CoV-2 infection to infants during the peripartum period;
- Assess if SARS-CoV-2 infection during pregnancy is associated with adverse pregnancy and infant outcomes;
- Assess the extent to which COVID-19 disproportionately impacts pregnant people from underserved communities
- Assess the indirect impact of the COVID-19 pandemic on maternal and infant health;

- Describe knowledge, attitudes, and practices of pregnant people related to COVID-19.

Data collected as part of these efforts can help us answer key questions about the impact of COVID-19 during pregnancy. They will help direct public health action for pregnant women and infants. Findings will be rapidly translated into updated clinical guidance for pregnant women and infants. They could also help inform prevention and/or treatment options for these potentially vulnerable populations. We are also working closely with key clinical and public health partners.

Surveillance Reporting

- **Question:** Birth data and mortality data for 2018 are available in CDC's National Vital Statistics System. However, CDC's abortion surveillance reporting is only current through 2016, even though CDC acknowledges these data are important for several public health reasons, including the prevention of unintended pregnancy. Can you please explain why the abortion statistics lag so far behind the birth and death statistics?

RESPONSE: Most state health departments, the District of Columbia, and New York City collect data from the medical providers performing abortions in their jurisdiction. These reporting areas compile the information they collect and then send aggregate numbers to CDC on a voluntary basis. CDC publishes these aggregate numbers in its annual Abortion Surveillance Report.

CDC works to allow the states/areas sufficient time to compile their own abortion records before sending a summary of the information to CDC. CDC cannot begin summary and analysis of all the data until the last state/area has reported.

In some states/areas, the data is collected on paper and must be manually compiled before it can be submitted. It takes approximately 18 months from the time initial requests are sent to states/areas, when CDC receives data from these reporting areas and then compiles data into the annual Abortion Surveillance Report.

- **Question:** What steps are being taken to ensure this data is reported at the same frequency as other birth and mortality data?

RESPONSE: CDC is continuously working to improve the timeliness of data reporting. As such, we anticipate releasing abortion data from 2017 and 2018 in November 2020.

- **Question:** Four reporting areas declined to share abortion data for CDC's most recent abortion surveillance report. Together, these four reporting areas account for approximately one fifth of all abortions performed in the United States, and their nonreporting means that CDC reports are incomplete. Could you please describe the steps that CDC is taking to ensure these reporting areas to collect and share abortion data?

RESPONSE: Each year, CDC requests abortion data from the central health agencies of 52 reporting areas (the 50 states, the District of Columbia, and New York City). CDC requests data from all areas so that CDC surveillance data are as complete as possible. However, it is important to note that these reporting areas send aggregate data to CDC on a voluntary basis. When CDC analyzes the data to calculate nationwide rates and ratios, we do not include birth and population data from non-reporting states/areas in the denominator such that they only reflect estimates in reporting states/areas. We will continue to work with states and reporting areas to obtain this information, highlighting the value of their participation in order to have national data.

Submitted by Chair DeLauro

Unaccompanied Children

The CDC order, Suspending the Introduction of Certain Persons from Countries Where a Communicable Disease Exists, which authorizes the summary expulsion of non-citizens arriving at the border without valid documents, has been the basis for the expelling of over 900 unaccompanied migrant children. These children are not given the opportunity to plead for asylum and are deprived of the historic legal safeguards that have been put in place to protect them from violence, exploitation and human trafficking.

- **Question:** Given the dangers unaccompanied migrant children face upon return to the Mexico and Northern Triangle countries, will the CDC look to exempt these children from suspension of entry?

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government's recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

- **Question:** Given that appropriate implementation of the law would remove most unaccompanied migrant children from border facilities expeditiously, would it be fair to say that the Order's rationale does not squarely apply to that population, and that they could be exempted from the Order?

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government's recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

Pursuant to the May 19 amendment, the Order will stay in effect until you determine that the danger of further introduction of COVID-19 into the country has ceased, and every 30 days you will review the latest information to determine if the Order remains necessary.

- **Question:** What criteria, aside from a reduced number of migrants in U.S. detention, will you apply to establish that the entry of asylum seekers to the country poses a threat to U.S. public health? Will the Order continue indefinitely until a vaccine is developed? Will you give special consideration for unaccompanied migrant children?

RESPONSE: This question raises complex factual and legal issues that are the subject of ongoing litigation. Accordingly, CDC respectfully declines to provide a response and refers you to the Department of Justice. For further reference, you may wish to review the Government's recent filing in *J.B.B.C. v. Wolf*, CA No. 1:20-cv-01509 (CJN) (D.D.C. 2020), Dkt. No. 28.

Questions from the COVID-19 Response Hearing

The following questions were posed to Dr. Redfield during the June 4, 2020 COVID-19 Response hearing and were not answered during the questioning.

- **Question:** How is CDC adjusting its approach to messaging to different groups, locations, etc.?

REONSE: CDC utilizes various approaches to ensure that resources and information are culturally appropriate including message testing to ensure materials are applicable to different regions and populations. CDC continues to work with state, tribal, local, and territorial health departments and healthcare systems to collect data on the number of COVID-19 cases, hospitalizations, and deaths, which is used to better direct resources to address target populations. CDC is also supporting partnerships between researchers, professional groups, community groups, tribal medicine leaders, and community members to share culturally

tailored information to prevent COVID-19 which allows for messaging to be more applicable to specific groups. Additionally, CDC continues to publish and update COVID guidance that is designed for specific target population including occupational, race & ethnicity, and regional populations. CDC has also published messaging in several different languages to increase access to non-English speaking populations.

- **Question:** Will CDC begin to disaggregate the AAPI community data?

RESPONSE: CDC is working to identify the best way to disaggregate COVID data on the Asian American & Pacific Islander community, in a manner that is more specific to the subgroups within the AAPI population. CDC understands that examining differences for the racial and ethnic groupings on which health departments typically report (Asian and Native Hawaiian or Other Pacific Islander) and disaggregating within those categories (to the level of Chinese, Filipino, Vietnamese, etc.) is an important practice and we are exploring ways to pursue such analyses. As we collect data from state, local, and territorial health departments, it is our goal to use this information to allow us to identify specific needs, and allocate resources to address the identified needs for AAPI populations. An important consideration in disaggregating COVID-19 data on AAPI individuals is to ensure that in so doing there is no risk of disclosing confidential health information or exposing an individual's identity in situations where a subgroup may be small in size in a given community or area.

We are also taking additional steps to identify the specific needs of the AAPI community in response to the COVID-19 pandemic. CDC recently funded a project, Forging Asian and Pacific Islander Community Partnerships for Rapid Response to COVID-19, with the goal of forming national partnerships with organizations serving AAPI communities to enhance the agency's ability to support the needs of AAPI communities in response to COVID-19. Specifically, this project will build upon the existing relationship CDC has with the Asian & Pacific Islander American Health Forum, a national AAPI organization based in Oakland, California. The grantee is being asked to expand the number of partners involved, as well as identify subgroups among AAPI communities who may be at higher risk for COVID-19, because of underlying medical conditions, occupation, or other reasons. The project will include local civic organizations and involve doing rapid community assessments related to COVID-19 (e.g., access to care, language needs, cultural practices) and then working with community members to develop, adapt, and disseminate culturally and linguistically appropriate strategies and education materials that adhere to CDC recommendations.

- **Question:** Have you given any advice to the President or report to any police agencies or the military to not use teargas or chemical agents with the recent protestors because obviously that could cause an increase in COVID-19 due to the coughing?

RESPONSE: We currently do not know how the use of teargas or chemical agents impacts the spread of COVID-19.

- **Question:** We need more clarity as to what the new demographics reports are going to look/contain.

RESPONSE: CDC recognizes COVID-19 continues to disproportionately impact some populations. CDC is continuing to make progress to ensure key data are available to identify those most affected by this pandemic. For surveillance of COVID-19, and the virus that causes it, SARS-CoV-2, CDC is using multiple surveillance systems run in collaboration with state, local, territorial, healthcare and academic partners to monitor COVID-19 disease in the United States. COVID-19 surveillance draws from a combination of data sources from existing influenza and viral respiratory disease surveillance, syndromic surveillance, notifiable disease case reporting, commercial lab reporting, the healthcare safety system, ongoing research platforms, de-identified patient healthcare records and medical claims and other new systems designed to answer specific questions. These systems, combined, create an updated, accurate picture of SARS-CoV-2 spread and its effects in the United States and provide data used to inform the U.S. national public health response to COVID-19.

COVID-19 is a nationally notifiable condition, with state, local, and territorial health departments voluntarily sending case reports to CDC through the National Notifiable Diseases Surveillance System (NNDSS). Case-based reporting received through NNDSS helps to determine case numbers, estimate infection rates, examine trends over time, determine geographic distributions, and identify outbreaks. As of July 24, CDC has received a total of 3,075,283 case reports, which represent approximately 80% of total COVID-19 cases in the US. CDC continues to work with its state, local, and territorial partners to improve their case reporting.

CDC, in collaboration with the Council of State and Territorial Epidemiologists (CSTE), updated the [Case Report Form \(CRF\)](#) in May for COVID-19 cases (first implemented on February 24). CDC developed the CRF to standardize the reporting of information on COVID-19 cases. The initial CRF included questions for sex, age, race and ethnicity and whether the case is part of a recognized outbreak. The revised form includes additional variables for populations that may be at higher risk for severe illness (e.g., tribes) and risk factors (e.g. homelessness, disabilities, and other factors).

CDC also modified existing surveillance systems to track COVID-19. The weekly surveillance report on CDC's website, [COVIDView](#), summarizes and interprets key indicators, including information related to COVID-19 outpatient visits, emergency department visits, hospitalizations, and deaths, as well as laboratory data. As part of our weekly reporting, CDC reported data on hospitalization rates and demographics as part of its

COVID-Associated Hospitalization Surveillance Network (COVID-NET) surveillance system since early March. COVID-NET also provides important clinical information on COVID-19-associated hospitalizations, including age group, sex, race/ethnicity and underlying health conditions.

CDC's National Healthcare Safety Network (NHSN) continues to support the nation's COVID-19 response with COVID-19 Modules for Long-Term Care facilities, including nursing homes. Key indicators are confirmed and suspected COVID-19 cases and deaths among residents and staff, ventilators in use, and shortages of healthcare personnel and personal protective equipment (PPE), which provides a better understanding of the burden of disease in nursing homes and enhances the nation's ability to combat COVID-19 this high risk healthcare setting. Specifically, this information is used to strengthen COVID-19 surveillance locally and nationally; monitor trends in infection rates; and help local, state, and federal health authorities get help to nursing homes faster. Without the nursing home data, the nation would have no actionable, standardized information about the burden or needs of nursing homes in the pandemic. Prior to July 15, CDC's NHSN also had COVID-19 Modules for Acute Care, Long-Term Acute Care, Inpatient Rehabilitation, and Inpatient Psychiatric facilities. Effective July 15, 2020, hospitals will report COVID-19 capacity, staffing, and supply-related data to HHS. CDC is committed to working with HHS to report publicly on COVID-19 hospitalizations.

Because of the delay in COVID-19 diagnoses due to the long turnaround time for laboratory testing, CDC's National Syndromic Surveillance Program (NSSP) is working with state and local health departments to monitor for COVID-like Illness (CLI) in patients seen in emergency rooms. NSSP receives data from over 70% of emergency departments nationwide and has been an early warning system for COVID-19 trends for state and local governments. CDC is able to monitor for CLI based upon de-identified reports shared by health departments.

CDC has worked with the six largest commercial laboratories in the United States to compile COVID-19 laboratory results from across the nation. This effort was particularly important early in the response to track COVID-19 testing volumes and percent positive by jurisdiction. CDC is coordinating with and providing technical assistance in every state to send individual-level laboratory data for all COVID-19 testing in order to provide a national view of COVID-19 laboratory results.

CDC's National Center for Health Statistics oversees the National Vital Statistics System (NVSS) that is tracking COVID-19 related mortality through examination of cause of death found on death certificates. NVSS represents crucial information regarding the most important outcome of COVID-19-related illness, death. CDC is analyzing risk factors for COVID-19 related death which will help focus disease mitigation measures moving forward.

On Thursday, June 04, HHS released new guidance related to laboratory result reporting specified in section 18115 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The new guidance covers entities required to report, methods for submission, required data elements, data reporting and transmission requirements, and recommendations for capturing laboratory data in electronic health records. This guidance requires healthcare providers that order a laboratory test to include complete demographic information such as race, ethnicity, and sex and requires data to be collected through “ask on order entry” (AOE) questions, which include asking whether the patient is symptomatic, hospitalized, employed in healthcare, or a resident in a congregate care setting beginning August 1, 2020. These data are to be coded into Electronic Health Records or Laboratory Information Management Systems. CDC is working with and providing technical assistance to public health and commercial laboratories to add these new data elements in the test results being reported.

- **Question:** Is there any science that informs us as to what percentage of the population needs to be tested and their information traced, if necessary, before we know that we are really in a healthy mode as opposed to a lulling off of a curve simply because of the few numbers that we are testing? What is the percentage of the population that should be tested?

RESPONSE: On May 24, 2020, the Secretary of Health and Human Services (HHS) submitted a Report to Congress on COVID-19 Strategic Testing that outlines efforts to increase testing nationwide. Testing is a critical component of the public health response to SARS-CoV-2 (the virus that causes COVID-19). It enables clinical decision making, informs resource allocation and disease prevalence monitoring, and is necessary to minimize economic and community disruption through targeted infection prevention and control measures. Testing a majority of the U.S. population, recurrently, is neither feasible nor necessary to assure safe return to work, school, and other activities. In fact, a targeted strategy based on diagnosis, contact tracing, and smart surveillance is the optimum approach – especially when combined with syndromic surveillance and hygiene interventions. HHS recommends that all states have an objective of testing a minimum of two percent of their population, pending additional new data on infections and impact of reducing mitigation.

To support states in carrying out these strategic testing initiatives, in May, CDC awarded a total of \$10.25 billion to states, territories, and localities through the Paycheck Protection Program and Health Care Enhancement Act on behalf of HHS. This funding is to be used to implement each jurisdiction’s testing plan. Each funded state or jurisdiction is required to submit a specific testing plan to the HHS, guided by ongoing technical assistance from HHS. Plans for May and June were due to HHS on May 30, 2020, and plans for remainder of 2020 were due on July 10, 2020. Plans are required to detail how a minimum of two percent of the state’s population will be tested each month beginning immediately; as well as plans to increase that number by Fall 2020.

By September, the Federal government projects that the U.S. will be capable of performing between 40 and 50 million tests per month. This estimate includes approximately 25 million point of care tests, including new SARS-CoV-2 antigen tests. HHS will re-evaluate goals and objectives for the remainder of 2020 based on the testing plans developed by States, as well as the ongoing epidemiology of COVID-19. HHS will continue to aggressively support and conduct programs such as Rapid Acceleration of Diagnostics (RADx) (www.nih.gov/research-training/medical-research-initiatives/radx) to accelerate the development and commercialization of new COVID-19 diagnostics for the fall, which could add to this overall number of tests – or improve the performance of the testing at this numeric level.

Estimates about how many tests are needed vary widely based on assumptions, such as the prevalence of active cases, the number of contacts per case, the effectiveness of mitigation in the community, and the sensitivity of the assays to detect cases. Diagnostic testing, contact tracing, and surveillance testing are the most critical components of the immediate federal testing strategy. The specific number of tests that are required in each state, and in each geographical region within each state, depends on numerous factors, including but not limited to:

- **The percent positives in a state, territory, or tribe:** The World Health Organization (WHO) set an objective that the percent of tests being positive should be 10 percent or lower, demonstrating that 10 times as many people are being tested as have the disease. This indicates enough testing exists to ensure broad coverage of the population. While the amount of testing needed in a community is situational (based on geography, transmission, vulnerable populations, etc.), but in general, achieving this benchmark begins to ensure rapid diagnosis of symptomatic and asymptomatic individuals.
- **The characteristics of the population:** Areas with large numbers of individuals at high risk of contracting or transmitting the virus, or who may be highly vulnerable for having poor outcomes, will require increased surveillance testing.
- **The degree of mitigation employed in that community:** Mitigation strategies such as social distancing help control the spread of disease. In areas where mitigation strategies are strictly implemented, there will be less contact tracing needed and less concern of spread to vulnerable populations. When mitigation measures are relaxed, the number of social contacts will increase, as does the potential risk of infection, making widespread testing and early warning more critical than during full community mitigation.

- **Question:** Explain your plans for a massive vaccination campaign. What activities/plans are already in the works? What activities? What are the funding requirements for both influenza and a future COVID vaccine?

RESPONSE: Each year through the Vaccines for Children program and the section 317 immunization program and in partnership with state immunization programs, CDC safely

distributes over 80 million doses of vaccines from every vaccine manufacturer to approximately 40,000 public and private health providers across the country. We have strong networks connecting public health departments, health care providers, community groups, and others that can be used to efficiently reach the population. During an emergency, CDC has a proven system that can be scaled up and expedited to manage and distribute many additional doses of vaccine.

CDC has worked for decades with its state and local partners to ensure public health systems are prepared with plans, trained personnel, strategic relationships and partnerships, data systems, and other resources needed for sustaining a successful routine immunization infrastructure, which will help ensure effective distribution can occur once a safe and effective COVID-19 vaccine is available. CDC is working closely with our government partners in response to this pandemic, including with our sister agencies at HHS.

As we expect SARS-CoV-2 to continue to circulate in fall, CDC is working to increase seasonal flu vaccination coverage, particularly for populations most at risk. Increasing flu vaccine coverage is an important public health goal in its own right, but also serves to reduce the strain on the health care system that will be facing COVID-19 at the same time as seasonal influenza. CDC is enhancing communications to target special audiences, including older Americans, people of any age with underlying health conditions, workers in long-term care facilities, other essential workers, African Americans, and Hispanics. Understanding that African American and Hispanic communities have lower rates of flu vaccination and a higher risk for COVID complications, we will enhance our education and communication efforts toward these key communities.

In addition, CDC's Vaccinate with Confidence (<https://www.cdc.gov/vaccines/partners/vaccinate-with-confidence.html>) framework aims to strengthen public trust in vaccines and prevent vaccine-preventable disease outbreaks. The framework emphasizes three key priorities: protect communities, empower families, stop myths. CDC is working with local partners and using trusted messengers, to establish new partnerships and contain the spread of misinformation.

Vaccination will be a complex effort, because once available it will be an entirely new vaccine that will require broad distribution . The Department of Health and Human Services, working through Operation Warp Speed, continues to assess and adjust plans as necessary, including plans for financing these efforts. Some variables that will impact cost and planning are unknown until the vaccine is licensed or granted Emergency Use Authorization.

- **Question: Given the President wanting to break from WHO, are you worried about our impact to develop a vaccine?**

Response: The United States is, and will continue to be, a leader on global health issues, whether or not we are a WHO Member State. The United States is leading on the research and development of vaccines, diagnostics and therapeutics to combat COVID-19 and will work with our partners to exchange information and understanding.

The United States is focused on developing a safe and effective COVID-19 vaccine through Operation Warp Speed. Among its other objectives, Operation Warp Speed aims to have substantial quantities of a safe and effective vaccine available for Americans by January 2021. The federal government is making investments in the necessary manufacturing capacity at its own risk, giving firms confidence that they can invest aggressively in development and allowing faster distribution of an eventual vaccine. In preparation for the US withdrawal from WHO effective on July 6, 2021, we are continuing to review all collaborations with WHO to determine if there are certain activities that only WHO can undertake, and if this is the case, decisions will be made about how to address each situation on an individual basis.

TUESDAY, DECEMBER 8, 2020.

**THE IMPACT ON WOMEN SEEKING AN ABORTION BUT
ARE DENIED BECAUSE OF AN INABILITY TO PAY**

WITNESSES

**HERMINIA PALACIO, PRESIDENT AND CEO, GUTTMACHER INSTITUTE
JAMILA PERRITT, PRESIDENT AND CEO, PHYSICIANS FOR REPRODUC-
TIVE HEALTH**

**AMANDA BEATRIZ WILLIAMS, EXECUTIVE DIRECTOR, LILITH FUND
CHRISTINA BENNETT, COMMUNICATIONS DIRECTOR, FAMILY INSTI-
TUTE OF CONNECTICUT**

Ms. DELAURO. Good morning.

The hearing will come to order. Let me just say a thank you to all of the members for joining us today. Given the virtual environment, I am going to ask unanimous consent that the chair be authorized to declare a recess at any time to address technical difficulties that might arise with such remote proceedings.

Unanimous consent, so ordered.

I will proceed. Before we start the hearing, I have been asked to do a few housekeeping points as well. We are holding the hearing virtually, as in compliance with the regulations for committee proceedings pursuant to House Resolution 965. Consistent with the regulations, the chair or staff designated by the chair may mute participants' microphones when they are not under recognition for the purposes of eliminating inadvertent background noise.

Members are responsible for muting and unmuting themselves. We are not permitted to unmute members unless they explicitly request assistance. If I notice that you have not unmuted yourself, I will ask you if you would like the staff to unmute you. If you indicate approval by nodding, staff will unmute your microphone. They will not unmute you under any other conditions.

To ensure that committee members are given the opportunity to question each witness, we will have two rounds of questions after witness testimony has concluded. Each member of the committee will be given 5 minutes to question the witnesses. We will proceed in the order of committee seniority, alternating between the majority and minority.

Finally, for the committee, we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings or mark-ups, including documents to be inserted in the record by unanimous consent, amendments, motions, and other unanimous consent requests, and so on. The email address is Houseappropriations.submissions@mail.house.gov. That information has been provided to your staff, so not to worry if you didn't get it down.

Let me just thank you for your patience and your understanding as we navigate the technology and the platform. I think I get more

nervous about all the instructions that we have to follow as much as the content or, you know, of any of our hearings. I want to make sure it is right and that everyone gets their opportunity to be able to communicate and to participate.

So are there any questions?

If not, let's go.

As I said, the subcommittee will come to order.

Good morning to all. Let me welcome our witnesses today. We are going to examine the impact on women seeking an abortion but are denied because of an inability to pay. *Roe v. Wade* is the law of the land, but for too long some women in this country have been denied their right to an abortion. The Hyde amendment is a discriminatory policy, and for more than 40 years, it has been routinely extended every year as a legislative rider, but the time has come in this current moment to reckon with the norm, with the status quo, view it through the lens of how it impacts communities of color.

Connecticut's Medicaid program has covered abortion services using State funding since 1986, based on the Connecticut Supreme Court decision. To date, that decision has never been appealed. Eight other States provide funding for abortion pursuant to a court order, while seven fund abortions voluntarily are all using State dollars. However, 33 States and the District of Columbia deny State funding to women seeking access to abortion.

As a result, the millions of economically insecure women in these States are hostage to their geography. For the women in these States covered by Medicaid, the Hyde amendment has a tremendous impact on their economic, mental, and physical well-being. We know that, without insurance coverage of abortion, a legal healthcare procedure, they face costs of more than \$500 on average but can exceed a thousand dollars depending on where they live and the type of abortion.

This does not include out-of-pocket expenses like childcare, time off from work, and travel. These costs are prohibitive for too many women. One study found even a State like California that uses its own funds to provide coverage, because these providers are typically concentrated in urban areas, rural patients have had to travel more than 50 miles to obtain an abortion.

A study published in the January 2020 edition of the American Journal of Public Health found that more than 75 percent of requests to an online telemedicine abortion service hailed from States with hostile restrictions, including the Hyde amendment, with cost being the most common barrier.

The landmark Turnaway Study, led by Dr. Diana Greene Foster, a demographer at the University of California, San Francisco, who evaluates the effectiveness of family planning policies and the effect of unintended pregnancy on women's lives, found that women's health and well-being suffered serious consequences after being denied a wanted abortion. This was the largest study to examine women's experiences with abortion and unwanted pregnancy in the United States with the goal—with the goal—to understand mental health, physical health, and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term.

And it found the following: For women denied an abortion despite wanting one because it was the right decision for themselves and their families, women being forced to carry an unwanted pregnancy to term are four times more likely to live below the Federal poverty level. Women are more likely to experience serious complications at the end of their unwanted pregnancy, including eclampsia and death, contributing to the maternal mortality rate in this country that should be embarrassing and unacceptable to everyone participating today.

These women denied an abortion are more likely to stay with an abusive partner. These women who were denied a safe and legal medical procedure are more likely to suffer anxiety, loss of self-esteem, and less likely to have aspirational plans for their futures after being denied an abortion. Finally, the Turnaway Study found that being denied has serious implications for the existing children in the family.

And who is being harmed the most by the Hyde amendment and being forced to continue unwanted pregnancy? More than half, 58 percent of the women affected by the Hyde amendment are women of color; almost one-third, 31 percent, are Black; 27 percent Latina; nearly one-fifth, 19 percent, Asian Americans and Pacific Islander women, as well as indigenous women also covered by Medicaid.

While the Labor, HHS, Education bill has carried the Hyde amendment every year since 1976, this is the last year. The inequities in our country's healthcare system that have been exposed by the COVID-19 pandemic all further expose the impact of the Hyde amendment. All of these issues deny the humanity of people of color and their ability to do well for their families and their communities.

Now is the time to empower all women to be able to make deeply personal life decisions without politicians inserting themselves into the doctor's office to ensure that, regardless of geography, all women are treated fairly and equally, and to improve women's health.

I thank everyone for being here today and for lending your expertise. And before I turn to our witnesses, however, let me turn to my friend, the ranking member of the subcommittee, Ranking Member Tom Cole, for any remarks that he would like to make. My colleague, Congressman Cole.

Mr. COLE. Well, thank you very much, Madam Chair.

Let me begin with a few personal remarks before I get to my prepared remarks. I want to thank the distinguished chairwoman of the full committee for joining us as she so frequently does. Today this may well be her last appearance with our committee as our full chairman, and we all admire her as our leader and appreciate her as a friend and know that she has had a special place in our hearts for the Labor, Education Subcommittee throughout her tenure, and we do notice that, Madam Chair, in our allocation, and so we are grateful.

But I would also be remiss if I didn't start by congratulating you on your ascension to the position of full chair of the Appropriations Committee in the next Congress. You know, the great British statesman Benjamin Disraeli, when he finally became Prime Minister after a long career told his colleagues that he had gotten to

the top of the greasy pole. Well, you have gotten to the top of the greasy pole of the Appropriations Committee, and we should all remember that is quite an achievement. Not very many appropriators—and we have a distinguished subcommittee here, and I think we have a very distinguished committee—ever reach the level that you have reached.

You are the second woman to ever do that after our trailblazing Chairman Nita Lowey, and I think this is actually—while you will forgive me, I would prefer a Republican majority to a Democratic majority, but if we are going to have a Democratic majority—we are—I couldn't think of a better person to chair this subcommittee or, excuse me, chair the full committee. And I say that for a couple of reasons.

First, I have had the opportunity to work with you as both chairman and ranking member. I am very proud when I was chairman on four occasions when we finally got to the final negotiation with our colleagues in the Senate, we were able to vote together for the passage of the bill after we had made the appropriate compromises. I was very proud last year to be able to vote with you on your very first bill, and as I know members of this committee know, you and I are working with our colleagues Senator Blunt and Senator Murray right now in the hope that we can achieve a bill that all of us can, once again, vote for in a bipartisan matter and move ahead.

So, while we belong to different parties and we certainly disagree pretty sharply on some issues, you have always been someone who has been willing to work together and find common ground, and I know you will continue that characteristic in your role as the full committee chair.

A second reason why I am happy is I really do know who your favorite subcommittee is going to be. So I think that is good news for all of us on this subcommittee. And I don't presume to know what role you will take as the chairman of the full committee, but, again, I know we will always be close to your heart and in your thoughts as you make the decision for the full committee.

So thank you for that, and, again, Madam Chair, and soon to be chair of the full committee, congratulations on a well-earned honor.

And to my Democratic colleagues, I congratulate you on your good judgment. You had several excellent candidates, I know, but you picked, in my view, the absolute best person for the institution and certainly for our committee. I could not be more pleased.

Madam Chair, you have chosen in this hearing to pick a pretty contentious topic for us to deal with and an important topic, but a topic that not likely to see much change of position on either side and that, of course, is your prerogative, and I respect that. But I am going to be fairly forceful in my statement because, just as you feel strongly about this issue, so do I, so do many of the colleagues on my side of the aisle.

So I am proud to have the opportunity today to publicly state my unwavering support of the Hyde amendment. This language, named for its original sponsor, the late Congressman Henry Hyde, prevents Federal taxpayer dollars in the Labor, Health, and Human Services Appropriations bill and the Federal contribution to the Medicaid program from being used to pay for abortions with limited exceptions to save the life of the mother or in very difficult

circumstances of a pregnancy that result from an act of rape or incest.

It is estimated that this provision has saved the lives of over 2 million people since it was first adopted in 1976, most of them people of color. Before the enactment of this provision, the Federal Medicaid program was paying for nearly 300,000 abortions annually. The Hyde amendment has been included in some form in every appropriations bill for almost 45 years. It has enjoyed bipartisan support every year regardless of which party held the White House, the House, or the Senate.

During the Obama administration, President Obama maintained the Hyde amendment in each one of his budget proposals. As recently as last year, then-Vice President Joe Biden expressed his support for the Hyde amendment. Sadly, he seems to have abandoned that long-held position just this year.

The majority of the American people, however, including the majority of low-income women, also support the Hyde amendment. Even most people who identify themselves as pro-choice on abortion issues don't want their taxpayer dollars to be used to pay for someone else's abortion. The Hyde amendment protects the conscience rights of the great majority of Americans who are opposed to publicly funding abortions for religious, moral, or simply fiscal reasons. Hyde leaves the people and the legislators of all 50 States free to provide State funds for abortion if they wish. In fact, most States have voluntarily decided to follow Hyde's policy, sometimes by a direct vote of the people.

Rescinding the Hyde amendment would impose a pro-abortion funding policy on States that have decided against it. Hyde allows States to choose whether or not to fund elective abortions with taxpayer dollars, and the people and elected representatives of 34 States have voluntarily chosen not to do so. Without the amendment, abortion would likely become just another basic service that all States must fund as a requirement to participate in the Medicaid program.

Finally, I want to address head on what I believe is perhaps the most insidious falsehood about the Hyde amendment, and that is that free abortions are necessary to help low-income women and women of color succeed in this country. Most Americans who support the Hyde amendment believe that an abortion is the intentional destruction of innocent human life. It is not healthcare for women. Refusing to cooperate with or pay for the destruction of someone's child is not an action against that person, but for them and their community. Americans should want life for poor women, women of color, and all women and their children.

As stewards of the Federal tax dollar, we cannot and should not participate in encouraging a choice for taxpayer-subsidized abortion. Women of color and all women deserve resources, such as prenatal care, well baby care, and more childcare options and support to enable them to fully care for their children.

These are policies I support as chair of this subcommittee and as ranking member and will continue to support as long as I am in public office. Put simply, abortion capitulates the despair and says there is no hope for the woman as a mother or for the child. Supporters of abortion should also question whether the promotion of

abortion is itself structurally racist since it disproportionately affects people of color and substantially reduces births of women of color to a much greater extent than births of White women.

For example, Planned Parenthood, which operates the largest chain of abortion clinics in the United States, disproportionately locates them in or within close walking distance of minority neighborhoods.

Finally, Black women are disproportionately represented in the Medicaid population, and their abortion rate is over three times that of White women. Ending the Hyde amendment and providing State-funded abortions to low-income women will mean more Black lives lost. Especially at this time when our country is facing some very difficult and appropriate conversations about how groups have been treated in the past and continue to be treated today, we need to be advancing public policies that support women of color and their families, and not policies that end the lives of the unborn.

Let me make a final point, Madam Chair, if I may, and that is political reality. I don't think opinions on this issue are likely to change, and should the Hyde amendment be removed from the Labor, Health and Human Services Appropriation bill, I think it would be very little Republican support for it in either the House or the Senate. And particularly in the Senate, it looks, no matter what happens in Georgia, as if the filibuster rule is likely to be maintained, given the statements of Democratic Senators.

So I would see this as an effort that is not likely to bear fruit in the next Congress, although, again, I respect your prerogative as chairman certainly to hold a hearing on whatever matter that you think is appropriate.

And before I close, I want to especially thank our witness, Christina Bennett, for speaking to us today. Christina has a powerful story to tell, and she has a voice for many who have no voice.

Christina, I look forward to our discussion today and thank you for coming before us.

With that, Madam Chair, again, congratulations to you for becoming our chair. For our current chair, thank you for being with us, once again. We have always been your favorite, just as we will be the next chairman's favorite. And I yield back the balance of my time.

Ms. DELAURO. Thank you so much, Ranking Member, and, in fact, I think you hit a true note in, you know, knowing my love for this subcommittee, as it was for my predecessor here. So, and I think that was true of David Obey, as well, a while back, et cetera.

But let me just say thank you to you.

And while you pointed out that we do, you know, disagree and we disagree on the content of today's hearing, let me just say, I just treasure—and I mean this very sincerely—our friendship as we go forward because it is so important, especially now in these times, to look at how we are going to help this country survive a pandemic, the biggest economic and healthcare crisis that we have faced in a generation. And our ability to do that depends not on how much we disagree but how much we can agree to move forward on, and I think that we have that great opportunity within this subcommittee and with the Appropriations Committee at large.

And it is the greatest honor of my career to have been elected to serve in this position. And as we all know, when your peers put their faith and their trust and their confidence in you, there is no higher accolade. They are the people who know you best, who watch you under good circumstances and bad circumstances, but they concluded this, and I could not be a happier, and I thank you for your very, very beautiful remarks.

So, with that, I want to extend to our witnesses this morning a very, very warm welcome. We have Dr. Herminia Palacio, who is president and CEO of the Guttmacher Institute and was Deputy Mayor for Health and Human Services for the city of New York.

Dr. Jamila Perritt, president and CEO of Physicians for Reproductive Health and a fellowship-trained board certified OB/GYN practicing in Maryland, Virginia, and the District of Columbia.

Ms. Amanda Beatriz Williams, executive director of the Lilith Fund.

And Ms. Christina Bennett, communications director of the Family Institute of Connecticut.

We will hear testimony momentarily, but first up, there has been a significant interest from advocacy groups to submit letters or statements for the official hearing record. I have spoken with Ranking Member Cole, and we have agreed to leave this hearing record open for 24 hours to accommodate this interest in submitting letters or statements for the record.

And before we proceed with our witnesses, Congressman Cole, you aptly noted that today is our dear friend Nita Lowey's, the chair of the full Appropriations Committee, what will be her last Appropriations hearing. And for me, personally, I have had the unbelievable value and closeness of her friendship over these years.

Along with Speaker Pelosi, Nita Lowey and I have always been plotting ways to advance women's health, and a lot of progress we have made for women through Federal spending bills started with a side conversation. Congresswoman Lowey's legislative director, Dana Acton, recently found a letter sent by Congresswoman Lowey, a Congresswoman at the time, Pelosi, and myself to the then-President Bill Clinton from February 1, 1994, urging him to submit a budget that is completely unencumbered by the Hyde amendment. This letter came 7 months after a vote to repeal the Hyde amendment failed in which Congresswoman Lowey is quoted in The Baltimore Sun saying, and I quote, "It certainly wasn't a great day; in fact, it was most nasty and unpleasant," end quote.

The fight for reproductive rights in the Congress has not been without its ups and downs, victories and defeats, but Congresswoman Nita Lowey has never stopped working to ensure that women have access to reproductive healthcare. She is responsible for saving the Title 10 Family Planning Program that millions around the country rely on.

In 1996, when the Republican budget eliminated it, Nita Lowey sprang into action. She created an ad hoc bipartisan whip team. She saw an attack on reproductive health and an attempt to deny access to the people who need it the most. She stood up. She acted. And she won. Congresswoman Lowey's leadership, her grit, her determination, and her ability to build a consensus across the aisle saved this critical program.

And, next year, when the Labor, Health and Human Services, Education Appropriations bill for fiscal year 2022 is released without the Hyde amendment, it will be in large part due to my dear friend, our dear friend, Congresswoman Nita Lowey.

I am honored to have worked under the auspicious leadership of a path-maker, path-breaker, and a change-maker. And I know that I have large shoes to fit next year beyond the critical work we have done together, which has been an unbelievable honor, Nita.

Nita Lowey is more than a colleague or a friend; she is family.

And I would now like to turn it over to our distinguished chairwoman for any opening remarks that she may have.

Congresswoman Nita Lowey.

The CHAIRWOMAN. Well, what can I say to my dear friend, the chair, Rosa DeLauro and my dear friend, my good friend for so long, Ranking Member Tom Cole, for your work and your dedication to this subcommittee. It really is bittersweet that this will be my last hearing in Congress. Early in my career, I had the privilege of chairing the Pro-Choice Caucus back when it was bipartisan.

I have been fighting for reproductive rights and combating the Hyde amendment for decades. In fact, as my dear friend Chair DeLauro referenced, my staff recently came across the letter from 1994 to then-President Clinton signed by my sisters on this subcommittee, Representative Rosa DeLauro, Nancy Pelosi, and myself, urging him to submit a budget completely unencumbered by restrictive Medicaid abortion language. That letter could be written today.

Sadly, that is because the Hyde amendment and other restrictions on access to reproductive healthcare continue to attack the dignity of low-income Americans. The Hyde amendment has created two sets of rules: one for those with resources and one for those without. After more than 40 years, it continues to impose judgment and bully low-income women with a disproportionate impact on women of color.

In this subcommittee, we had debated the issue of reproductive rights at length. We could all probably recite the speeches our friends on both sides of the aisle make at markups, but more often than not, we talk past each other. We don't talk about what Federal policies mean for a woman sitting in a doctor's office with fear of the risk to her own health or financial security. We don't talk enough about how to help her. The truth is that woman has been discriminated against by the laws of her country just because of her income. That this continues to happen in 2020, in my judgment, is a disgrace.

Regardless of what we feel about the issue of abortion, it is well past time that we, as members of this great committee, discuss the harmful legacy of the Hyde amendment. We should listen to the experts and understand the harms and real-life consequences imposed by this rider.

It is my fervent wish that the next Congress will correct this historic inequity in women's healthcare and remove Hyde once and for all. It deserves to be in the dust pan of history with other policies that were designed to limit the rights of the powerless. I will be cheering you on.

So, before I close and say thank you, I just want to say that it is such a thrill for me to be turning over the head of Appropriations to my dear friend, strong advocate, principled leader, Rosa DeLauro. I know, I know she will continue to fight for the issues that we care about because not everyone may agree, but we feel we are on the right side of history.

And I do want to say to my dear friend Tom Cole, we have worked together a very, very long time, and although we may disagree on this issue and a couple of other issues, I have such respect for Tom Cole's intellect, his character, and his determination to fight for what is right.

So, Tom, I do love you, and I do appreciate your leadership, and for me, it has been an honor to serve on this committee with you and Rosa DeLauro, and I do wish you both, of course, first of all, good health, strong advocacy, and we all keep fighting for what we believe is right. That is what this is all about.

So I expect that some of us differ on this issue. Others differ on other issues. But we have all had for the past years—I have been here 32 years; I can't even believe it, Rosa and Tom. We all are determined to fight for what is right. So, for me, I want to wish my dear friend as chair, Rosa DeLauro, and my dear friend Tom Cole, the ranking member, good luck, good health, God speed. Thank you for giving me the opportunity to say a few words. I love you both, and I love this committee.

Ms. DELAUBRO. You will always be a member of this committee, Nita, and you will always be in touch. I know. You are not walking away. You are not going away. And we need your advice and counsel.

So, with that, let me just move to our witnesses this morning. Again, I extend a very warm welcome to you, and we will proceed in this order: Dr. Herminia Palacio, Dr. Jamila Perritt, Ms. Amanda Beatriz Williams, and Ms. Christina Bennett.

Dr. Palacio, please.

Dr. PALACIO. Thank you very much, Chair Lowey. Good morning, Chair DeLauro, Ranking Member Cole, and members of the subcommittee, I appreciate the opportunity to testify on this important issue.

My name is Dr. Herminia Palacio. I am the president and CEO of the Guttmacher Institute, a nonprofit research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally. Guttmacher has collected and analyzed U.S. abortion data for more than 50 years and has tracked State abortion policy since the early 1970s.

I also bring 30 years of public health and healthcare experience, including 15 years practicing medicine in San Francisco during the height of the HIV/AIDS epidemic. My patients experienced first-hand how supportive or how oppressive Federal and State policies could be with respect to their sexual health, reproductive autonomy, and healthcare access.

Today, I will highlight three main points backed by science and evidence. First, abortion is a healthcare experience shared by many people. Abortion patients include people of every race, religion, political affiliation, and socioeconomic group. And the majority are already parents. One in four cisgender women in the United States

will have an abortion in their lifetime. Likewise, trans men and gender nonconforming individuals require access to the full range of pregnancy-related care. Overall, 75 percent of abortion patients in the United States are low income, and the majority are people of color, which brings me to my second point.

The harmful burdens of the Hyde amendment are intentionally and unjustly imposed on Black and Brown people and on people with low incomes; in other words, on people who have been historically marginalized. Across 34 States and the District of Columbia, the Hyde amendment leaves 7 million women who are already struggling financially without abortion coverage.

On average, an abortion at 10 weeks costs around \$550, which could be somebody's entire rent payment. And the cost increases over time. Contrast that with the fact that, even before the current recession, 37 percent of Americans said they would struggle to cover an emergency expense of \$400 for any purpose.

Because of the legacy of systemic racism in this country, Black and Brown women are disproportionately likely to be insured through Medicaid. Thirty-one percent of Black women and 27 percent of Hispanic women aged 15 to 44 are enrolled in Medicaid, compared with 16 percent of White women.

As our country undergoes a racial reckoning, I want to be very clear: the Hyde amendment is a racist policy. My final point centers on the evidence demonstrating the serious and long-lasting consequences of withholding abortion coverage. Many people with low incomes experience delays in accessing abortion care because of the time and effort needed to pull together funds. People get caught in the cruel cycle in which delays associated with raising the money leads to additional costs and subsequent delays. A literature review conducted by Guttmacher concluded that among women with Medicaid coverage subject to the Hyde amendment, one in four who seek an abortion are forced to continue the pregnancy. Forcing someone who wants an abortion to continue a pregnancy is not only a violation of their reproductive autonomy; it is tantamount to requiring them against their wishes to accept the risk of pregnancy and labor-related complications, including preeclampsia, infections, and death.

The United States has the highest maternal mortality rate among developed countries with dramatic but preventable racial inequities. Black and indigenous women's mortality rates are two to three times that of White women. I ask you to reflect on these overlapping and perverse indignities. The Hyde amendment disproportionately withholds abortion coverage from Black and Brown communities, a potential consequence of which is being forced to continue pregnancy in a system in which Black and indigenous people are astonishingly more likely to die.

Moreover, the risks of consequences do not end with a safe delivery. As the chairwoman pointed out, the Turnaway Study by researchers at the University of California, San Francisco, found that women who don't attain a wanted abortion have four times the greater odds of subsequently living in poverty and three times greater odds of being unemployed. In addition, women experience intimate partner violence. Being forced to carry an unwanted preg-

nancy to term can delay separation from their partner, resulting in ongoing exposure to violence.

In sum, the Hyde amendment has been unjust and harmful from the very beginning. Congress, starting with this subcommittee, has both the opportunity and ethical imperative to lead toward reproductive justice, beginning with this first step of eliminating the Hyde amendment.

I thank you for this opportunity and look forward to answering your questions.

Ms. DELAUBRO. Dr. Perritt.

Dr. PERRITT. Thank you. Good morning. And thank you Chairwoman Lowey, Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee. I am here today on behalf of the people I care for in the community I serve every day, people profoundly impacted by insurance coverage barriers like the Hyde amendment.

My name is Dr. Jamila Perritt. I am a board-certified, fellowship-trained, obstetrician and gynecologist. I am here today to talk with you about my patients. Whether they are ready to build a family or are already parenting or focus on their education or career, the patients I care for share something in common: They are all making thoughtful, sometimes difficult decisions about their health and well-being, and all deserve high-quality care.

As the subcommittee is aware, annual appropriation bills include harmful bans on coverage for abortion care, including the Hyde amendment. Hyde-like restrictions have also been added for groups including Federal employees and people serving in the military. The Hyde amendment is discriminatory. It disproportionately harms people of color, young people, and those living in rural areas. I am not a legislature, but I am a doctor, and I take care of real people who are not able to get the care they need and deserve because of this discriminatory legislation.

As was mentioned in the introduction, I live and provide care in the District of Columbia, which is prevented from covering abortion even with our own local revenue, unlike other States. As an OB/GYN, I see what happens when women don't have access to services because they lack coverage and cannot afford to pay. Abortion care is no different. The Hyde amendment denies my patients the ability to make decisions about their bodies and their pregnancies because of where they live and how much they make.

More than 177,000 people in the District are Federal employees. This is 7.56 percent of the Federal workforce, and they too lack coverage for abortion. For those living paycheck to paycheck, the cost of reproductive healthcare and additional expenses, like childcare, transportation, and time away from work, can be insurmountable. They are placed in the untenable position of deciding whether to pay their bills or pulling together the resources to access the care that they need, or they may forego an abortion all together and carry an unwanted pregnancy to term.

This outcome is not insignificant. As you have heard, the Turnaway Study that was mentioned previously identified serious consequences when people were denied the abortion care they were seeking: a greater likelihood of living in poverty, more likely to experience pregnancy complications, to stay tied to abusive partners,

and to suffer mental health effects. Withholding coverage continues to perpetuate a two-tiered system of healthcare dictated by one's income, socioeconomic status, and Zip Code.

In the four decades of the Hyde amendment, we have seen worsening health inequality for Black, indigenous, and other people of color in this country. Healthcare disparities, manifested by a lack of accessible, preventive care, like contraception, preconception care, and other preventive health measures work to maintain these inequities for women of color while rates for other communities continue to fall.

For my entire career, the Hyde amendment has been used to intentionally limit my ability to give patients the care that they need. I must be clear today in saying abortion is healthcare. Insurance coverage of abortion should be comparable to other essential health services, and abortion should not be singled out for exclusion or have additional burdens placed upon it.

The American College of Obstetricians and Gynecologists, ACOG, has identified abortion as an essential health service that requires timely access to care. ACOG also recommends the elimination of abortion coverage restrictions to ensure that all people, regardless of socioeconomic status, have access to care. Many factors influence a person's need to have an abortion. These influences are valid and people should be able to access this care without unjust policies creating insurmountable barriers.

I took an oath to provide compassionate care. Coverage bans like the Hyde amendment stand in the way. What I want us all to understand is that no one is making decisions in a vacuum. Our lives are intersectional, our identities and experience factor into decisions around contraceptive use, pregnancy, and abortion.

Organizers and advocates, reproductive justice leaders who are carrying this work forward every day know what I am telling you: coverage restrictions like Hyde harm patients. Lawmakers have an opportunity today to take steps, steps that are necessary to ensure all people are able to access the care that they need, regardless of where they live or how much money they make.

I urge you to do so. My patients and, more importantly, our communities deserve it.

Thank you for your time.

Ms. DELAURO. Thank you. Ms. Williams.

Ms. WILLIAMS. Yes, thank you. Good morning, Chairwoman DeLauro, Ranking Member Cole, and members of the committee. Thank you so much for having me before you today to speak about the impact of policies that deny insurance coverage for abortion, including and especially the Hyde amendment.

My name is Amanda Beatriz Williams, and I am a queer Tejana and daughter of an immigrant with a decade of experience in the reproductive health, rights, and justice movement in Texas. I serve as the executive director of the Lilith Fund for reproductive equity, the oldest abortion fund in Texas. Abortion funds exist to help people navigate the intricate web of antiabortion restrictions, including abortion coverage bans like the Hyde amendment that prevent people from obtaining safe abortion care.

Lilith Fund provides direct financial assistance and emotional support to those in the central and southern regions of Texas and

is one of 10 abortion funds serving our State. I am also a proud storyteller with We Testify, an organization dedicated to the leadership and representation of people who have abortions, to change the conversation to one of compassion and remind us that everyone loves someone who had an abortion.

However any of us feel about abortion, politicians should not be allowed to deny someone's health coverage for it just because they are struggling to get by. Unfortunately, that is exactly what Congress has done for the last 44 years through the Hyde amendment.

Across the country, the Hyde amendment has had devastating impacts for people unable to make ends meet, who are more likely to be women of color, LGBTQ people, immigrants, and young people. And for too many, coverage bans like the Hyde amendment can act as de facto bans on abortion altogether. At Lilith Fund, we know firsthand the impact that coverage bans have on the Texans we serve. During the year 2019, 68 percent of Lilith Fund clients were people of color, 45 percent uninsured, 42 percent did not have paid employment, and they traveled an average of 158 miles to reach the abortion care they needed.

The harms of the Hyde amendment are further compounded by additional State restrictions, including State-mandated ultrasound, medically inaccurate and biased counseling, and a mandatory 24-hour waiting period that forces Texans to needlessly delay their care.

Since 2013, my State has also shuttered nearly half of its abortion clinics forcing people to travel far distances and shoulder additional expenses. In addition to affording the abortion care, there are costs for travel to one's nearest clinic, lodging for overnight stays, lost wages from missed work, and childcare for the nearly 60 percent of our clients who already have children.

On top of all of this, Texas restricts private insurance coverage of abortion forcing people to pay completely out of pocket. These unnecessary delays can take weeks forcing people to delay accessing care until later in their pregnancy. As the COVID-19 pandemic and economic fallout ravages Black, Brown, and indigenous communities, the same people impacted by the Hyde amendment are already marginalized by inequities in our healthcare system and systemic racism.

Antiabortion Texas officials also exploited the pandemic by banning abortion care in our State for nearly a month. During the first week of April when the ban was in effect, half of our callers were forced to travel out of State to receive their abortion care.

The average distance traveled by our clients in 2019 before the pandemic was 158 miles, about the distance from D.C. to Philadelphia, but during the pandemic when our callers were forced to travel out of State for their care, it increased to 635 miles, which is more than the distance from D.C. to Louisville, Kentucky.

Even before the COVID-19 pandemic, almost 40 percent of Americans did not have roughly \$400 saved to cover an unanticipated expense. For many of our hotline callers, expenses like groceries, rent, and childcare were already difficult to afford, but with so many losing their jobs this year, paying out of pocket for an abortion can be next to impossible. And I know this personally because the stress was all too real for me. When I was 19 years old

and a freshman at the University of Houston, I had an abortion. While my decision was clear, the path to coming up for the money to pay for my care was difficult and nerve-wracking. I was privileged enough to borrow money and make an appointment.

When I arrived for my procedure, I was overwhelmed by the kind support I received from clinic escorts, clinic staff, and my provider who all made me feel comfortable and safe. And I keep them in mind every time that we are able to help someone get the care that they need. Everyone having an abortion deserves to be met by people who support them and care for them in loving and respectful ways every step of the way, and we deserve to be trusted.

I also want to leave you with a story of another Texan, Rosie Jimenez, whose legacy we continue to honor in our work every single day. Rosie was a beloved mother of a young child, a student, and a young Chicana living in McAllen, Texas, in the late 1970s. Rosie was enrolled in Medicaid, but Medicaid did not cover an abortion at a clinic in her hometown due to the recently passed Hyde amendment. Instead, she sought a cheaper, unsafe procedure and ultimately died due to complications. Rosie became the first known person to die as a result of the Hyde amendment. And to be clear, Rosie died because of Hyde.

When each of us can make our own decisions about our reproductive health care, when we can forge families we love on our own terms, we have more control over our lives and our economic security. It is long past time to strip the Hyde amendment from Federal appropriations legislation and help ensure that everyone, whoever they are, wherever they live and however they get their insurance can get the abortion care they need safely and without political interference.

Thank you so much.

Ms. DELAURO. Thank you.

Ms. Bennett.

Ms. BENNETT. Thank you.

Greetings, Chairwoman DeLauro, congratulations.

Ranking Member Cole and members of the subcommittee, my name is Christina Bennett. I am the communications director for the Family Institute of Connecticut, a wife, mother, and a pro-life advocate for the past 15 years. I was born in 1981, a year after the Supreme Court reaffirmed the Hyde amendment. My mother faced intense pressure to abort leading her to schedule an abortion at Mount Sinai Hospital in Hartford, Connecticut. The kind words of an elderly Black janitor who asked, "Do you want to have your baby?" gave her the strength to keep me. Before she left, the doctor pressured her to go through with the abortion, reminding her that she had already paid for. When she insisted on keeping me, he yelled, "Don't leave this room." My mother wanted me, even though, she paid for an abortion. My mother represents women who have been coerced into abortion and received substandard care from medical professionals.

While working 4 years at a Connecticut pregnancy center, I served hundreds of women, some who were coerced by partners, kicked out of their homes, and left to continue with their pregnancies alone. For 44 years, the Hyde amendment has protected vulnerable women like the ones I have known. Since 1976, the

Charlotte Lozier Institute estimates the Hyde amendment has led over 2.4 million mothers to carry their pregnancies to term. An estimated 60,000 lives are here because of the protection of Hyde. One in every nine people born to a mother on Medicaid is here today because of the Hyde amendment, and the Hyde amendment has had 44 years of bipartisan support from Democrat and Republican legislators and voters.

A Marist Poll released in January of 2020 found that 60 percent, or 6 in 10, American voters oppose taxpayer funding of abortion. The Hyde amendment aids communities disproportionately impacted by abortion. So Black women are just 14 percent of the childbearing population; we are three times more likely to abort, and we make up over 36 percent of the abortions.

Repealing Hyde would lead to an increase in abortion in our community that already has high rates. Prior to Hyde, the Federal Government paid for an estimated 300,000 abortions yearly, accounting for roughly one-third of all abortions and forcing the cost of \$45,000,000 to \$55,000,000 million a year on taxpayers. Forcing taxpayers to fund elected abortions means low-income women of color will be prey for an industry that has been found guilty of overbilling Medicaid, accepting racially motivated abortion donations, selling fetal remains, manipulating medical claims to increase financial gain, as well as aiding sexual abusers.

It is irresponsible and unjust for a Federal Government charged with providing aid to those dependent upon them to encourage the termination of their offspring. What message does it send to a woman who lives in a State where Medicaid won't cover her yearly dental exam, but she can get a free abortion?

A recent poll found that 55 percent of low-income respondents said they specifically supported the Hyde amendment. Although the Turnaway Study is used to claim abortion as a benefit to women, Dr. Michael Newt exposes the study relies on poorly done surveys of a nonrandom sample in which nearly 70 percent of women refused to participate and half dropped out. Its findings are not statistically valid for a general population of U.S. women.

The Hyde amendment is accused of being racist, but it is not racist to preserve Black lives. Hyde protects women from an industry that is actually rooted in racism with a documented history of eugenics philosophy, population control, and the unlawful targeting of the Black community. This is why Planned Parenthood of Greater New York recently removed Margaret Sanger's name from their Manhattan building looking to separate themselves from a leader who targeted the Black community through her Negro Project, thus leading to 79 percent of abortion facilities being located in lower income minority neighborhoods. And former abortion workers have come forward to share stories of coercing women and being encouraged to reach abortion quotas.

If unacceptable practices are taking place, then why should this organization or those like it be trusted with additional taxpayer dollars? Black women, such as Cree Erwin, Lakisha Wilson, Tonya Reaves have died at the hands of the abortion industry, while others have been wounded like my dear friend Destenie, who spent 3 days in the ER after a Medicaid-funded abortion in Hartford, Connecticut, left fetal remains inside of her almost killing her.

Although abortion-related complications and death are under-reported, I have heard stories of women who have suffered botched abortions and even those who are left infertile. Free abortions is not in the best interest of our community. We need healthcare, better housing, paid leave, affordable day care.

A study of over 7 million Medicaid-eligible women shows that having one abortion put them at risk to have another abortion, leading to hemorrhage and infection, two causes of maternal mortality. Abortion on demand is a Band-Aid to the wound of economic and health disparities that cause women to seek abortion. Please focus your efforts on better funding Medicaid across the country to improve the quality of lives instead of unjustly ending them.

Thank you.

Ms. DELAUBRO. Once again, let me just say a very sincere thank you to all of our witnesses for their testimony, and we are delighted that you are here today. What I would like to do, we are going to start our questioning. And with that, if I can start here.

We are engaged in a pandemic, and we have seen, in my view, the lack of leadership from the current administration which has had devastating effects on the health and the financial well-being of all Americans.

Now, clearly these times exacerbate where there are existing inequities and fall hardest on the same communities that are adversely impacted by the Hyde amendment.

To all of you—and this is a question that comes from myself as well as our colleague Congresswoman Jan Schakowsky—how has the increased reliance on Medicaid and the need for reproductive and abortion care been affected during the pandemic? How have restrictions like the Hyde amendment made it harder to access abortion services during the pandemic?

Again, a question for all of you, and please jump in and start.

Dr. Palacio, you want to kick it off here?

Dr. PALACIO. Yes. Thank you very much, Chairwoman, for that important question.

As somebody who has had both the responsibility and, honestly, the privilege of working in many disaster situations, you are exactly right, disasters exacerbate preexisting inequities. This is true whether it is infections, such as we are seeing now. It is true whether it is hurricanes, such as Hurricane Katrina.

In this current environment, where we have an unprecedented confluence of a global pandemic, a massive economic crisis, and a racial reckoning, it is critically important to understand how all of these three things interface, especially how they interface in people who have been historically marginalized either because of their race, their ethnicity, or their lack of wealth.

At Guttmacher, my colleagues conducted a survey in April and May, just months after COVID began shaping the American landscape. We discovered that Black and Latina women were more likely than White women to want to delay pregnancy or to have fewer children because of the pandemic.

Simultaneously, they were also more likely to experience delays in sexual and reproductive care or have trouble getting birth control. So at the same time that they were trying to make important decisions for themselves and their families because of the situation

around them, they were having trouble accessing the very services that they needed to get to be able to make those decisions.

This is a matter of dignity. It is a matter of people being able to get the affordable care when they need it. You know, needing to make decisions about when to have children and how many children to have doesn't suddenly stop being important because there is a global pandemic. In fact, it may be more important than ever as people are trying to protect their own safety and their economic well-being.

Ms. DELAUBRO. Dr. Perritt.

Dr. PERRITT. Absolutely. I will just add to that to say that the same inequities in healthcare delivery that we are seeing in communities in accessing care more broadly, including access to care to alleviate the impacts of this global pandemic, are the same ones that are playing out when we are thinking about restricted access to abortion care.

The reality is that access to healthcare, including abortion, shouldn't depend on where you live or how much money you make. Healthcare is a human right, and insurance programs should cover the full range of reproductive healthcare services, including abortion.

We saw, as a result of the global pandemic, attempts to eliminate access to abortion care. We heard Amanda talk about what is happening and what happened in Texas as a clear example of that.

So understanding that people have the right, patients who rely on Medicaid and other Federal programs for health insurance should have the same access to healthcare services as those who have private insurance, and understanding that as justice is really important.

Ms. DELAUBRO. I have got about 38 seconds left to go, Ms. Williams, Ms. Bennett, and I can come back afterward because I would like to get your views.

Ms. Williams.

Ms. WILLIAMS. Yeah. Thank you, Chairwoman.

I will just add that even before the pandemic these communities that are disproportionately affected by COVID-19 are struggling to put food on the table. They are worried about making rent on time. They are worried about paying for diapers. They are mothers caring for their families.

So I think, especially now, because of this pandemic, we should be coming together to be thinking of solutions for expanding healthcare, not withholding coverage for it.

Ms. DELAUBRO. Okay. My time is expired, but Ms. Bennett, I will catch you so that you can have an opportunity to speak as well.

With that, let me yield to Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair. If you want to take a minute and finish up, go right ahead.

Ms. DELAUBRO. Any comments, Ms. Bennett?

Ms. BENNETT. Sure. We are in a pandemic, and it is obvious that there are millions of Americans who are suffering, even in my own community of Middletown, making sure to give to St. Vincent de Paul's and different charities, because people are in need, and food lines and food banks are reaching capacity.

But this puts women who are pregnant, who are already vulnerable, in an even more difficult situation, and it is important to make sure that they aren't going to be coerced to have an abortion because of the fact that they are in a difficult situation, because most women who have an abortion already are doing it because of financial lack. And what they need is resources, they need support, they need aid, not the termination of their children, which is a decision that they can never come back from.

And so I would say that in this time when women are increasingly vulnerable because of what is happening with the pandemic, we have to give them support, not take something away from them that is so precious.

Ms. DELAUBRO. Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair. I will follow your lead and actually ask one question to all the panelists, and it is a yes-or-no question, but you are certainly free to elaborate if you have something you want to add.

Do you believe that Federal taxpayer dollars should be used to pay for abortion on demand at any stage of pregnancy for anyone who seeks an abortion but says they cannot afford one?

So let me start, as you did, Madam Chair, with Dr. Palacio, and then sort of work across the panel if I may.

Dr. PALACIO. Thank you. Thank you, Representative Cole.

We are here to really think about what is important is about covering insurance for medical care. Abortion is a healthcare procedure. What we are talking about is the discrimination against people who are low-income or people who are typically Black and Brown who aren't able to access affordable, timely services in the same way that you or I are.

It is an important issue of equity to be able to have Medicaid pay for robust, comprehensive services, and robust, comprehensive services includes the full spectrum of reproductive services, including abortion.

Mr. COLE. Thank you very much.

Dr. Perritt, same question.

Dr. PERRITT. Sure. Thank you for that.

Not surprisingly, I agree. I believe that healthcare is, as I stated, a human right, and that every person has the right, whether they are getting their health insurance through the Federal Government or through private insurers, to have access to the same services.

The community that I take care of, the patients that I see, should not have to make decisions based on their economics and incomes. And it is not either/or. They also need support. They also need childcare. They also need prenatal care. But it is a both and not an either/or.

Mr. COLE. Okay. And Ms. Williams?

Ms. WILLIAMS. Yes. Thank you, Representative Cole.

The reality is wealthy people will always be able to access abortion care because they have the means to do so. What is really at stake here is the discriminatory policy that is jeopardizing low-income people's lives and futures.

You know, when we withhold coverage from someone who is enrolled in Medicaid coverage, we are telling them a message, a stigmatizing message, that they are not worthy of safe, affordable

healthcare and that we do not care about their rights and we will not uphold their right, their constitutionally protected right to an abortion.

This has been on the books for far too long. We need to start telling them a different message, one of compassion, one of support, and we can show them that by covering all forms of healthcare, including abortion.

Mr. COLE. Thank you.

And Ms. Bennett?

Ms. BENNETT. Saying that abortion is just healthcare or that abortion is merely a woman's right denies the reality that abortion is a destructive act, through violent means, that ends the life of a human person. If I was aborted in Hartford, I would have been dismembered, my body would have been thrown into a trash can, and that would have been the reality of what happened.

And we can use all sorts of words to describe abortion, but we can never deny the fact that abortion is the intentional taking of a human life. And taxpayers who are morally opposed to this, whether it is for religious reasons or secular reasons, should not be forced to have to fund this, especially for those of us in the Black community who view abortion and what has happened to our community as an act of genocide. We should not have to work hard to give our money to institutions that take innocent lives.

Mr. COLE. Thank you.

Ms. Bennett, let me follow-up with a question on that as well. You mention in your testimony we can both love women and children and strive for a society that treats us all with the dignity that we deserve.

What are the best ways to provide honestly for this empowerment, for care for women in financial need, who are facing unwanted or unexpected pregnancies? What are the services, what are the things we should make available to folks in that circumstance?

Ms. BENNETT. Thank you for that question.

There are so many ways that we can provide. I worked at a pregnancy resource center for 4 years, and we were offering free, at no cost to women, parenting resources, parenting classes, emotional support. We were throwing baby showers for them. We were helping them to find jobs and helping them with doing resumes. We were really getting involved in their lives in a personal way because many women are abandoned.

My own mother even, unfortunately, I didn't mention this in my testimony, but she went to church when she got pregnant and her mentor at church told her: Don't come back here because you are pregnant out of wedlock. And so she was rejected by people that she loved.

But we have the opportunity to serve pregnant women and to love them, providing the resources and support that they need.

In addition to that, we have to change laws, and we have to make sure that the government is taking care of them through programs that we already have, like WIC, like SNAP, that provide for mothers and provide for their children, but as well as providing for housing, because so many pregnant women are at a lack for housing, so many pregnant women are struggling with transportation.

They need paid parental leave, they need affordable daycare, they need better healthcare.

So we all have a part. Whether you are in a religious institution, whether you are in the government, we can all pitch in and we can all help because the need is so great.

Mr. COLE. Thank you very much.

Thank you, Madam Chair. I yield back.

Ms. DELAURO. Yes.

Congresswoman Lowey.

The CHAIRWOMAN. Thank you very, very much.

This question is for Dr. Palacio of the Guttmacher Institute.

My staff recently reminded me of a floor speech I gave in 1993 before the House voted to reimpose the Hyde amendment on the Labor-HHS bill. In it, I spoke of the human face of Hyde, of Rosie Jimenez, as Ms. Beatriz Williams mentioned, a 27-year-old college student too poor to pay for an abortion and unable to access coverage for a safe and affordable procedure due to the Hyde amendment, who died in agony after a botched back alley procedure. We have failed Rosie and countless women like her.

Dr. Palacio, your testimony referenced the Hyde amendment's disproportionate impact on women of color. Can you provide more detail about the compounding effects of racism on your patients, and in particular how Hyde disproportionately harms women of color?

Dr. PALACIO. Thank you very much, Chairwoman, for that question. Such an important issue. And I want to begin just by reflecting a little bit on the last answer.

And I am very grateful that Ms. Bennett's mother was able to choose to carry a pregnancy to term when she wanted. I am equally grateful that Ms. Williams was able to terminate a pregnancy when she wanted.

This is reflective of what reproductive autonomy really is. It is about assuming that women have the agency to make decisions for themselves. It is about assuming that women have the full capacity to make dignified human and humane decisions for themselves and their families.

The Hyde amendment builds on a legacy of racism. There is a direct line from the reprehensible policies of our past, such as forced sterilization of Black women, to policies like the Hyde amendment today. There is a direct line from the fact that enslaved people, even when they had their children, were told they couldn't parent those children, and those children were placed elsewhere. There is a direct line from the way that Black bodies have been experimented on and forced sterilization was the rule of the day.

You cannot remedy a racist history by continuing racist policies in the current and into the future. So these are both true. Yes, we have a racist history, and yes, Hyde is a racist policy. These are not incompatible truths, and it is time to remedy the past by taking this bold step for the future. And I thank you for your leadership on this issue.

The CHAIRWOMAN. Dr. Perritt, as a physician, in your experience, how has the Hyde amendment impacted the patients you treat?

Specifically, have you had a patient unable to pay for an abortion because her insurance restricted coverage? And what are the health impacts and risks of delaying an abortion to later in pregnancy?

Dr. PERRITT. Thank you for that question.

Yes, unfortunately, it is all too common that we see individuals, especially here in the District of Columbia, who don't have insurance coverage for abortion services. As I mentioned, there is a large community of folks here in D.C. who work for the Federal Government who are excluded from coverage for abortion care.

We also were voted to be unable to use our own tax dollars to pay for abortion coverage, despite the fact that D.C. voters wanted to do so, because we lack home rule here in the District.

And the reality is that it creates a situation where folks are really making very difficult situations. Often people who are having abortions also already have children, and so they know what it means to parent. This is not a theoretical concern or a theoretical risk.

I trust the people that I take care of to know what is best for them. They need access to the care that they decide when they need it. Delaying care does not eliminate access to care. It just pushes it further away and out of reach for more people. We have robust data from the Turnaway Study that tells us this.

And beyond the study data, I talk to patients every day that I am providing care who are clear about their decision, who articulate the risk to them and the children that they are already parenting. And so the risk is not in theory, it is real, and it is real people that we are talking about.

The CHAIRWOMAN. I see my time has expired, so I yield back. And I thank you very much, Madam Chair, and it is wonderful seeing you sitting there as our Madam Chair.

Ms. DELAURO. Thank you. Thank you. Thank you.

Congressman Harris.

Mr. HARRIS. Thank you very much.

And thank you, everyone, for appearing today.

First of all, there has been a claim that Hyde is somehow to blame for delays in medical care. But the State of Illinois did a study from 2013 to 2016 that actually 752 Illinois enrollees, Medicaid enrollees, died while waiting for care. So this is a problem with Medicaid in general, not necessarily with the Hyde amendment.

Dr. Perritt, well, with regards to home rule, you have to take that up with the U.S. Constitution.

And, Madam Chair, I ask to offer into the record an article from the National Review entitled "A Flawed Study Claims That Few Women Regret Abortion" that discusses the problems with the Turnaway Study.

Ms. DELAURO. So ordered.

Mr. HARRIS. Okay.

So, Dr. Perritt, I think it said somewhere in your history, in your bio, that you are licensed in Maryland. So I am sure you are aware that in Maryland there really is no functional barrier for Medicaid women to have abortions. Is that right? Dr. Perritt?

Dr. PERRITT. That question is misleading. There are a number of barriers to accessing abortion care in the State of Maryland.

Mr. HARRIS. Okay. Well, let's go through the figures, because in 2017 only 18 percent of Marylanders were covered by Medicaid, but 27 percent of the abortions performed in Maryland were funded by Medicaid. So actually a disproportionately higher number—and you and I both know it is through the mental health loophole, because in the last year the data is available of the over almost 8,000 Medicaid-funded abortions—and it was funded through State funds, I agree, Maryland agreed to do it—but in Maryland there actually is no functional barrier to that. Is that right, based on the statistics?

Dr. PERRITT. No, that is incorrect. The patients that I talk to every day can identify any number of barriers to accessing care. You mentioned barriers to accessing care through Medicaid more broadly. The same is absolutely true for accessing care to abortion.

Mr. HARRIS. Okay. But the figures will show that, in fact, a higher number of Medicaid patients actually have their abortions paid for with public money, albeit State money, but public money nonetheless.

The risk to health, I assume—and I think—I think the chairwoman mentioned the risk to health—but in fact, in Maryland, the data is that it is all mental health.

Now, Dr. Perritt, I don't know if you have ever done an abortion in Maryland or done it on a Medicaid patient with a mental health referral, but are you aware that an abortionist who claims that there is a mental health issue does not have to refer for mental healthcare? You are aware that that requirement does not exist. Is that right?

Dr. PERRITT. Well, I am aware that patients are in the best position to decide whether or not continuing a pregnancy would pose long-term mental health impacts to their life. And the patients that I take care of, I talk to them about that, and I believe them when they say that this is something that will be harmful to them. I trust their response and their view of their health.

Mr. HARRIS. So, Dr. Perritt, globally, is that the way you feel about mental healthcare, that basically we don't really need it because people can kind of decide what is in their best interest and not—that is a rhetorical question. You don't have to answer it.

Dr. PERRITT. I would be happy to answer it.

Mr. HARRIS. No, that is okay. You don't need to.

Christina, could you go over, because you mentioned the problems with Planned Parenthood, and obviously I wish Planned Parenthood, which is a (c)(3), the money they got from selling baby body parts, I wish they had actually funded abortions free for some of their clients. But you mentioned the sexual abuse issue, and we know that there are numerous reports of Planned Parenthood's providing abortions when the client has said they are underage and, for instance, the father is an adult. Is this what you are referring to, Christina?

Ms. BENNETT. Yes, that is actually what I am referring to. Specifically, I am referring to the study by Live Action, which is an organization that I work with, who has talked to different women who have been abused, and, unfortunately, that has been covered up by Planned Parenthood. And they have a report that you can

find online called "Aiding Abusers," where it goes into that information.

I personally, as I mentioned before, I live in Connecticut, which is a State that does not have parental notification laws. So that means that minors are allowed to access abortion without even notifying their parents.

And at the same time, we are in a State, like many States across the country, where we have the horrible reality of sex trafficking where women are being taken advantage of.

And it is not hard to understand that for women who are taken advantage of through sex trafficking, for them to be able to keep those girls and those women in business, they have to make sure that they do not keep their pregnancies.

Obviously, they become pregnant because they are being raped brutally over and over again. But one of the ways in which they make sure that they can go back to business is by taking them to abortion providers.

And it is easier in States like Connecticut where there is no parental notification laws because then traffickers and pimps and abusers can take underage girls to get abortions and there is no questions asked.

And so this is a reality that we don't often like to talk about, but it is horrible.

Mr. HARRIS. Thank you. I yield back.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Thank you very much. Let me thank you and congratulate you, Congresswoman, Chairwoman DeLauro, for your commitment, your commitment and your passion and your clarity of the purpose of the Hyde amendment being not included in the next appropriations bill.

And I want to thank you so much, along with our committee members, for this hearing today. It truly is really a historic hearing. It is a long time coming, but it is important that we discuss these issues within the context of what we know, and that is the context of racial justice.

With the COVID-19 pandemic, we see just how inaccessible healthcare, especially reproductive healthcare and access to abortion for women of color and low-income individuals is.

I want to just thank our witnesses today for being here and for sharing your experiences with the subcommittee. And let me take a moment to thank the All Above All coalition who have worked so hard to ensure that we finally begin to end this discriminatory policy, such as the Hyde amendment.

I do co-chair the Pro-Choice Caucus and the lead sponsor of H.R. 1692, which is the EACH Woman Act, and so this hearing is especially important to me.

Also personally, I just have to say once again, I remember the days of back alley abortions. I remember the days before Roe v. Wade. I know exactly the decisions, the crucial decisions, the heart-wrenching decisions that go into especially young girls having to make decisions and women having to make personal decisions with whomever they decide as to whether or not they choose to have an abortion for whatever reason.

And so this is extremely important that we recognize that the policy of the Hyde amendment has been discriminatory against women of color and low-income women and that the history of this also be remembered. Because I want to remind you, and I just want to say, first of all, I was a staffer when the Hyde amendment passed, and Henry Hyde said that those that would be impacted would be little ghetto kids.

So, Dr. Palacio, let me just ask you, because we started talking about systemic racism and the moment that this day is in terms of the racial reckoning, but the history of how we got to this point is so important, because sometimes systemic racism is overt, sometimes it is subtle and covert. But the facts speak for themselves.

So can you just once again continue along your line of testimony as it relates to the history and why people need to understand how structural racism works within the context of the Hyde amendment?

Dr. PALACIO. Thank you very much, Congresswoman Lee, and thank you for your leadership on the EACH Woman Act.

It is critically important to contextualize the moment that we are in, in the Hyde amendment, and understand the arc of history rather than view it as an isolated thing.

As I said, the history of Black and Brown people not having autonomy over their own bodies is long and steeped in our society. And these are not accidental occurrences. These are occurrences that are the result of law, regulation, and policy on the governmental level and sometimes the result of institutional policy at the organizational level.

The very fact that Black and Brown people are disproportionately represented among Medicare is not an accident. That is a result of the long history of economic policy, of housing policy, of educational policy that has made it very difficult for Black and Brown people to enjoy the same accumulation of wealth over time.

These things are related. We need to understand that where we are now is a direct line from where we have been, and that the only way to change that is to take a different action.

And the action that this committee is considering today, to pass a clean appropriations bill without the Hyde amendment, is one, but only one of the critical steps needed to change the trajectory of history to the future, so that we don't continue down the same path, overlaying racist policy on top of racist policy.

Ms. LEE. Thank you very much.

Thank you very much, Madam Chair.

Ms. DELAURO. Thank you. Thank you.
Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

You know what, I have some questions, but I wanted—can you hear me? Can you hear me okay?

Ms. DELAURO. Yes.

Ms. HERRERA BEUTLER. You know, I need to start by saying, as a woman of Hispanic descent, a woman of color, who came from—you know, I think about my dad growing up as one of ten Mexican Americans at times in a one-room house, where they didn't even always have running water. I just have to say I completely, fundamentally reject the notion that getting rid of one of those ten or

more of those ten would make life better for the rest of them. It just doesn't work that way. We are talking about a human life.

And to me the Hyde amendment strikes a really important balance. We are not talking where the life of the mother is in danger. We are not talking about life for life. We are talking about someone who is—should be protected under the Constitution as having that life.

We know, the doctors on this call can tell you, that a baby in utero can have a completely different blood type than its mother. It is not an extension of the mother's body. It is its own life with its own DNA that is separate from the mother's.

So we keep taking this back up to just talking about one person in the equation, and that is the mother, but you have to acknowledge the personhood of the other person in this equation who pays the ultimate price.

And I reject the solution that Dr. Palacio proposed to maternal mortality rates, to decrease them, is to just get rid of pregnancies. We know that 70 percent of women who experience maternal mortality, or those complications, it happens actually during that first year after the baby is born, which is why I proudly supported extending Medicaid coverage to the mother, to cover the mother and the baby during that year when we know most of those things occur. I proudly support it.

It was one of the reasons I voted against our party's ObamaCare repeal, and I told Vice President Pence: Look, if we are going to tell young women who are poor or who are from minority neighborhoods have your baby, then we need to step up and make sure that they have the coverage they need and the wraparound services. It is why I support family medical leave, it is why I support these services, because I am putting my money where my mouth is.

I think one of the things that keeps getting lost here is we are talking about the Hyde amendment as in some way it is racist. The reality is the Hyde amendment is one of the things that helps us root out systemic racism in this area. Thirty-three percent more women of color have abortions. And it is no secret that Planned Parenthood's founder had built this whole methodology into place to go into these areas with a eugenics mindset, to get rid of poor Black women.

Oh, my goodness, that is so outrageous, to say that because you are poor or because you are Black the solution for your life and your success is to take away your pregnancies? I mean, it is hard for me understand that this is how we are talking about this.

And I wanted to make the point—there are a couple points—70 percent of Americans—this is from June of 2020, Gallup—want abortion to be illegal in all circumstances, or legal only in certain narrow subsets of circumstances, compared to 29 percent who say abortion should be legal at any point during pregnancy.

We are not talking about private funds. We are talking about taxpayer funds. The Hyde amendment has a 40-year legacy of being bipartisan. It has a 40-year legacy of enjoying the support of the American people.

Some of the arguments I keep hearing are women need to be able to make decisions on their own terms with their own bodies, reproductive autonomy. But they are not using private dollars. We are

not talking them using their own dollars, right? You are asking for taxpayers, 70 percent of whom do not wish to have their money spent here. That is what we are talking about. We are not talking overturning Roe v. Wade. We are talking about protecting this taxpayer funding and people's conscience here.

And one thing I wanted to hear Christina Bennett expand upon this with regard to the allegations that somehow the Hyde amendment is racist. I view it quite opposite.

Ms. BENNETT. Well, I view it the same way that you do. I share your thoughts. I think it is absolutely ridiculous. I am alive today because my mom walked outside of her abortion appointment.

And so to think that encouraging abortion—and make no mistake, that is what this will do, it will encourage abortion. When women are already vulnerable they will think: All I have to do is just go over to the clinic and give them my Medicaid card and my life can change. They will believe the lies that society tells them, that their problems will be erased.

Their partners may be pressuring them, their parents may be pressuring them. I have been outside of abortion clinics. I have seen mothers dragging their children, their teenagers into clinics. I have seen guys pressuring their girlfriends and even their wives. And this makes it easier for them if they know it is free.

Ms. HERRERA BEUTLER. Let me add in my last 17 seconds—thank you for that—studies, including a study specifically of poor women on Medicaid in California, show much higher death rates for women who have had abortions compared to women who have given birth, especially from suicide. This needs to be explored.

Ms. DELAURO. Congressman Pocan.

Mr. POCAN. Thank you, Madam Chair. And if I can, since this is the first time I have seen you since you have been elected to be the Appropriations chair, I just want to say congratulations. You have been a mentor to me since I came into Congress. Your passion, your energy is contagious. Your values are impeccable. And I am really looking forward to the 117th Congress.

Ms. DELAURO. Thank you. Thank you. Thank you.

Mr. POCAN. Thank you to the witnesses.

And I guess let me offer from this perspective, of being a White man who makes the salary of a Member of Congress, I am unlikely to personally intersect with the Hyde amendment in my life, although largely it is people like me who have made the decisions for everyone else in the country.

You know, I believe in healthcare. I think healthcare is healthcare, exactly that. You have to give it to people who need it. And discrimination based on someone's income essentially is what the Hyde amendment is, is just that, discrimination.

In hearing, Ms. Williams, your story about—your very personal story, thank you for sharing that—about having an abortion when you were 19, but having to talk about clinical escorts, I can't think of a cancer patient or an HIV patient or a heart disease patient, like myself, who has had to have clinical escorts in order to get healthcare. And just the idea that is a debate in 2020—although 2020 is quite a year, I will admit—but the fact that that is still a debate at this point I find rather amazing.

I guess I would like to ask questions of our two doctors, Palacio and Perritt, since you are physicians and this is about healthcare, even though the Hyde amendment necessarily isn't, but the idea of abortions is healthcare.

Let me ask you the question, is there anything else that you know of that is explicitly banned by Federal law that is healthcare based on income, that people can't do, other than the Hyde amendment? Is there anything that stands out in your practice? Dr. Palacio first and then maybe Dr. Perritt.

Dr. PALACIO. Thank you so much, Congressman, for that question, because I want to contextualize a little bit of what we are talking about here, which you elucidated so well, which is the stigmatization of individuals.

And as somebody who really was working in the height of the epidemic in San Francisco with people who were infected with HIV and AIDS, predominantly men and women of color was my particular patient population, I can tell you that we have a history of stigmatizing people by their characteristics and not being willing to pay for their care. Right?

The Ryan White AIDS—the Ryan White CARE Act was because we didn't have sufficient public funding through Medicaid to take care of people who were living with HIV because they were perceived not to be worthy of that kind of care.

We have a history of having mental health services not funded very well by public dollars because people who were mentally ill were perceived to be crazy and other stigmatizing ways, and not seen worthy of taxpayer dollars being used to fund their care.

We have a history of people with substance abuse disorders not being able to get comprehensive substance abuse treatment care because they were seen as "other" and not being worthy of getting care.

So this is not isolated. And it is important that we recognize it for what it is. Women who seek an abortion are being systematically characterized as "other" and not being worthy of getting their care covered.

Mr. POCAN. Thank you.

Dr. PERRITT. Thank you for that question. And I will just join Dr. Palacio in talking about some of the other ways that reproductive health, particularly reproductive healthcare and decisionmaking for low-income women, is also stigmatized. It shows up in how we decide who gets coverage for assisted reproductive technology, for example, and for different kinds of contraception.

And so we decide that for poor people we won't cover things like help getting pregnancy or fertility examinations or evaluations.

So banning coverage for abortion is part of a larger schema in which we decide that poor women, who are disproportionately communities of color and rural people, do not have the agency and autonomy to decide what is best for them, for their lives, and for their bodies.

Mr. POCAN. And thank you for actually helping me define that question more because I think we know there is more in this category where we ban some from getting healthcare, but really raising the stigmatization that comes out of doing this by having some-

thing banned simply because of people's values rather than the science. And I thank you both for that.

I yield back.

Ms. DELAUBRO. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair. I was having a little trouble unmuting there.

Ms. DELAUBRO. I know the feeling.

Mr. MOOLENAAR. I want to thank our witnesses also.

And just to follow up on the previous discussion for a moment, you know, I feel like when we start talking about care or services related to abortion, we kind of forget that an innocent unborn child that is created in the image of God is not a disease, a cancer, an HIV/AIDS, a virus, or a substance that is being abused. It is a child. And I just want to put that on the record, because when we are talking about science, I think the science more and more is indicating the importance of recognizing the value of these innocent human lives.

I want to begin by asking Ms. Bennett, you have mentioned your mother—and thank you for sharing your story—and also you mentioned that women like your mother would need resources and support as they are going through a challenging time.

And you mention in your written testimony in the State of Connecticut housing for young mothers beyond homeless shelters is hard to come by and lament that St. Agnes Home, a faith-based home for teenage mothers, closed in part because the State stopped referring clients and providing funding.

And I can relate to that because in my home State of Michigan we have recently seen a similar loss of support for women who have chosen to carry their baby to term. And in 2019 the Michigan Pregnancy and Parenting Support Services Program received \$700,000 in the State budget.

The funding is a small fraction of the State's \$58 billion budget. But the legislature and Governor were unable to agree on funding, and it was, unfortunately, vetoed. And without this funding many pregnancy centers throughout the State will either be forced to reduce their [inaudible] or shut down their [inaudible].

Since June of 2014 they have served 8,393 clients. Ninety-eight percent of the women were connected to a healthcare provider for prenatal care, 94 percent took their child to pediatric appointments, 93 percent kept their child's immunizations updated. And through two local providers alone, Pregnancy Aid and Catholic Charities of Southeast Michigan, over 2,600 women have received support services at no cost to the mothers or their families.

And, Ms. Bennett, I am wondering, how do you think the loss of programs like the Michigan Pregnancy and Parenting Support Services Program, as well as St. Agnes Home, affects low-income women?

Ms. BENNETT. Well, I believe that it hurts them. And I have personally sat next to women who are in need of housing and called shelters just to hear that they were full, especially in the long winters that we have here in Connecticut. And, thankfully, I have been able to turn to a few faith-based organizations, like the Nehemiah House and the Malta House, but it is just not enough.

And you mentioned the great work of pregnancy resource centers, and I want to let you know and to let everyone know that in Connecticut they are under attack. The Democratic legislators are literally trying to shut them down by bringing forth false legislation accusing them of manipulating women and having false advertising.

So these pregnancy center leaders have to take time away from helping women to go to their LLB and to defend themselves year after year against these false allegations.

So not only do we in our State not have enough support as we need for women that are in crisis and don't have housing, but at the same time the very people who out of the goodness of their heart are freely offering services to women in need, they have to defend themselves.

I have had to go multiple times and speak out and testify and defend pregnancy centers from these [inaudible] from pro-abortion radical groups, all the while we are funding abortions. The Catholic Conference says in Connecticut that 75 percent of the abortions here are funded by Medicaid. It is just wrong.

Mr. MOOLENAAR. Thank you.

Ms. BENNETT. We are punishing and hurting the women who are helping and we are aiding those that aren't.

Mr. MOOLENAAR. Well, and that is a point that I guess I am wondering, and if in your line of work you have met women who have been harmed by abortion or regretted a previous abortion or have even been coerced.

Ms. BENNETT. Yes. Absolutely. I have met women who had suicidal thoughts after an abortion. I have met women who every year they will think about how old their child would have been and they will see another child on the playground and think, my child would have been 5 years old, or, my child would have been 6 years old.

I have met women who had a previous abortion, and then when they got pregnant again and they saw their baby on the ultrasound screen, they felt guilt and remorse because they didn't realize their baby, the one that they aborted, looked like that in the womb, was that developed.

So I have heard so many stories. I have met women who have had an abortion 30 years ago and they still have tears in their eyes because they have never really been able to heal from the trauma.

And I will say, that is not everyone's story. I will say that there are some women who told me: I have had an abortion, I was fine. I have had women say: I have had six abortions, I was fine.

But every woman's story is different, and many of the ones that I have met have had pain and remorse and guilt. That is why there are post-abortion healing programs all throughout the country, like support after abortion at Rachel's Vineyard, because there is a need for them.

Ms. DELAUBRO. Thank you very much.

Mr. MOOLENAAR. Thank you very much. And I know I am over my time. And thank you. I yield back.

Ms. DELAUBRO. Representative Clark.

Ms. CLARK. Oh, thank you, Chairwoman DeLauro. I just also want to add my congratulations and my deep gratitude for your leadership, your sisterhood. And as Ranking Member Cole noted,

we know that this will still be your favorite subcommittee as we move into your chairmanship. So congratulations again and really looking forward to the next Congress.

And I think this hearing is an example of exactly the issues we need to be addressing as we sit at a Nation in the middle of a pandemic, but also at a crossroads of how we are going to address racial and economic justice in this country. And there is no way to fully address either with the restrictions of the Hyde amendment in place.

And we see this play out for women, 40 million women who are enrolled in Medicaid across this country. And it does come down to not just a matter of reproductive freedom, but a matter of economic freedom.

And so my question is for Ms. Williams.

We know that women are the backbone of our economy. We know that this pandemic and the resulting economic fallout has disproportionately affected women, as we see one in four women leaving the workforce. But the reality is we still are interfering in these deeply personal decisions for women through the Hyde amendment.

So I am hoping you can help us understand how access to reproductive choice affects economic outcomes for women. And is there evidence to suggest that being denied access to an abortion has persistent negative effects on a woman's financial well-being?

Ms. WILLIAMS. Yes. Thank you, Representative, for this question. And thank you again for inviting me, as someone who has had an abortion and can speak to my own experience.

You know, studies show that when policymakers restrict Medicaid of abortion about one in four low-income people seeking abortion are unable to obtain one. I mean, the data is there. We have heard from our renowned physicians and doctors on the panel that there are a number of outcomes for people who are denied access to care.

And today this is not a question of whether or not we believe abortion is the right decision for anyone, because we don't know what everyone's circumstances are. But the solution is not to deny someone access to that care. That is their constitutional right.

In my own experience, as I mentioned before, I have had an abortion. I was working two jobs. I was in classes full time as a young person in a new environment at the University of Houston, and I was focusing on pursuing my own education and building the future that was best for me. And having a child at that time wasn't what I was ready for. It is not what I wanted.

And economic security was a big factor in my decision, but like all decisions there are complexities and nuances, and economic security wasn't the only factor. I needed an abortion because I needed to be in control of my own body and my own wellness.

And being able to access my care was about affirming the fact that I am the expert in my own life. And we give everyone that we help on our hotlines that same dignity, without shame, without stigma, and without judgment.

And we should be able to make these kinds of healthcare decisions with trust and dignity and respect, and it should be covered like any other form of healthcare, because it does have such long-term effects on the trajectory of our entire lives. We do not make

these decisions without—we don't make any vital decisions about the future of ourselves, our families, and our communities with—you know, we do give it the kind of thought that it deserves. And to assume that we aren't, that we don't make the best decisions for ourselves, is insulting.

Ms. CLARK. Thank you.

With 30 seconds remaining, Dr. Palacio, do you see a tie to the Hyde amendment and maternal mortality outcomes for women of color?

Dr. PALACIO. I think they are part and parcel of the same underlying problem, which is that Black and Brown women can't access the care when they need it, the right care, the right time, in an affordable way, in ways that are not the same as the way that, frankly, majority White populations or wealthier populations have access to that care.

So they are clearly manifestations of the same type of, frankly, wrongheaded approach that we have to allowing Black and Brown and low-income communities to access the quality care, affordable care in a timely manner.

Ms. CLARK. Thank you.

Thank you, Madam Chair.

Ms. DELAUBRO. Thank you.

Congresswoman Frankel.

Unmute. Lois, unmute.

Ms. FRANKEL. Okay. I got it.

Ms. DELAUBRO. Okay, okay.

Ms. FRANKEL. Hi, everybody. Hello. Thank you, Madam Chair. Congratulations on your new role.

Nita Lowey, I am going to miss you. Love you. Thank you for all you have done for us.

And thank you, everybody on the panel today.

So I am going to—I want to just start off by saying that my proudest achievement is my son Ben, and my greatest joy is my grandson. And with that said, I want to just say that I am—you could put me firmly in the pro-choice category. I believe that access to full reproductive care by women is a necessity for them to have full productive lives and to take care of their families.

And thank you, Barbara Lee, for your leadership on this issue to get rid of the Hyde amendment.

You know, I was just doing a little bit of research. In 1965—and this is before Roe v. Wade was instituted—illegal abortions made up about one-sixth of all pregnancy-related deaths. Today abortion has a safety record of over 99 percent. So if your concern is about life, you do want women to have full access to safe, legal abortion.

You know, we were all pretty horrified when we saw the brutal murder of George Floyd, and there was a real awakening—or I should say a reawakening—for many in this country about systemic racism and injustice. And to me, the Hyde amendment is one of the best examples of the systemic racism.

You know, you think about it, the Supreme Court gave us in Roe v. Wade, gave women the right to access to safe, legal abortion, a constitutional right to safe, legal abortion. There are certain limitations.

With that said, with the Hyde amendment that right is really for people who can afford it, people who can afford access. And I ask my friends who support this Hyde amendment, would you deny a poor woman to go into a church, or freedom of speech, or freedom to be free from search and seizure, unreasonable search and seizure because of the color of their skin, because of how much money they have in their pocket? And I am sure that answer would be no.

So with that said, I do have a question.

Ms. Williams, you testified about the harms of the Hyde amendment being compounded by additional State restrictions. I would like you, if you could, to give some more examples. And I would ask Dr. Palacio and Dr. Perritt to also comment on that.

Ms. WILLIAMS. Yes. Thank you, Representative.

As I have mentioned in my testimony, Texas is one of the most restrictive States on abortion access, and there are a number of State-level restrictions that make it very difficult to access abortion care. And on top of that, we do have restrictions on private health insurance, as well as, of course, Hyde.

And in Texas, the majority of our communities are without a local clinic. And so this means that a lot of people in my communities are traveling potentially hundreds of miles to get to the nearest clinic to them, which can be very expensive.

So we are talking about childcare. Again, the majority of our clients are parenting, caring for their families. So that also means childcare expenses or potentially taking their child out of school, bringing them with them on what could be a multiple-day trip because of a mandatory 24-hour waiting period. It could be two separate appointments.

And this also means that without paid sick leave people may have to forego wages, take time off of work if they are even able to, if that is an option for them. And this is also a matter of opening up States. This is an entire ordeal. It is a logistical roller coaster for people in my State to access abortion care in a safe way, and it is a time-sensitive procedure.

And I also just want to add that because of the COVID-19 pandemic we should not be forcing people to travel any more than they have to or bringing themselves or their child outside of the home to potentially expose themselves to the risk of COVID-19.

So all of these factors really compound and can make it extremely difficult for people to access the care they need, on top of being able to pay out of pocket potentially hundreds of dollars and dig into their savings.

Ms. DELAURO. Congresswoman Watson Coleman.

Bonnie, can you unmute? No?

We need some technical assistance for Congresswoman——

Mrs. WATSON COLEMAN. I got it now.

Ms. DELAURO. Got it.

Mrs. WATSON COLEMAN. Thank you very much.

First of all, I don't know if Nita is still there, but I just wanted to say to her that last night's hanging of her portrait was so touching, and the wonderful things that they said about her and her leadership were the things that I experienced in my few—2 years on this committee.

And I am so glad that, Rosa, you will be taking up the mantel here. What you have done today is an illustration of the kind of proactive, very progressive policies that you are committed to. And your leadership is authentic and your concern is indeed authentic. So I look forward to working under your leadership.

So I am, like, really a bit concerned here, because I have heard from a number of organizations, faith-based organizations, organizations that are women of color, organizations that are Latina organizations and affiliations, as well as Asian and Black, and all of them have solidly come out in support of the elimination of the Hyde amendment in our appropriations language and ultimately the repeal of the Hyde amendment.

I think that a lot of this discussion has revealed that that—can you hear me? Okay. I am sorry. A lot of this discussion has revealed that there are lots of restrictions in access to healthcare that negatively impact poor women and Black women, and the Hyde amendment is most definitely, definitely one of them.

I was going to ask about the impact of COVID-19 on it, but I think I want to shift now to a discussion about these restrictions on abortion and how they negatively impact long- and short-term healthcare outcomes for both maternal and infant mortality and morbidity. And I wanted to ask both of the doctors, Dr. Perritt and Dr. Palacio, to respond to that specifically.

What is the outcome, the negative outcome, for women who are—first of all, we don't take the need or desire to have an abortion lightly. It is a decision that comes out of our personal experience and need. And so to suggest that this is an issue of coercion and other things just really kind of throws me off and makes me very concerned that we are not really expressing what is actually happening here.

But, Drs. Palacio and Perritt, could you please talk to me about the impact of the Hyde amendment, as well as in general the kind of unequal access that Black women in particular and poor women have had to healthcare and to the right to have a safe abortion based upon their needs?

Dr. PERRITT. Yes, thank you for that question. You know, I have been practicing obstetrics and gynecology for more than 15 years, and I am honored to have the opportunity to provide the full range of reproductive healthcare to thousands of patients over this time. And whether it is delivering babies or providing compassionate abortion care, I am really moved by the trust that my patients extend to me to listen to their needs, to discuss their unique circumstances, to provide them with the safest care possible.

I, too, am troubled by the description of coercion by some of the testimony because what it tells me is that those folks who believe that are happening really don't trust any women and especially Black women to make the decisions about what they need in their own lives.

As a mother myself, I know what it means to parent, and I believe my patients when they tell me that this is the right decision for them. And so, if we are really concerned about improving the lives of Black mothers and children, of indigenous women and children, then I would encourage us to advocate for programs that we know have a clear benefit. We need to be advocating for social sup-

port instead of co-opting language around the movement for Black lives in this moment in time. We should be strengthening community support. We should be addressing overpolicing. We should be working to decrease violence in our community. The claims, those other claims are distraction.

Mrs. WATSON COLEMAN. Thank you.

Dr. Palacio, for my 24 seconds that are left.

Dr. PALACIO. Sure. You know, I have to wholeheartedly endorse Dr. Perritt's comments. And just to sort of set the policy landscape, since 2011, States, have enacted more than 450 new abortion restrictions. So let's understand that this is something that is happening with force and emphasis. And 40 percent of those restrictions have been—that is 40 percent of the restrictions since 1973. So Hyde is no accident. Hyde is not just racist; it is part and parcel of a, frankly, wicked web to try to constrain people's autonomy to make their own choices.

Ms. DELAUBO. Thank you. Thank you.

What I would like now to do is—I am hoping that our witnesses are all right with staying, and to my colleagues, what I would like to do is do a second round but do it for just 3 minutes and so to move as rapidly and as quickly as possible.

So, with that, let me ask you, again, to follow up on what you were saying, Dr. Perritt. You are the only abortion provider in the hearing today. Is there any misinformation that you would like to clear up for the committee this afternoon?

Dr. PERRITT. Absolutely. I think there are a number of things, but one thing that I will name is really the fact that we are being encouraged and sometimes forced to think about this issue as a binary or dichotomy, as black or white. And the reality is that it isn't that way. It is not me versus them. It is not pro-choice versus anti-choice. I am a physician. I am a provider of healthcare, and my job is to support my patients no matter what, and that includes for folks that are seeking care for abortion services.

The patients that I take care of are making thoughtful decisions. They are making informed decisions. They are supported by their families, by their communities. We are providing compassionate care, and I am providing care in the community that I grew up in.

Ms. DELAUBO. So the issue about collusion, can you address that at all?

Dr. PERRITT. Absolutely. You know, one of our other witnesses mentioned these so-called pregnancy support centers, and what we are actually talking about are crisis pregnancy centers and fake clinics that are designed and strategically placed next to and near abortion facilities to coerce and to mislead folks that are seeking care.

I have cared for patients who have mistakenly, accidentally gone in to those places and have been held, in a sense, hostage, been unable to leave. They are falsifying themselves as healthcare providers in many cases and are coercing patients to carry on with the pregnancy that they may or may not want.

The concerns around coercion I think really come down to what we are doing when we say that we are restricting the ability for people to get the care that they need through our insurance coverage. That is coercive. Deciding that you, your healthcare is dif-

ferent than mine because of your inability to pay or your reliance on governmental insurance, that is coercive. Because what that means is that you do not have the dignity of choice that someone with a different insurance carrier may have.

And so, if we are really concerned about coercion for folks that are seeking abortion care, the solution to that is to eliminate the Hyde amendment and allow folks the ability to make those decisions that they need, that they know that are best for themselves and their family without these unnecessary and burdensome restrictions.

I believe every person should have access to compassionate and quality care, and the Hyde amendment inhibits people's ability to access that care by putting barriers in their place.

Ms. DELAURO. Thank you. I will yield back my time. It is about 12 seconds left, and I will yield to the ranking member, Congressman Cole.

Mr. COLE. Well, thank you very much, Madam Chair. Just quickly, I stepped off camera, but you are always within ear shot. I was trying to get lunch in, but I didn't think anybody should have to watch me eat spaghetti.

So I apologize to all, but I did listen to the testimony and appreciate that, appreciate my colleague's question. I just have one question here, and it is to get at what I think is an important distinction. Look, I have very strong views on this subject. Everybody on the panel does. I respect that. But there is a lot of charges about the Hyde amendment being racist. I knew Henry Hyde. I served with him. There wasn't a racist bone in his body. You can disagree with the policy. He was very strongly pro-life, and I think you can argue that this has disproportionate impacts on different races or ethnicities, but I think it is pretty hard to argue that it is itself a racist policy or is designed that way.

So I guess I would ask each one of our witnesses, I would start with, I guess, Dr. Palacio and then work through, do you think, genuinely think, that the Hyde amendment is designed to be racist, that is, designed to be punitive to communities of color and to lower-income communities?

Dr. PALACIO. Thank you, Congressman, for that question. I think it is an important question in terms of the way that racism is really impactful. So, regardless of intent or regardless of what Representative Hyde was thinking at the moment, the impact is clearly racist.

And this is what structural and systemic racism is. It is different from a bias of an individual person. It is the cumulative effect of policies that systematically exclude people from opportunity based on their situation in life which is based on race and ethnicity—

Mr. COLE. Excuse me.

Dr. PALACIO [continuing]. The impact is clearly racist.

Mr. COLE. I just want to give the others an opportunity because I only have a minute here. And I appreciate your answer. Very clear.

Dr. Perritt.

Dr. PERRITT. I would echo Dr. Palacio's statement. The intent is irrelevant. The impact is very clear. As a healthcare provider—

Mr. COLE. If I could, let me move on to Ms. Williams because I am down to about 20 seconds.

Ms. WILLIAMS. Absolutely. I would agree with my colleagues. The Hyde amendment is racist, and it is classist, and our inability to respond to the impacts is also racist, and it is long overdue.

Mr. COLE. Thank you very much. And if I could, Ms. Bennett, do you think the Hyde amendment is inherently racist?

Ms. BENNETT. No. I will never believe that an amendment that has helped save over 2.4 million lives, many of them Black, is racist. I don't think that racists are in the business of trying to preserve Black lives and generations of children that will come after them. It is absolutely ridiculous to claim that the Hyde amendment is racist.

Mr. COLE. Thank you very much. I have exhausted my time.

Thank you, Madam Chair.

I yield back.

Ms. DELAUBRO. Congressman Harris, I don't see you, but are you there?

Mr. HARRIS. Yes, I am here.

Ms. DELAUBRO. Okay. Go for it. Three minutes.

Mr. HARRIS. Thank you very much.

And, Ms. Bennett, could you just elaborate on that? It is 2.4 million lives, and a large portion of those are, in fact, minorities. Is that correct?

Ms. BENNETT. Yes, absolutely. And when we are talking about forced sterilization, we are talking about these things in the hearing today, we have to remember that these things were pushed by Margaret Sanger, that these things were pushed by people that were eugenicists, that were involved in the abortion industry that we have today. And so that is where we see real racism with 79 percent of abortion facilities located in lower income minority neighborhoods preying on Black and Brown mothers and their children.

Mr. HARRIS. Now, do you personally find it discouraging the implication that you might be racist because you support the Hyde amendment?

Ms. BENNETT. Honestly, I am used to it because I have been doing this work for 15 years. And so even when I used to live in Atlanta and we talked about how abortion was disproportionately affecting the Black community, we were called racist because of that. It doesn't matter. I almost died, and now I am alive, and I am going to speak out for those who have no voice. And I really don't care what people say about me, even if they say I don't trust Black women. I trust Black women. I love Black women. I am a Black woman, and I have listened to the ones who have told me they have been hurt by abortion, they were pressured to have abortion by their partners, by their parents, by their professors. I listened to them, and I care, and I know that abortion hurts women and families, and it is a moral injustice.

Mr. HARRIS. So you basically just don't believe the Turnaway project? You find that—I know there are flaws. Obviously, they have a very low percentage of people actually provided answers, things like that. So your impression dealing in the Black community is that that is a truly flawed study. Is that right?

Ms. BENNETT. Yes. Over 70 percent of women didn't even want to participate in that study. Dr. Michael Newt and the Charlotte Lozier Institute have done many articles debunking that study and how false it is. It does not represent the majority of women in America. In fact, we haven't even heard from women and men also who have been hurt by abortions because so often their voices are silenced. They are afraid to speak out. They are not willing to maybe shout your abortion as other people are because they feel sometimes shame and sometimes guilt, and we haven't even really began to understand the negative impact that abortion has had on the hearts and souls and minds of individuals in our Nation. Maybe we never will know.

Mr. HARRIS. Thank you. And I know one of the panelists somehow disparaged the crisis pregnancy centers, which are really volunteers who just want to help pregnant women, and that is disappointing. But I know that, in Baltimore, they tried to drive them out of business and, fortunately, you know, Federal courts overturned that.

Finally, Madam Chair, I ask unanimous consent that the Family Research Council Study on taxpayer funding of abortion and abortion businesses be entered into the record.

Ms. DELAURO. So ordered.

Mr. HARRIS. Thank you.

And I yield back.

Ms. DELAURO. Congresswoman Lee.

Ms. LEE. Okay. Yes, thank you very much. Let me ask about Roe v. Wade and its impact in terms of denying certain women who don't have access to resources, who are low income, which happen to be women of color, really aren't allowed to be included, actually, as part of their constitutional rights to an abortion.

While Roe v. Wade, while it granted a legal right to abortion supposedly for everyone, it only ended up for some because the restrictions on abortions, like the coverage ban, the Hyde amendment, it has made the ability to access abortion care burdensome, especially for young people or people of color, indigenous women, as well as queer, trans, and nonbinary young people. And so let me just ask any of our panelists about I would say the morality and the ethical questions around having a constitutional right and yet the Constitution really does not apply to women who can't access their constitutional right. So they are denied their constitutional rights because they don't have the money or the resources to exercise those.

Maybe Ms. Williams, would you like to respond to that because we are seeing this now everywhere in Texas how basically women aren't able to access their constitutional rights to an abortion.

Ms. WILLIAMS. Yes. Thank you so much, Representative Lee. I appreciate this question.

There is no right without access. And this is something that abortion funds and direct service organizations like me, like the Lilith Fund and volunteers across the country who are part of over 80 local grassroots abortion funds, know very, very well. We work to support people navigating a variety of compounding barriers that prove to us that simply—it is important, but it is simply not enough. And we do need to work further to ensure that people can access their constitutionally protected right, and a big piece of that

must be to repeal Hyde so that everyone can equitably get the care that they need, especially low-income communities of color.

Ms. LEE. Thank you.

Dr. Perritt, could you respond?

And then Dr. Palacio, if we have time.

Dr. PERRITT. Sure. I would briefly say that I absolutely agree with Amanda that it does us no good to have a right in theory when in actuality folks can't access that care. And so, for folks who are really seeking the care that they know that they need, that they know is best for them, then it is our obligation if we are upholding the Constitution to provide those benefits in reality for people who are seeking them, not just in theory.

Ms. LEE. Thank you. Very much. I think my time is up.

Thank you, Madam Chair, again for your leadership and for really ensuring that we have this public hearing so that the public understands what really systemic racism is in our healthcare system. Thank you.

Ms. DELAURO. Thank you. Yes.

Congressman Moolenaar. There you are.

Oh, no, no. I missed—Congressman Moolenaar, can you hold? I am sorry. I skipped over Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. That is all right. I just want to make a couple points. So what I am hearing is that if we—so that the Hyde amendment is systemically racist is what I am hearing in terms of the answers from the physicians on the call, but I believe refusing to cooperate with or pay for the destruction of someone's child is not an action against that person but for them and their community. Seventy percent of Americans agree with me on this. Sixty percent believe that we should not fund taxpayer—have taxpayer funding of abortion.

In my view, abortion is a failure to serve a woman in need. It capitulates to despair, and it says there is no hope for that woman as a mother and there is no hope for her child. But when I look at some of the great Black Americans who are radically changing this country for the better, many of whom grew up in poverty, what if their parents had received and believed that message? Who would be making that change today?

You know, supporters of abortion on this meeting should question whether the promotion of abortion itself is structurally racist since it disproportionately affects people of color and class and substantially reduces, first, to women of color to a much greater extent than White women. Planned Parenthood operates the largest chain of abortion centers in the United States and disproportionately locates those centers in or within close walking distance of minority neighborhoods. Ten percent of Planned Parenthood clinics are in majority Black ZIP Codes, yet majority Black ZIP Codes make up much less than 10 percent of ZIP Codes in the United States. To me this translates to Black lives lost. I don't know how you can see that any other way, especially when the founder of Planned Parenthood was an open supporter of Eugenics. This was part of her goal, and we are buying into that right now.

And when we talk about risk to women, there are studies, including a specific study of poor women on Medicaid in California—this is a recent study—or it was released, showing a much higher death

rate for women who have had abortions compared to women who have given birth, especially from suicide.

You know, I would ask the people on this call to support a longitudinal study of Planned Parenthood clinics where abortions are provided of those women's mental health, of their physical health, and actual study with statistical data that we can all look at and say, what is happening to these women's physical health? To pretend that there is no risk, I think the 99 percent risk-free comment, it can't be based in science, and we have to be talking about statistical data here.

You know, I just really support and am grateful for this. I am even grateful for this hearing, grateful for the opportunity to talk about it.

Ms. Bennett, I think you have really illustrated some of the impacts to women of color in this hearing. Even though you are the minority witness, you have done a fabulous job of defending the life of minority children, 30 percent of whom have been aborted in the last number of years. Let's change that trend.

I yield back.

Ms. DELAURO. Yes, Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chair.

This is a question for Dr. Perritt. We know that women's reasons for seeking an abortion are complex and deeply personal, but sometimes they are also a medical necessity. Can you walk us through what happens when a woman who is receiving care through Medicaid needs an abortion due to a medical complication and how it is to navigate a complex system of often State-imposed restrictions on the lifesaving care they need?

Dr. PERRITT. Thank you for that question. It is important to understand that navigating the healthcare system at baseline can be difficult and complicated regardless of your insurance status. When you add to that an insurance program that puts unnecessary restrictions on the care that you can and cannot access because of government-sponsored funding, then it becomes even more insurmountable to navigate those systems.

Now, for people who are seeking care, what this looks like is, depending on where you are living in the country, even your ability to find a provider who can care for you in the way that you need and you deserve can be very challenging and difficult. Amanda talked about the need to travel, the need to find childcare, just even the logistics to be able to get in to see that person. We have had a ton of legislation—Dr. Palacio mentioned legislation that has been passed over the last year that is focused on restricting access to abortion care. For someone who is living in a complicated situation that is then exacerbated by the need to access abortion care for whatever reason, medical reason or not, medical indication or not, being able to navigate these systems and structures in the context of the rest of your life is very difficult.

Representative Lee mentioned context. For me, all of my work is grounded in understanding that every person's life, every person's story, every person's experience is profoundly different. And while we all may never come to the same agreement on whether or not a person should have the right to parent or not, we must all agree that deciding care for someone else is not our role.

This is a decision that should be held by the individual and by controlling the insurance benefits, like the Hyde amendment, eliminating access to abortion, it does just that; it says we decide for you what you need and what you deserve.

Ms. CLARK. Thank you.

Ms. DELAURO. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

Ms. Bennett, you mentioned a friend, Destenie, who went to the ER after a Medicaid-funded abortion. Can you tell us more about her story and how that impacted her?

Ms. BENNETT. Absolutely. My friend Destenie she had an abortion at 5 months in Hartford. The abortion providers let her know that she was actually too far along, but based on Connecticut law, but they decided to do it any way. Supposedly, Connecticut law, although it does pay for abortion, supposedly they are supposed to consider if there is a health issue, but she wasn't asked any questions about her health. She told me they just billed the State.

After the abortion, she was rushed to the emergency room and—not directly after, but, you know, shortly after the abortion, she was rushed to the emergency room, and they found fetal remains inside of her body, which is something that does happen to some women who have had abortion, a botched abortion. There are baby parts that can be left inside of moms, and she was in the ER for 3 days, and she easily could have died. If she had died, there would have been no justice for her because she signed papers, and they would have just said, well, that is the risk that goes along with abortion. And, unfortunately, that is what happens when women have abortions, and they are not familiar with the risk, and they sign the papers. If something happens to them afterwards, well, it is on them; it was their choice.

I know a woman who is a nurse at Yale in New Haven and she also volunteers at a pregnancy center that I worked for, and she told me how many times women who have had abortions at other facilities would then come to the emergency room at Yale later on in the night because they couldn't go back to their abortion provider and they had botched abortions whether that was a perforated uterus, whether that was a blood clot, or whatever it may be.

Mr. MOOLENAAR. Thank you.

And, Dr. Perritt, I have a question for you. When a pregnant woman comes to see you as her doctor, I am assuming she is your patient. Do you have any role with the unborn child as your patient, or is that simply a separate than your patient?

Dr. PERRITT. So what I would say is that the question is a little bit confusing and I would say slightly misleading. So, when people are coming to me to seek care, if they are seeking obstetric care, if they are seeking reproductive healthcare services, if they are seeking abortion care, then I take care of certainly the woman that is in front of me. And more importantly, I talk with her about what her desires are—

Mr. MOOLENAAR. So just to be clear—if I can interrupt you just a second, so the child really is not your patient. Is that correct?

Dr. PERRITT. That is not how medicine works. That is not how the practice of care works in terms of who is my patient and who

is not. So what I do is talk with the person about what is the care that they are seeking.

So, for someone who is seeking care, then absolutely I take care of the person that is in front of me then.

Mr. MOOLENAAR. Okay. Well, thank you, Madam Chair.
I yield back.

Ms. DELAUBRO. Thank you.
Congresswoman Frankel.
Unmute, hello.

Okay. Thank you.

Ms. FRANKEL. Let me just clear up about some things that had been said. First, I want to say, hooray for Planned Parenthood for serving so many women and men in underserved communities, and they have served millions of people with things like HIV and testing, birth control, cancer screening, pap test, pregnancy services, and information.

And let me also talk about racism, systemic racism. It differs from racism on an individual level, but has the same roots of evil. Systemic racism arises when that hierarchy and those privileges get baked into the systems and institutions that govern daily life. Okay. That is what systemic racism is.

Let me ask a question I think of Ms. Williams, which is about the dangers of pregnancy crisis centers. Can you expand on that, please?

Ms. WILLIAMS. Yes. Thank you, Congresswoman, for this question. There are certainly more crisis pregnancy centers or fake clinics than abortion providers in my State of Texas, and we know that they do not provide medically accurate information. We know that they lie to people seeking abortion access, telling them that abortion is not an option. We have had clients who call our hotline and tell us that they performed an ultrasound and told them that they were farther along and that they were no longer eligible for an abortion in Texas, which was not accurate. And they often use religious, you know, ideology to coerce and manipulate people who are faced with making this emotional decision. So, unfortunately, they do prey on the people that are seeking abortion access and ultimately deny them all of their options and can in many cases leave them without understanding their rights.

Ms. FRANKEL. I thank you for that. I think that is—you know, I know this is for another discussion at another time, Madam Chair, but the gag rule, the domestic gag rule has to go. The international gag rule has to go. We have got to clean up a lot of injustice, not only for our women of color and poor women but for all the women of our country and our world.

And, with that, Madam Chair, I yield back.

Ms. DELAUBRO. Thank you. Thank you.
Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you very much, Chairwoman.

There is a couple things I want to say. Number one is that there was a comment that Congressman Hyde never, ever intended this to be discriminatory in nature, yet the reference that Barbara Lee read clearly says that, well, those who will be affected are those who live in ghettos. May I ask you to think about who typically has been living in economic ghettos? I think it speaks for itself.

Secondly, I think that there is no question that this Hyde amendment has negatively impacted access to healthcare and a right to an abortion, a safe abortion, for women. Women make this decision for a variety of reasons, the underlying issue here is the issue of choice, not whether or not you are pro-abortion or pro-life, but do you respect the woman's right to make those decisions? And if she is insured under some Federal program, should she not be entitled to the same healthcare that a very wealthy woman is?

And, lastly, I would just like to know if either one of the doctors would like to clarify anything that has been said today just for the record because, from my perspective, there have been a number of statistics mentioned and, quote/unquote, facts mentioned that I believe are quite misleading.

And, with that, I yield back.

My question is to either one of the doctors, Dr. Perritt or Dr. Palacio, if there is anything you would like to clarify.

Dr. PALACIO. Yes, thank you so much, Congresswoman. I will start and allow my colleague to weigh in.

There have been a number of misstatements, a number of citations of unreliable data and a number of misinterpretation of data that has been going on, including impugning of the Turnaway study in ways that just don't stack up.

This is a study that has been published in numerous, numerous of very highly regarded peer-review journals. More importantly, I want to say that what I would like to clarify for me the issue here today is really about justice, right? The issue has become a debate on abortion, but this is an issue about justice.

Abortion should be accessible to people who are poor the same way that it is accessible to people who are wealthy. Abortion should be accessible and affordable to people who are Black, Brown, and indigenous the same way it is accessible to people who are White.

This is clearly about justice. I have heard people say that if we are going to be telling, you know, people that they need to continue their pregnancies, the point is we shouldn't be telling people they need to continue their pregnancies any more than we should tell people they should be terminating their pregnancy.

I, as a Black woman, also as an Afro-Latina, as a first-generation daughter of immigrants, I can also say that people need to treat me with respect, that I have agency to make decisions on my own, and I believe that other women, all women, have the same agency.

Ms. DELAUR. Yes. Let me just ask now my ranking member, Congressman Cole, we are going to wrap up if you have any final comments, and then I will make some comments, and then we will bring the hearing to a close.

Mr. COLE. Well, thank you very much, Madam Chair.

And I want to thank all of our witnesses for coming to testify.

I want to thank our members for very robust participation, not surprising on a topic like this, but I think done civilly and professionally and each person is stating their point of view and why in an appropriate way. And I thank all the participants in the discussion and certainly you, Madam Chair, for presiding over it.

Let me make a couple of quick points. First, this is not an issue on which we are likely to agree. I think that is evident here and,

again, I respect people have a different point of view than I do on this issue, but my point of view isn't casually arrived at.

Early in the hearing, our distinguished still current chairman of the full committee made the point that she had, I think, presided over or been the leader of a group of pro-choice legislators back when that was a bipartisan group.

When I arrived in Congress, being pro-life was very bipartisan as well. There were a lot of pro-life Members in the Democratic Party. And for whatever reason we don't have that on either side any more. I mean, this has become a highly, not just polarized issue, but it falls very strongly along partisan lines. No question about that. And I say that with no disrespect to people that have a different point of view than me. But I do think as legislators it presents us with a daunting reality and that reality is, with all due respect to my friends, if this bill requires Republican support, it is not likely to have it in the House, and it is almost certainly not likely to have it in the Senate if Hyde is removed.

Now, we can have the fight, and, again, I don't think anybody on this committee on either side of this issue ever shies away from a fight. I have a lot of respect for my colleagues having been in the trenches with them and sometimes against them, and people here are passionate about what they believe, and that is appropriate, but as the Appropriations Committee, I think our main job is to get the job done, to make sure that we legislate.

I think this issue is going to be very difficult, certainly, obviously, we are not going to do anything on the balance of this Congress, but I think it will be difficult in the next Congress given the narrow majorities in the House and the Senate, again, no matter what happens in Georgia and given the rules of the Senate. So I just say that to, again, say I respect the opinions of all concerned here, but I feel very strongly about mine as well.

And I want to thank, again, all our witnesses. I thought you were all very professional and very fair in presenting your opinion. I particularly want to single out Ms. Bennett for obvious reasons. I agreed with her, with all due respect, than I did more with the other three, but I think it is tough whenever you are the minority to come forward and lay out your positions, and I thought this was done respectfully, again, by all concerned and professionally.

So, Madam Chair, I have never seen you shy away from a fight or a contentious subject, and I took this hearing as being a sign that that will be, once again, a sign of your leadership, but I also end in knowing that we may not agree on everything, but we know how to work together on a lot, and we demonstrated that over the last 5 years.

I look forward in finishing that job this year with a little bit of luck and then going on when you are the full committee chair in the next Congress and working together with you, again. But in this area, I just notice to my friends, I don't expect your opinions to change at all, and I respect that. Please don't expect mine to change at all either because it won't.

With that, Madam Chair, I yield back.

Ms. DELAURO. Thank you.

First of all, I want to thank the ranking member for your comments, and I, too, look forward to our wrapping up what we are

trying to get done for 2021. And we are on that path and I think with some good outcomes.

I want to just say a thank you to our witnesses for really very thoughtful and committed testimony and the professional credentials that you bring in your years of experience in this very important and critical discussion. I want to thank our members, both sides of the aisle, for their commitment, their determination, their years of trying to address this issue.

The issue that—a couple things I want to do in terms of setting the record straight, if I can, at the outset. And I want to make just that Planned Parenthood, as of January 2019, 56 percent of Planned Parenthood's health centers were located in health professional shortage areas, that is rural or medically underserved areas. And about 4 percent of Planned Parenthood health centers that provide abortion services are located in communities where more than one-third of the population is African American. African American. Their mission is to build a world in which every person, regardless of race, income, insurance, gender identity, sexual orientation, abilities, or immigration status, can access expert, compassionate, sexual and reproductive healthcare information and education without shame and without judgment.

I also want to say that I am proud of my State of Connecticut in what they have done to remove barriers in accessing comprehensive healthcare, which does include abortion, so that people who need it can access it. I would also just state for the record that, in fact, Connecticut has mandatory counseling for those who are under 16 years old. It is—the issue was spoken about in terms of parental notification, but you need to have mandatory counseling in the State of Connecticut.

And there is only one point more that I would make in terms of the record because I heard loud and clear that, what are the other services that are critically important to women? And if you take a look at the issues and assistance for housing, childcare, nutrition, we are debating those issues right now. We are looking at housing services and eviction notices that are going to [inaudible] To save a childcare industry. And we are losing that battle because—and women are dropping out of the workforce because their kids are at home and are dealing with schooling online, and there are no childcare centers. So they are staying home, and they are not going back to work. That is the reality of the services that we speak about but that are not there for their families. If we could say we were moving in that kind of a direction, maybe we could have some different views on some of these issues, but it is not the case. And I am so grateful for the discussion this morning. And I just say whatever your views are on the issue of abortion, whatever they are, our public policy decisions and their effect on the people we represent, that is where our responsibility lies is what is happening.

This is an important issue. It is a sensitive issue, and it is one that we had been reluctant to address. And it is long overdue for over 40 years of the Hyde amendment. You know, in 2015, we had an anti-Hyde hearing. We have not had a conversation about Hyde in this way in decades—in decades.

What are we afraid of? What are we afraid of? Nobody's here to question Henry Hyde's motives, but look at the consequences that have been discussed here today, and who are the people that these consequences have affected in so many ways? It is women of color; it is communities of color.

Our goal, as Members of Congress, is to ensure that women of color and all women have access to the reproductive healthcare that they deserve, that they need and that they deserve. One has to look at the consequences of the public policy initiatives that we enact and maybe take another look at those consequences and say, is this what we want to do? Is this where we want to go?

That is what we need to be addressing and that policies that fail the test of providing women, women of color, who are most affected by this, that they have access to the reproductive healthcare that they deserve. That is what our job is. We are in the business of dealing with public policy and its effect on women.

And I will speak for myself that the Hyde amendment has failed women, women of color, and communities of color to be able to access the healthcare and the reproductive healthcare that they need.

And I thank everyone, again. I thank us for an open discussion about this.

And, yes, to my ranking member and my colleague and my friend, I am not sure that positions will change, views will change, but let's hope, again, that we can look at some of these effects and how it is that we can change the ability for women and women of color to be able to access that healthcare.

I think the discussion has been very good. It has been thorough, and we will continue to have these discussions. We cannot shy away from what are sensitive issues but critically important issues as we go forward in doing our job for good public health policies that have led to racial inequities in our society.

And I thank everyone.

And, with that, this hearing is concluded. Thank you very, very much all of you for participating. Thank you.

[Statements for the record follow:]

CATHOLICS
FOR
CHOICE

IN GOOD CONSCIENCE

December 7, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole:

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Jamie Manson

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Catholics for Choice submits this testimony in unequivocal support of the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2019 (HR 1692/S 758) and urges the Committee to advance this important legislation. Catholics for Choice shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to individual well-being and respect and affirm the capacity of each person to make moral decisions about their lives. We serve as a voice for more than 70 million Catholics across the nation—the vast majority of US Catholics—who believe in the primacy of conscience and support access to abortion and other reproductive healthcare as an extension of the principles of our faith.

As Catholics, we are called by our faith to follow our consciences in all matters of moral decision-making and to respect the right of others to do the same. This includes the right to make decisions about abortion and reproductive healthcare. Decisions about how to respond to a pregnancy are sacred and deeply personal. Bans on abortion coverage erode this right, letting politicians interfere with an individual's sacrosanct personal decision, as well as cultivating judgment and stigma around such decisions.

Catholics' respect for conscience leads us to support the conscience-based decisions that each person makes, regardless of how we might make that decision ourselves. In fact, a majority of Catholics believe abortion can be a moral choice.

(more)

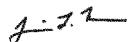
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Furthermore, our Catholic social justice tradition compels us to advocate for the poor and those marginalized in our community. We know that the Hyde Amendment and similar restrictions on access to abortion disproportionately affect people with lower incomes, people of color, those living in rural areas, the young and LGBTQ communities; they are hurt first and worst. Catholics respect the dignity and the worth of each person and are committed to building a just society. Already, too many are denied abortion coverage because of how much they earn, where they live, the color of their skin or their gender identity. Since the passage of the Hyde Amendment in 1976, anti-abortion policymakers have continually enacted bans on health coverage and funding for abortion that push this decision out of reach for many, particularly those struggling to make ends meet. Restricting care from individuals and communities who need it most is morally unconscionable.

The EACH Woman Act allows us to uphold our call as Catholics to treat every person, no matter their station, with dignity, respect and compassion. This is why a majority of Catholics believe that insurance plans, whether government or private, should include coverage for contraceptives and abortion care. We support the EACH Woman Act because it reinforces the principles of social justice we are taught and enables the most vulnerable people to access the reproductive health services and medications they need. EACH Woman empowers each person to make the conscience-based decisions that are best for themselves and their family.

We urge the Committee to advance the Equal Access to Abortion Coverage in Health Insurance Act, eliminate harmful abortion coverage bans and pass future appropriations bills free from such unfair coverage restrictions. We invite the committee to reimagine what it looks like to create a society where individuals are trusted to make moral decisions about their lives and priority is given to implementing policies that create a more just and compassionate society for all. Thank you for your consideration.

Sincerely,



Jamie L. Manson
President



ACOG COMMITTEE OPINION

Number 815

(Replaces Committee Opinion 613, November 2014)

Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the Abortion Access and Training Expert Work Group in collaboration with committee member Daniel Grossman, MD.

Increasing Access to Abortion

ABSTRACT: Individuals require access to safe, legal abortion. Abortion, although legal, is increasingly out of reach because of numerous restrictions imposed by the government that target patients seeking abortion and their health care practitioners. Insurance coverage restrictions, which take many forms, constitute a substantial barrier to abortion access and increase reproductive health inequities. Adolescents, people of color, those living in rural areas, those with low incomes, and incarcerated people can face disproportionate effects of restrictions on abortion access. Stigma and fear of violence may be less tangible than legislative and financial restrictions, but are powerful barriers to abortion provision nonetheless. The American College of Obstetricians and Gynecologists, along with other medical organizations, opposes such interference with the patient-clinician relationship, affirming the importance of this relationship in the provision of high-quality medical care. This revision includes updates based on new restrictions and litigation related to abortion.

Recommendations

The American College of Obstetricians and Gynecologists (ACOG) recommends the following to ensure the availability of safe, legal, and accessible abortion services free from harmful restrictions:

- The federal Hyde amendment and other federal and state restrictions on public and private insurance coverage of abortion should be eliminated. Public and private insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens.
- ACOG calls for the cease and repeal of legislation that creates barriers to abortion access and interferes with the patient-clinician relationship and the practice of medicine, including, for example:
 - bans on abortion at arbitrary gestational ages,
 - requirements that only physicians or obstetrician-gynecologists may provide abortion care,
 - telemedicine bans,
 - restrictions on medication abortion,
 - requirements for mandatory counseling and forced delay before obtaining care,
 - ultrasound requirements,
 - mandated parental involvement, and
 - facility and staffing requirements known as Targeted Regulations of Abortion Provider (TRAP) laws.
- ACOG recommends that funding for opt-out abortion training for medical student, resident, and advanced-practice clinician education (where training is routinely integrated but those with religious or moral objection can opt out of participation) be ensured, and governmental restrictions on training programs and funding be removed.
- The pool of clinicians who provide first-trimester medication and aspiration abortion should be expanded to appropriately trained and credentialed advanced-practice clinicians in accordance with individual state licensing requirements.
- Enforcement of the Freedom of Access to Clinic Entrances Act and other criminal and civil provisions and vigilance by local law enforcement to protect patient, clinician, and abortion clinic staff safety should be enhanced.
- Hospitals and other health care institutions should be encouraged to support abortion care as essential

medical care, eliminate barriers to the provision of abortion care in these settings, and preserve availability of comprehensive reproductive health services in communities undergoing hospital mergers.

Introduction

Safe, legal abortion is a necessary component of comprehensive health care. The American College of Obstetricians and Gynecologists supports the availability of high-quality reproductive health services for all patients and is committed to improving access to abortion. Access to abortion is threatened by state and federal government restrictions, limitations on insurance coverage of abortion care, restrictions on funding for training, restrictions imposed by hospitals and health care systems, stigma, violence against clinicians who provide abortions, and a subsequent dearth of clinicians who provide abortions. Legislative restrictions fundamentally interfere with the patient-clinician relationship and decrease access to abortion, particularly for those with low incomes and those living long distances from health care practitioners. The American College of Obstetricians and Gynecologists calls for advocacy to oppose and overturn restrictions, to improve access, and to integrate abortion as a component of health care.

Background

ACOG supports women's right to decide whether to have children, the number and spacing of their children, and to have the information, education, and access to health services to make these choices (1). In the United States, one quarter of women will obtain an abortion by age 45 years (2). The majority of abortion patients identify as Black, Hispanic, Asian, or Pacific Islander, and 75% of those seeking abortion are living at or below 200% of the federal poverty level (3). People of all genders have sexual and reproductive health needs, including women, transgender people, nonbinary people, and those who are otherwise gender-diverse. This Committee Opinion will use the terms women, patients, individuals, and people interchangeably, and will address specific health needs of transgender, gender nonbinary, and gender-diverse people where appropriate.

Many factors influence or necessitate an individual's decision to have an abortion. They include but are not limited to contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, and exposure to teratogenic medications. Additionally, pregnancy complications such as placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, chorioamnionitis, and cardiac or renal conditions may be so severe that an abortion is the only measure to preserve a patient's health or save their life. All terminations are considered medically indicated.

Individuals require access to safe, legal abortion. Although abortion is legal in the United States, it has become increasingly excluded from its appropriate place

in mainstream medical care. It is often the only essential health care service not offered by a patient's usual health care practitioner or health care system. A 2019 national survey of ACOG Fellows and Junior Fellows found that although 72% reported having a patient in the previous year who needed or wanted an abortion, only 24% provided this care (4). Additionally, many hospitals and health care systems limit the scope of reproductive health care for a range of reasons (5).

Abortion is extremely safe (6, 7). The risk of death associated with childbirth is approximately 14 times higher than that with abortion (6). In the United States, 88% of abortions occur within the first trimester, when abortion is safest. Serious complications from abortions are rare at all gestational ages (8).

In contrast, historical and contemporary data show that where abortion is illegal or highly restricted, pregnant people may resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, and reliance on unqualified or predatory abortion providers (9, 10). Today, approximately 25 million women around the world resort to unsafe abortions each year, and complications from these unsafe procedures account for as many as 15% of all maternal deaths, approximately 44,000 annually (11, 12).

In 1973, the U.S. Supreme Court decision *Roe v Wade* established that the legal right to privacy under the due process clause of the 14th Amendment extends to a person's decision to have an abortion (13). It is estimated that before 1973, approximately 800,000 U.S. women resorted to illegal abortion each year, resulting in preventable complications and death (14). After the Supreme Court ruling, mortality because of septic unsafe abortion decreased precipitously (15). Similar trends and improvements in women's health have been documented in other countries after the legalization of abortion (16).

Restrictions Limiting Access to Abortion

Abortion, although legal, is increasingly out of reach because of numerous restrictions imposed by the government that target patients seeking abortion and their health care practitioners. Recent years have seen a dramatic increase in the number and scope of legislative measures restricting abortion. In 2019, states enacted 58 restrictions on abortion, of which 25 would ban all, most, or some abortions (17). Several states passed laws banning abortions at 8 weeks of gestation or earlier, and Alabama enacted a law making abortion provision a felony; as of 2020, these laws have been blocked by the courts. Health care practitioners face inappropriate laws unique to the provision of abortion that mandate procedures and counseling that are not evidence-based or ethical and compromise the quality of care (see Box 1). ACOG, along with other medical organizations, opposes

such interference with the patient-clinician relationship, affirming the importance of this relationship in the provision of high-quality medical care (7, 18, 19). ACOG calls for the cease and repeal of legislation that creates barriers to abortion access and interferes with the patient-clinician relationship and the practice of medicine, including, for example, bans on abortion at arbitrary gestational ages, requirements that only physicians or obstetrician-gynecologists may provide abortion care, telemedicine bans, restrictions on medication abortion, requirements for mandatory counseling and forced delay before obtaining care, ultrasound requirements, mandated parental involvement, and facility and staffing requirements known as Targeted Regulations of Abortion Provider (TRAP) laws.

Facility and Staffing Requirements

Facility and staffing requirements enacted in some states under the guise of promoting patient safety single out abortion from other outpatient procedures and impose medically unnecessary requirements designed to reduce access to abortion. Also known as TRAP laws, these measures have included unnecessary requirements, such as mandating that:

- facilities meet the physical plant standards of hospitals
- staffing, medications, and equipment be maintained at unnecessary levels
- physicians providing abortions in the clinic setting obtain hospital admitting privileges, with no mechanism to ensure that hospitals will grant such privileges
- the same physician must provide in-person counseling, ultrasonography, and the abortion procedure, resulting in difficulties for patients and clinicians who travel long distances to receive or provide abortion care in rural areas and for multi-day procedures
- clinicians who provide abortion must be board certified obstetrician-gynecologists even though clinicians in many medical specialties can provide safe abortion services

ACOG opposes such requirements because they improperly regulate medical care and do not improve patient safety or quality of care (7, 20).

These laws make abortion more difficult and expensive to obtain, imposing additional costs on the patients who can least afford them (21). Compliance with some of the most onerous regulatory requirements has proved to be so difficult that practices have closed (22). TRAP laws make abortion inaccessible for some people and create delays for others, leading to an increase in abortion after the first trimester (23–25).

Box 1. Types of Measures Restricting Abortion

"Personhood" measures—Establish fertilized eggs as separate legal individuals subject to laws of the state and would likely criminalize abortion, embryonic stem cell research, infertility treatments, cancer treatments, and some methods of contraception.

Physician and facility requirements—Require that only physicians, sometimes with admitting privileges at a nearby hospital, or only obstetrician-gynecologists, may provide an abortion, and establish certain requirements for the facility where the procedure is performed, which may vary by gestational age.

Gestational age bans—Legislate arbitrary gestational age cutoffs, often 20 weeks of gestation but as early as 6–8 weeks of gestation, beyond which an abortion cannot be performed except to prevent the patient's death or irreversible morbidity, often with no exception for fetal anomalies.

"Partial-birth" abortion bans—The federal Partial-Birth Abortion Ban Act of 2003 (upheld by the Supreme Court in 2007) makes it a federal crime to perform procedures that fall within the definition of so-called "partial-birth abortion" contained in the statute, with no exception for procedures necessary to preserve the health of the patient. Although "partial-birth abortion" is not a medical term and is vaguely defined in the law, clinicians and lawyers have interpreted the banned procedures as including intact dilation and evacuation unless fetal demise occurs before surgery. Several states also have passed bans on so-called "partial-birth abortions," which impose additional restrictions and penalties on clinicians who provide abortions in those states.

Biased counseling—Requires scripts mandated by the state to be used in patient counseling, often including inaccurate data and misinformation about pregnancy, fetal development, and abortion. Some states have mandated that clinicians provide information to patients about so-called abortion "reversal," an unproven regimen of progesterone treatment aimed at increasing the likelihood of pregnancy continuation in the rare case that a patient decides to try to continue the pregnancy after taking mifepristone for medication abortion.

Mandated ultrasound—Requires ultrasonography and often additional requirements that the patient receive a detailed description of the image, view the image, or listen to Doppler cardiac tones.

State-level mandatory delay requirements—Requires individuals to make two trips for a one-day procedure, typically with a 24- to 72-hour mandated delay between counseling and the abortion procedure. These laws create additional burdens, especially for people in rural areas who often have to travel for many hours to reach a health care practitioner.

(continued)

Box 1. Types of Measures Restricting Abortion (continued)

Parental involvement—Requires one or both parents to be notified or give consent before a minor may undergo abortion despite any potential danger to the minor.

This box provides selected examples of types of legislation that restrict access to abortion and is not an exhaustive list. See <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> for detailed descriptions of legislation restricting abortion by state.

Box 2. Abortion Coverage Bans and Funding-Related Restrictions

Hyde Amendment and other federal restrictions—Federal Medicaid covers abortion only when a patient's life is endangered or in cases of rape or incest. Legislated in 1977 and renewed annually as a rider to federal appropriation bills. It was amended in 1994 to add rape and incest as exceptions. Restrictions also exist through the TRICARE military health care system, the Federal Employees Health Benefits Program, and within the Indian Health Service; Veterans Affairs prohibits abortion counseling or services in all cases.

State Medicaid coverage—As of 2020, only 16 state Medicaid agencies cover medically necessary abortions beyond those allowed under the Hyde amendment. South Dakota is the only state not in compliance with the minimum federal Hyde exceptions and excludes coverage even in cases of rape and incest.*

Private insurance coverage—A number of states have banned abortion coverage in the private insurance market, including in new exchanges being established under the Patient Protection and Affordable Care Act where individuals with low and moderate incomes can buy private health insurance. Many of these laws lack exceptions for cases in which an individual's health is jeopardized or in cases of fetal anomaly.

Residency training funding—Some states restrict state monies from being used to support or subsidize abortion training at public universities or hospitals.

Affiliation bans—Some states prohibit any medical or educational institution that provides abortion care, referrals, or training from participating in public health programs or from receiving public funding of any sort, including Medicaid reimbursements or family planning grants.

Punitive tax policies—Some states deny tax-exempt status to any nonprofit organization, hospital, or health center that provides, refers for, or covers abortion care.

*Guttmacher Institute. State funding of abortion under Medicaid. New York, NY: Guttmacher Institute; 2020. Available at: <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>. Retrieved August 19, 2020.

Insurance Coverage Restrictions

Insurance coverage restrictions, which take many forms, constitute a substantial barrier to abortion access and increase reproductive health inequities. The passage of the federal Hyde amendment in 1977, which denies federal Medicaid coverage for abortions except when a patient's life is endangered or in cases of rape or incest, and the annual renewal of this provision has severely limited Medicaid coverage for abortion; a majority of states also restrict state Medicaid coverage of abortion. Restrictions on abortion coverage also exist for military personnel, retirees, and their dependents through the TRICARE military health care system, for veterans accessing care through Veterans Affairs, for federal employees and their dependents insured through the Federal Employees Health Benefits Program, and for those receiving care through the Indian Health Service. These coverage restrictions impede access to safe abortion care, and in some cases function as a de facto abortion ban (26, 27). Legislative bans on private insurance coverage of abortion further marginalize abortion and represent a departure from the insurance industry's usual practice of covering abortion services equitably with other procedures. In addition, restrictions attached to appropriations and other public monies hospitals receive can jeopardize medical education and training programs for all clinicians, as well as affect patient care. A list of coverage-related and payment-related restrictions can be found in Box 2. The federal Hyde amendment and other federal and state restrictions on public and private insurance coverage of abortion should be eliminated. Public and private insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens.

Restrictions on Medication Abortion

Medication abortion accounts for approximately 60% of abortions up to 10 weeks of gestation in the U.S., yet federal and state-level restrictions limit the use of this safe and effective method (28, 29). The U.S. Food and Drug Administration's Risk Evaluation and Mitigation Strategy for mifepristone requires that the medication be dispensed in a clinic, medical office, or hospital. Clinicians may not write a prescription for mifepristone for

patients to obtain the medication in a pharmacy, which prevents some clinicians from offering the service (4). In addition, as of 2020, 18 states have banned the use of telemedicine to provide medication abortion, despite the evidence that the service is safe and effective and has a high degree of patient satisfaction (30–32); its introduction was also associated with a substantial reduction in second-trimester abortion (33). Most states also prevent advanced practice clinicians from providing medication abortion even though research from several countries indicates that outcomes are similar to those when the service is provided by physicians (34).

Additional Barriers to Abortion Access

Other formidable obstacles to abortion access include the stigma associated with obtaining and providing abortion services, a lack of clinicians who provide abortion care, and "crisis pregnancy centers" that use misinformation to divert pregnant people from appropriate care. These nonlegislative barriers can be exacerbated by or result from restrictive legislation and can further isolate people who face more barriers to timely medical care.

Stigma and Violence

Stigma, harassment, and violence discourage abortion access and provision and harm patients. Stigma and fear of violence may be less tangible than legislative and financial restrictions, but are powerful barriers to abortion provision nonetheless (35). The stigma of obtaining an abortion and providing abortion may lead to secrecy, marginalization of abortion from routine medical care, delays in care, and increased morbidity from the procedure (35, 36).

Since 1993, anti-abortion violence has led to 11 murders and 26 attempted murders (35, 37, 38). Most abortion clinics report harassment (39). Acts of harassment include picketing, picketing with physical contact or blocking, vandalism, picketing of homes of staff members, bomb threats, harassing phone calls, noise disturbances, taking photos or videos of patients and staff, tampering with garbage, placing glue in locks or nails on the driveway of clinics, breaking windows, interfering with phone lines, approaching cars, and recording license plates (39, 40). The Freedom of Access to Clinic Entrances Act became law in 1994 in response to clinic violence, and specifically prohibits the use of force against individuals accessing abortion care or reproductive health care clinicians. However, this federal law requires implementation by local law enforcement, which remains inconsistent (See "The Abortion Fight at Ground Zero: Is the FACE Act Being Enforced?" at <https://rewire.news/article/2010/04/30/abortion-fight-ground-zero/>). In addition, a 2014 Supreme Court ruling striking down a state law that established a fixed "buffer zone" around abortion clinics has resulted in other jurisdictions repealing or abandoning enforcement of similar laws. Clinicians who provide abortion care also have been directly targeted with death threats, other threats of harm, and stalking, among other violent acts (38). Enforcement of the Freedom of Access to Clinic Entrances Act and other criminal and civil provisions and vigilance by local law enforcement to protect patient, clinician, and abortion clinic staff safety should be enhanced.

Lack of Abortion Care Facilities and Practitioners

The number of facilities providing abortion in the United States decreased 38% from 1982 to 2000, and continues to decrease (40, 41). More than one third of U.S. women live in the 89% of counties that lack an abortion care facility, and more than 17% of women obtaining an

abortion in 2008 traveled more than 50 miles to obtain the procedure (28, 42). A 2017 study identified 27 U.S. cities with populations of 50,000 or more where people have to travel more than 100 miles to the nearest clinician who provides abortions (43). This dearth of abortion services also derives from a lack of health care practitioner training, institutional policies against abortion provision, and a restricted pool of health professionals qualified and willing to provide abortion care.

Despite the Accreditation Council for Graduate Medical Education (ACGME) requirement that obstetrics and gynecology residency programs include abortion training, programs widely vary in the scope and type of training offered (44–46). State laws, regulations, institutional restrictions, and funding restrictions also may influence administrative decisions to disallow abortion training and may ultimately jeopardize the accreditation of medical education programs (45). ACOG recommends that funding for opt-out abortion training for medical student, resident, and advanced-practice clinician education (where training is routinely integrated but those with religious or moral objection can opt out of participation) be ensured, and governmental restrictions on training programs and funding be removed.

Further, many religiously affiliated institutions, especially Catholic health care facilities, do not offer reproductive health services, including contraception, sterilization, and abortion (47, 48). Mergers of secular hospitals with religiously affiliated health systems can result in the elimination of previously available reproductive health services (49, 50). In other cases, hospitals cease to offer services not based on legal restrictions or religious opposition, but because of the associated stigma. Hospitals and other health care institutions should be encouraged to support abortion care as essential medical care, eliminate barriers to the provision of abortion care in these settings, and preserve availability of comprehensive reproductive health services in communities undergoing hospital mergers.

Laws that unnecessarily curtail scope of practice diminish the number of qualified medical professionals who can provide abortion care. The vast majority of states require that abortions be provided only by physicians, which limits the practice of advanced practice clinicians (51). However, several reports show no differences in outcomes in first-trimester medication and aspiration abortion by health care practitioner type and indicate that trained advanced practice clinicians can safely provide abortion services (34, 52–58). The pool of clinicians who provide first-trimester medication and aspiration abortion should be expanded to appropriately trained and credentialed advanced practice clinicians in accordance with individual state licensing requirements.

People Facing More Barriers

Adolescents, people of color, those living in rural areas, those with low incomes, and incarcerated people can face

disproportionate effects of restrictions on abortion access. As of 2020, parental involvement of some kind in a minor's decision to access abortion is required in 37 states and may contribute to delays accessing care (59, 60). Restrictions and requirements of clinicians who provide abortions, restrictions on the use of telemedicine, and legislatively imposed mandatory delay all have a disproportionate effect on rural people's access to abortion (61). People living on low incomes most acutely face federal and state restrictions on public and private insurance coverage of abortion, including plans offered through the insurance exchanges established under health care reform.

Although incarcerated people possess the legal right to abortion, accessibility varies widely (62, 63). A survey of prison and jail health care practitioners found that only 68% of respondents enabled incarcerated people to obtain abortion care (62), and a 2019 study representing nearly 60% of all U.S. incarcerated women reported only 11 abortions in 1 year, representing 1% of all pregnancy outcomes (63).

Immigrants also may face difficulties accessing abortion care, including language and financial barriers, as well as limited knowledge of available services (64). There have been cases of unaccompanied minor immigrants in detention who have been prevented by federal authorities from accessing abortion care, a policy that has been successfully challenged in court (65).

Transgender men and gender-diverse individuals also may face barriers accessing abortion services (66). Transgender individuals report experiencing discrimination and mistreatment when seeking health care, and clinicians providing abortion care should ensure their practices are welcoming to transgender patients (67, 68). More research is needed to understand the experiences of transgender men and gender-diverse individuals seeking abortion care.

Crisis Pregnancy Centers

Crisis pregnancy centers present themselves as health clinics offering pregnancy options services, but operate to dissuade individuals from seeking abortion care (69). They often provide inaccurate medical information, asserting false links between abortion and breast cancer, infertility, mental illness, and other misinformation (70). These efforts to misinform can divert pregnant people from accessing comprehensive and timely care from appropriately trained and licensed medical practitioners (70).

Summary

When restrictions are placed on abortion access, patients and families suffer. Abortion access is increasingly limited; research shows that restrictions dictate whether or not care is safely obtained, as well as the quality of care (7, 71). Restrictions disrupt the patient-clinician relationship, create substantial obstacles to the provision of

safe medical care, and disproportionately affect those with low incomes and those living long distances from clinicians who provide abortion care (72, 73). Additionally, clinicians who provide abortions may face stigma in the workplace, in their communities, and from colleagues. Clinicians who provide abortions face violence and threats to themselves, their staff, and their families. Finally, patients are prevented from or experience delays in obtaining abortion care because of inadequate health coverage, insurance coverage restrictions imposed by the state, or waiting periods, and are subject to stigma and shame. Individuals who are unable to obtain a wanted abortion report worse physical health and more economic insecurity compared to those obtaining the abortion (74, 75). These obstacles marginalize abortion services from routine clinical care and are harmful to people's health and well-being.

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Published online on November 19, 2020

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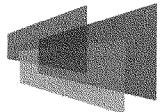
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**National
Latina Institute
for Reproductive
Justice**

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Ann Marie Benitez
Senior Director of Government Relations
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**Testimony to the U.S House of Representatives,
Committee on Appropriations, Subcommittee on Labor, Health and Human
Services, Education, and Related Agencies**

December 8, 2020

Dear Subcommittee Chairwoman DeLauro, Ranking Member Cole, and all members of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies:

The National Latina Institute for Reproductive Justice (Latina Institute) submits this testimony in strong support of repealing the Hyde Amendment once and for all. Today's Subcommittee Hearing is an important first step in ensuring that the legal right to abortion care is a reality for all those who need it. As an organization that advances Reproductive Justice for the almost 30 million Latinas/xs¹ and their communities, we

¹ Note: Latina Institute, conscious of the importance of the full range of gender identities, utilizes gender-neutral terms throughout its materials. "Latina/x" is a term that challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces. Due to the limitations of data collection, we use "Latina(s)," "Latino(s)" or "women" where research only shows findings for cisgender people. Moreover, Latina Institute uses the term "Hispanic" when the research cited uses the term.

believe everyone should have access to abortion care, regardless of their income, immigration status, or where they live.² Access to full reproductive health care, including abortion, is essential for Latinas/xs. "Let's be clear", says Latina Institute Poderosa³ Camila Rojas, "abortion is a vital part of reproductive health care. When individuals can determine if and when to have children, it benefits not just their families and communities, but society as a whole."⁴

Background

It is commonly assumed that the Supreme Court case *Roe v. Wade* made abortion care a right in 1973.⁵ However, Latina/x communities know that is not true. Immediately after *Roe* was decided, politicians started erecting specific barriers to cut off access to abortion care, which impacted communities of color and those with low-incomes. The most damaging of these barriers is the Hyde Amendment. It was originally passed as a rider to the Medicaid Act in 1976 by Representative Henry Hyde. Rep. Hyde wanted to ban all abortion care, but he knew that high and middle income communities would still have the resources to access it.⁶ As Rep. Hyde stated in the debate on the House floor, "I certainly would like to prevent, if I could legally, anybody having an abortion — a rich

² American Community Survey, 2019 1-year Estimates: Table B01001, available at <https://data.census.gov/cedsci/table?q=Race%20and%20Ethnicity&id=ACSDT1Y2019.B01001&hidePreView=false>

³ Poderosas are Reproductive Justice activists that drive the policy, work, and impact of the Latina Institute. They are based in Texas, Florida, Virginia, and New York.

⁴ Camila Rojas, *After 44 Years, end the Hyde Amendment, a Baseless Barrier to Reproductive Health Care*, South Florida Sun Sentinel, <https://www.sun-sentinel.com/opinion/commentary/fl-op-com-hyde-amendment-44th-anniversary-20200930-7svlfruc7fshnv2dqnbc6r14-story.html>, (Sept. 30, 2020).

⁵ *Roe v. Wade*, 410 U.S. 113 (1973).

⁶ Representative Hyde (IL). *No Taxpayer Funding for Abortion*, Congressional Record 123:16 (June 17, 1977) p.19700. Available from: <https://www.congress.gov/95/crecb/1977/06/17/GPO-CRECB-1977-pt16-3-2.pdf>.

woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the...Medicaid bill.⁷

This created a discriminatory class system in which wealthy communities had access to abortion care and communities who have low incomes did not. This classist system is also largely rooted in racism due to the structural inequality in the United States that has continually pushed Black, Indigenous, and People of Color (BIPOC) communities into poverty. The Latina/x community faces higher rates of poverty and higher rent burdens than white communities.⁸ In 2019, 17.2 percent of Latino/a households lived below the federal poverty line, compared to 10.3 percent of white households.⁹ Due to these systemic and discriminatory barriers, BIPOC communities, and specifically Latinas/xs, disproportionately rely on Medicaid for their health coverage. Data from 2018 shows that 27 percent of Hispanic women of reproductive age rely on Medicaid.¹⁰ That number dramatically increases to almost half, 47.3 percent, for Hispanic women with low incomes.¹¹ Policies like the Hyde Amendment trap Latina/x families and communities in a never-ending cycle of oppression simply because of their ethnicity and income.

⁷ *Id.*

⁸ Economic Policy Institute, *Latinx workers—particularly women—face devastating job losses in the COVID-19 recession*, <https://www.epi.org/publication/latinx-workers-covid/>, (Aug. 20, 2020).

⁹ American Community Survey, 2019 1-year Estimates, Table S1701, <https://data.census.gov/cedsci/table?q=Income%20and%20Poverty&tid=ACSST1Y2019.S1701&hidePreview=false>

¹⁰ Adam Sonfield, *U.S. Insurance Coverage, 2018: The Affordable Care Act Is Still Under Threat and Still Vital for Reproductive-Age Women*, Guttmacher Institute, <https://www.guttmacher.org/article/2020/01/us-insurance-coverage-2018-affordable-care-act-still-under-threat-and-still-vital>, (January 27, 2020)

¹¹ *Id.*

BIPOC communities have sought relief from the Hyde Amendment for over four decades, but instead of repealing it, anti-choice politicians have expanded its reach to include all federal funding.¹² Today, this rider and other Hyde-like riders are applied annually via appropriations bills that cover (1) Medicaid, Medicare, and the Children's Health Insurance Program, (2) Indian Health Services, (3) the military's TRICARE program, (4) federal prisons and ICE detention centers, (5) the Peace Corps, and (6) the Federal Employees Health Benefits Program.¹³ Similar Hyde-like restrictions were also written into the Affordable Care Act (ACA). President Obama conceded to anti-choice pressure and wrote an Executive Order that banned any use of federal subsidies in the ACA for abortion care.¹⁴ These federal subsidies help people with low incomes pay for the premiums of their private coverage purchased in the marketplaces established under the ACA.¹⁵ Another policy gave states the option to write in Hyde-like restrictions of their own to apply to all marketplace plans purchased in that state.¹⁶ As Camila came to find out when she needed abortion care, Florida is one of those states. "When I called my insurance company", she explains, "I was shamed by the person on the line, who told me in pointedly ugly terms that my plan, purchased through the

¹² Kaiser Family Foundation, *The Hyde Amendment and Coverage for Abortion Services*, <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>, (Sept. 2020).

¹³ *Id.* See also Megan K. Donovan, *In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact*, Guttmacher Institute, <https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact> (Jan. 5, 2017).

¹⁴ Exec. Order No. 13535, (March 24, 2010). Available at <https://obamawhitehouse.archives.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst>

¹⁵ Kaiser Family Foundation, *Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans*, <https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans/>, (June 24, 2019).

¹⁶ *Id.*

Affordable Care Act, did not cover the costs of any abortion-related services.”¹⁷ Left with no access to the care she needed and deserved, Camila realized that “these financial barriers and unnecessary hurdles are not incidental.”¹⁸ In fact, “They are part of a larger narrative that seeks to control the bodies of women of color and strip them of their reproductive agency.”¹⁹

Real-life Consequences

Make no mistake, the Hyde Amendment has real-life consequences. In 1977, Rosie Jimenez became the first known victim to die because of the Hyde Amendment. A single mother on her way to college with a scholarship, Rosie became pregnant and knew she needed abortion care to raise her family and make it through college. After the Texas Medicaid agency denied her coverage, Rosie sought out whatever abortion care she could find. Due to unsanitary conditions and lack of knowledge, Rosie died of complications from her abortion on October 3, 1977.

The harms of the Hyde Amendment are further compounded by anti-choice state policies and laws. Where you live should never dictate your access to care, including abortion care. Poderosa Zoe Avellan found that access to care in many states has only gotten worse for Latinas/xs. Zoe, who came from a similar town and family to Rosie explains, “My native state of Texas has some of the most restrictive abortion laws in the

¹⁷ Camila Rojas, *After 44 Years, end the Hyde Amendment, a Baseless Barrier to Reproductive Health Care*, South Florida Sun Sentinel, <https://www.sun-sentinel.com/opinion/commentary/fl-op-com-hyde-amendment-44th-anniversary-20200930-7svlfruc7ifshnv2dqnbcc6rl4-story.html>, (Sept. 30, 2020).

¹⁸ *Id.*

¹⁹ *Id.*

country. Due to the failure of our elected officials to center the health and wellbeing of their residents, we have less health coverage and fewer resources to take care of ourselves and our families.²⁰ Particularly in places like the Rio Grande Valley where Zoe lives, people seeking abortion care must travel hundreds of miles and pay dramatically higher out of pocket costs for their abortions than people in other areas.²¹ On average, medication abortions cost around \$500, but due to the web of coverage and access barriers in the Rio Grande Valley, Zoe had to scrape together \$700.²² Zoe firmly states that, "I have never regretted my abortion. I know I made the right decision. But I also know that I almost wasn't able to exercise my right to make that decision because of policies aimed at stripping people of color of our reproductive agency."²³

The COVID-19 pandemic has further exacerbated these barriers to care. In a pandemic, people need easier and faster access to care, not less. Abortion care is itself a time-sensitive medical need, along with COVID-19 testing, diagnosis, and treatment. Latinas/xs, a large population of essential workers, specifically need accessible care during this pandemic as they are more likely to have the very chronic conditions that make them particularly vulnerable to COVID-19.²⁴ This has resulted in Latinas/xs

²⁰ Zoe Avellan, *An Anti-Abortion Law Killed Rosie Jimenez 43 Years Ago. It's Still in Effect.*, Refinery 29, <https://www.refinery29.com/en-us/2020/10/10069843/hyde-amendment-abortion-funding-cost-care>, (Oct. 20, 2020)

²¹ *Id.*

²² Guttmacher Institute, *Induced Abortion in the United States*, <https://www.guttmacher.org/factsheet/induced-abortion-united-states>, (September 2019).

²³ Zoe Avellan, *An Anti-Abortion Law Killed Rosie Jimenez 43 Years Ago. It's Still in Effect.*, Refinery 29, <https://www.refinery29.com/en-us/2020/10/10069843/hyde-amendment-abortion-funding-cost-care>, (Oct. 20, 2020)

²⁴ Economic Policy Institute, *Latinx workers—particularly women—face devastating job losses in the COVID-19 recession*, <https://www.epi.org/publication/latinx-workers-covid/>, (Aug. 20, 2020).

leading in the death and unemployment rates resulting from this pandemic.²⁵ When the first wave of unemployment hit the United States in early 2020, one in four Latinas/xs were unemployed, by far the highest rate of unemployment as a direct result of this virus.²⁶ Bouncing back in this job market is also more difficult for Latinas/xs because they are more likely to work in benefit-less and low-wage jobs.²⁷ Latinas/xs who need abortion care during this crisis cannot get the coverage they need, and now more than ever, they cannot afford to pay out of pocket for their reproductive health care.

Yet when Latinas/xs needed care – including abortion care – the most, anti-abortion politicians leveraged the COVID-19 crisis to pass “emergency” abortion bans. Zoe explains that in Texas, “Even during the pandemic, our governor has been playing politics with people’s lives, forcing abortion clinics to shut down.”²⁸ When a pregnant person is denied the abortion they need, they are more likely to experience late-term pregnancy complications and four times more likely to live below the federal poverty level.²⁹ Abortion bans, including the Hyde Amendment, do not stop the need for abortion care, they instead put people and families at risk.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ Zoe Avellan, *An Anti-Abortion Law Killed Rosie Jimenez 43 Years Ago. It's Still in Effect.*, Refinery 29, <https://www.refinery29.com/en-us/2020/10/10069843/hyde-amendment-abortion-funding-cost-care>, (Oct. 20, 2020)

²⁹ ANSIRH, *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf, (Aug. 2018).

Im/migrant³⁰ Communities' Right to Care

Im/migrants are essential contributors to the identity of the United States and its wealth and culture. Yet discrimination based on im/migration status has been written into the fabric of our healthcare system. Discriminatory coverage exclusions create additional barriers to abortion care for im/migrants. The Medicaid program contains a five-year waiting requirement for most immigration statuses despite the fact they otherwise qualify for the coverage.³¹ States have the option to remove this waiting period for certain immigrants, but six states have instead created a permanent ban for immigrants from their Medicaid programs.³² States can also allow certain pregnant immigrants to receive limited care during their pregnancy if still subject to the five-year bar.³³ Communities who are undocumented are left completely without access to any federally funded medical coverage except in very limited emergency situations.³⁴ The coverage barriers imposed by our safety net healthcare system on im/migrants impede their ability to seek needed abortion services. For many families, the increased cost of care imposed by these barriers means having to choose between paying out-of-pocket for care and paying for basic necessities, such as food and shelter.

³⁰ Note: The Latina Institute uses the term "im/migrant" to recognize all persons and communities that are living in the U.S. who come from different countries or have migrated from different territories, whether temporarily or permanently. When the data referenced only includes "immigrants", those who have moved permanently, "immigrants" is used.

³¹ National Health Law Program, *An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program*, <https://healthlaw.org/wp-content/uploads/2019/09/NHELP-ReproGuide-Ch2.pdf>, (2019).

³² *Id.*

³³ *Id.*

³⁴ *Id.*

In addition to coverage barriers, the Trump administration's relentless and cruel implementation of xenophobic policies have caused additional stress for im/migrant Latinas/xs when seeking coverage and care, including abortion care. For example, the Department of Homeland Security's recent Public Charge Rule dramatically expanded what social services utilization would count against someone applying for permanent legal status.³⁵ Prior to the new rule, traditional Medicaid coverage could not be used against an application for new immigration status, now it can be.³⁶ This has created a wide-spread chilling effect, causing many im/migrant families to avoid or disenroll from benefit programs they would otherwise qualify for, due to fear of incarceration, family separation, and deportation.³⁷ Due to the Trump administration's anti-immigrant rhetoric and threats of mass raids, it was reported that im/migrant women postponed abortion care or decided to forego care all together.³⁸ In our 2018 poll, Latina Institute found that one in five respondents knew a friend or family member who had put off seeking reproductive healthcare because of their fears surrounding immigration issues in this country.³⁹ The cumulative effect of these policies only endanger more im/migrant Latinas/xs as they seek abortion care during this pandemic.

³⁵ *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41292 (August 14, 2019). Available at <https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-17142.pdf>.

³⁶ Priscilla Huang, *Immigrant Health Care in the Time of the Coronavirus*, National Health Law Program, <https://healthlaw.org/immigrant-health-care-in-the-time-of-coronavirus/>, (March 5, 2020).

³⁷ *Id.*

³⁸ Brianna Sacks, *Undocumented Immigrants Are Canceling Abortion Appointments Because They're Afraid Of Getting Deported*, Buzzfeed <https://www.buzzfeednews.com/article/briannasacks/undocumented-immigrantscanceling-abortion-appointments>, (July 2019).

³⁹ National Latina Institute for Reproductive Justice and Perry undem, *Latina/o Voters' Views and Experiences Around Reproductive Health*, https://www.latinainstitute.org/sites/default/files/NLIRH%20Survey%20Report_F_0.pdf, (August 2018).

Im/migrant families have been especially impacted by COVID-19. Compounding their vulnerability to the virus is a constant language barrier. Specifically in Latina/x households, 71.6 percent speak a language other than English at home and three in ten Latinas/xs are not fluent in English.⁴⁰ Yet public health information about COVID-19 safety was most commonly disseminated in only English. Even employers in essential worker sectors, the very sectors of the workforce that mostly comprise Latina/x workers, regularly gave COVID safety information in only English.⁴¹ Everyone deserves access to public safety information in the language they are most comfortable speaking and reading, ensuring that this critical information is fully understood. Bodily autonomy and health should never be conditioned upon language ability, documentation, or income status. Yet im/migrant communities live with this discrimination every day. Healthcare is a human right and healthcare must include abortion access and coverage for anyone and everyone that needs it.

Conclusion

Latinas/xs and all BIPOC communities deserve equal access to care. Yet the Hyde Amendment has relegated them to second class citizens for over forty-four years. As Camila states, "All of us, regardless of age, race, gender, economic or documentation status, deserve access to affordable reproductive healthcare so that we can take care of

⁴⁰ Economic Policy Institute, *Latinx workers—particularly women—face devastating job losses in the COVID-19 recession*, <https://www.epi.org/publication/latinx-workers-covid/>, (Aug. 20, 2020).

⁴¹ *Id.*

ourselves with dignity and self-determination.⁴² How much longer do women of color have to wait for basic equity?

To that end, the Latina Institute urges Congress to remove the Hyde Amendment permanently from all future appropriations bills and ensure each federal budget is working for all communities in the United States. We also encourage Congress to pass the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2019 to enshrine these principles in federal law.

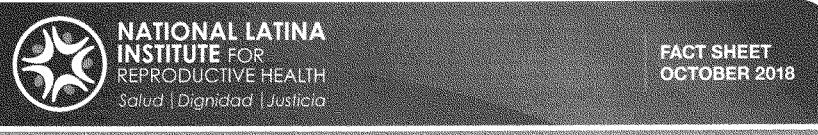
Thank you for your attention to this critical issue. If you have any questions or would like to follow up, please contact me at AnnMarie@Latinalnstitute.org.

Sincerely,



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⁴² Camila Rojas, *After 44 Years, end the Hyde Amendment, a Baseless Barrier to Reproductive Health Care*, South Florida Sun Sentinel, <https://www.sun-sentinel.com/opinion/commentary/fl-op-com-hyde-amendment-44th-anniversary-20200930-7svifruc7fshnv2dgnbcc6rl4-story.html>, (Sept. 30, 2020).



[SIN SEGURO, NO MÁS! WITHOUT COVERAGE, NO MORE: LATINXS' ACCESS TO ABORTION UNDER HYDE]

"I certainly would like to prevent, if I could legally, anybody having an abortion — a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the...Medicaid bill."

— U.S. Representative Henry Hyde (R-IL), 1977 Medicaid debate

THE HYDE AMENDMENT: HOW WE GOT FROM ROE V. WADE TO ROSIE JIMENEZ

While *Roe* enshrined the right to safe, legal abortion in concept, it did nothing to ensure that those services would be available or affordable. The Hyde Amendment, passed yearly by Congress in federal appropriations legislation, bans federal funding for abortion except in cases of rape, incest, and life endangerment.³ As first introduced by Representative Henry Hyde III (R-IL) in 1976, it banned only federal Medicaid coverage of abortion. After the Hyde Amendment was introduced, and subsequently passed each year since, similar policies have proliferated throughout appropriations legislation, with similar amendments finding their way into nearly every spending bill. Currently, restrictions on abortion coverage deny affordable abortion services to a growing segment of the population, including: Medicaid-eligible individuals and Medicare and CHIP beneficiaries; Federal employees and their dependents; Peace Corps volunteers; Native American communities; individuals in federal prisons and detention centers, including those detained for immigration purposes; military personnel and veterans, use by the District of Columbia of its own funds for abortion coverage for low-income people.³

The intent of the policy's author is of no question, as Rep. Hyde himself told his colleagues during a congressional debate over Medicaid funding in 1977: "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only available vehicle is the...Medicaid bill." For low-income people, the result of the Hyde Amendment has been their ability to access safe and affordable abortion care is once again left up to the states, as state legislatures can decide whether they provide state funds in order to ensure that Medicaid in their states includes abortion coverage.

Currently 17 states have decided (or are required by court order) to cover abortion care with state Medicaid funds.⁴ As a result, the disparities between states that do and do not provide abortion coverage are exacerbated and leaves people's reproductive health in the hands of the state legislatures or judges. Furthermore, those 17 states have largely resisted or rejected restrictions on abortion providers and those seeking abortion care. Thirty-three states and

the District of Columbia follow the federal standard and only cover abortions in their Medicaid programs in cases of life endangerment, rape, or incest.⁵ Of the 7.5 million women of reproductive age with Medicaid coverage in these states that do not cover abortion, just over half were women of color (51 percent in 2015).⁶ Therefore, taken together, new state-level restrictions and longstanding bans on insurance coverage for abortion divide the country in two: the states with fewer restrictions and where state funds are used to cover abortion, and states where politicians both severely restrict and deny insurance coverage for abortion services. Data from the U.S. Census indicates that today, nearly half of Latinas and approximately 70 percent of Black women, and a majority of all women of color, live in the latter, doubly hostile states.⁷

Rosie Jiménez



Shortly after the Hyde Amendment was first enacted, it claimed the life of a Latina who earned a low income. Rosie Jiménez was a 27-year-old college student and single mother who became pregnant after *Roe v. Wade* made abortion legal. She qualified for Medicaid, but because the Hyde Amendment had gone into effect two months earlier, she couldn't get coverage for an abortion. Rosie was six months away from graduating with a teaching credential, a ticket to a better life for her and her five-year-old daughter. Unable to raise the money to pay for a legal abortion, she turned to an unsafe and illegal procedure. On October 3, 1977, Rosie died of septic shock, the first known victim of the Hyde Amendment, and a painful reminder that legal abortion means little to a community that has no ability to access it.

SIN SEGURO, NO MÁS! OCTOBER 2018

ECONOMIC INJUSTICE:
Hyde forces those who earn low incomes in the Latinx community to pay for abortion care out-of-pocket



Nearly one in three Latinas of reproductive age are enrolled in the Medicaid program*



18.7% of Latinas live in poverty*

*https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion
**https://nadic-csw.org/guide-to-state-abortion-laws.com/wp-content/uploads/2017/03/Abortion-Snapshot-in-Latinas-2017.pdf

THE IMPACT OF HYDE IN REAL PEOPLE'S LIVES

Women of color are more likely to receive their healthcare from a program, insurer, or employer affected by these bans, only exacerbating the existing healthcare disparities and the ongoing impact of these bans on Latinas and other women of color.⁸ Abortion access is an essential component of reproductive healthcare that 18 percent of Latinas will need over their lifetime, compared to only 10 percent of their white counterparts.⁹ While abortion remains a safe, legal, and constitutionally-protected form of medical care in the United States, the federal restrictions on insurance coverage, exacerbated by increasing federal and state attacks attempting to limit access to abortion care, combine to render the constitutional right meaningless in the face of often insurmountable obstacles. Thus, millions of people in underserved communities currently lack access to abortion care, and are already living in a *post-Roe* world due to systemic barriers such as cost, lack of available clinics, insufficient culturally and linguistically competent health systems, and discriminatory immigration policies.

Due to systemic barriers and discrimination, a disproportionately higher number of women of color are enrolled in the Medicaid program and thereby denied abortion coverage under the Hyde Amendment.¹⁰ Nearly one-third (31 percent) of Black women of reproductive age and 27 percent of Latinas of reproductive age are enrolled in the Medicaid program.¹¹ In the aggregate, nearly one-

fifth (19 percent) of Asian Americans and Pacific Islander women are enrolled in the program, while enrollment rates for certain Asian ethnic subgroups are much higher (at 62 percent of Bhutanese women, 43 percent of Hmong women and 32 percent of Pakistani women).¹² Medicaid also provides coverage to more than one in four (27 percent) nonelderly American Indian and Alaska Native (AIAN) adults and half of AIAN children.¹³ Latinas, and other people of color, are also more likely to live in poverty and thus less likely to be able to afford abortion care (or other healthcare) out-of-pocket.¹⁴ The time that it takes to raise funds for the care they need, often results in delays from when a person has made a decision to when they are able to afford it, which in turn increases the cost of abortion care. In a 2014 study, the average costs to patients for first-trimester abortion care was \$461, and anywhere from \$860 to \$1874 for second-trimester abortion care.¹⁵

Bans on insurance coverage for abortion put Latinxs and their families in untenable economic situations. For many who qualify and enroll in Medicaid, the cost of ending a pregnancy forces them to choose between paying for rent or groceries and paying for the care they need. Research shows that one in four low-income women on Medicaid who seek abortion care is unable to afford to pay out-of-pocket cost and is forced to carry the pregnancy to term.¹⁶ A woman who wants to get an abortion but is denied is more likely to fall into poverty than one who can get an abortion.¹⁷

STATE BATTLEGROUND: HOW RESTRICTIONS IN THE STATES COMPROMISE LATINX HEALTH AND DECISION-MAKING

The harms of the Hyde Amendment are exacerbated and confounded by state-level restrictions on abortion. Since 2011, politicians have passed 401 new laws in 33 states across the country that shame, pressure, and punish people who have decided to have an abortion.¹⁸ Already, 57 percent of U.S. women of reproductive age live in states classified as hostile or very hostile to abortion rights.¹⁹

These new laws have forced doctors to give patients medically-false information about abortion, including that abortion leads to

breast cancer, required young people to secure parental consent for abortion, and in some states required people to make multiple, medically-unnecessary appointments for care. Others would ban abortion at a particular point in pregnancy, as early as six weeks, before a person might even know they are pregnant. Other laws have required clinics to meet medically unnecessary licensing requirements that force clinics to close down, such as the law in Texas that was struck down by the Supreme Court that would have shuttered 75% of its clinics.²⁰



The gap is widening between those states where a person can find an abortion provider and access care in a safe and affordable manner, and those states where abortion services are almost altogether out of reach. These restrictions disproportionately affect low-income people of color who are forced to travel long distances and pay steep fees out-of-pocket to obtain abortion care. As restrictions increase, and clinics close down, the landscape is looking increasingly like the *pre-Roe* landscape. People who can afford to do so travel long distances and across

state lines to obtain abortion care. Those who cannot afford to pay cut-of-pocket have much more limited access. Undocumented Latina immigrants, many of whom cannot travel for fear of detention and deportation, have even fewer options. For many Latinxs, especially for those who are living with low-incomes, are uninsured, or underinsured, Roe v. Wade is an abstract promise with little bearing on their reality. In some cases, these endless hurdles act as a complete obstacle and will force some people to carry an unwanted pregnancy to term.

POLICY RECOMMENDATIONS

- Lift all federal bans on insurance coverage for abortion.
- Remove all language in annual appropriations legislation that restricts coverage for or provision of abortion care in public health insurance programs. This includes repeal of the Hyde Amendment, and all policies that restrict funding for abortion care and coverage for: Medicaid-eligible individuals and Medicare and CHIP beneficiaries; Federal employees and their dependents; Peace Corp volunteers; Native American communities; people in federal prisons and detention centers, including those detained for immigration purposes; and use by the District of Columbia of its own funds for abortion coverage for low-income people. Eliminate federal restrictions on abortion coverage in private insurance plans.
- Enact the Equal Access to Abortion Coverage in Health Insurance Act (EACH Woman Act) and other proactive legislation to permanently repeal abortion coverage bans and prohibit states from interfering with abortion coverage in private insurance plans, including in state healthcare exchanges.
- Additional Recommendations
 - Repeal and oppose legislation that restricts access to abortion services, including but not limited to: bans on race or sex-selective abortion; pre-viability abortion plans; "personhood" amendments; and restrictions on abortion access for young people.
- Enact the Women's Health Protection Act (WHPA) and other legislation that expands access to abortion care, including the pool of licensed, qualified providers.
- Reduce unintended pregnancy by increasing funding to the Title X family planning program.
- Support the Healthy Equity and Access under the Law (HEAL) for Immigrant Women and Families Act which, among other provisions, would restore eligibility for Medicaid and CHIP to immigrants who are lawfully present without making them endure the current five year waiting period.
- Support the Health Equity and Accountability Act (HEAA), comprehensive legislation designed to eliminate racial and ethnic disparities. Introduced each Congress by the Tri-Caucus, this is the only legislation that holistically addresses health inequities with an intersectional lens that includes immigration status, age, disability, sex, gender, sexual orientation, gender identity and expression, language, and socio-economic status.
- Strongly oppose all legislative and administrative proposals that weaken Medicaid, such as proposals that implement work requirements or loosen the standards for section 1115 demonstrations.
- Support measures that improve economic security for Latinxs by increasing the minimum wage, closing the race and gender pay gaps, and ensuring that immigrants have access to lawful employment and benefits.



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- 1 "Latinx" is a term that challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces. Due to the limitations of data collection, we use "Latina(s)" or "woman" when research only shows findings for cisgender women, including Latinas.
- 2 In 1978, Congress added two exceptions—pregnancies resulting from "promptly reported" rape and incest and certification from two physicians that the pregnancy would cause "severe and long-lasting physical health damage." However, Congress again removed the "physical health danger" exception in 1979 and the rape and incest exceptions in 1981. The total ban version of the Hyde Amendment remained in place until 1993, when President Clinton and Congress introduced a budget that removed the Hyde Amendment. Representative Hyde reintroduced the amendment but included the rape and incest exceptions as a "compromise." In 1997, the Hyde Amendment was modified yet again. At that point, Congress restricted the life endangerment exception to "a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." *Allina, How Restrictions on Abortion Coverage, 2-3.*
- 3 All Above All, *Hyde Amendment Fact Sheet*, All Above All (Sept. 26, 2017), <https://allaboveall.org/resource/hyde-amendment-fact-sheet/>.
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- 10 Supra note 4 ("Women of color are more likely than white women to be low-income and to be enrolled in Medicaid. In 2015, 31% of black women and 27% of Hispanic women aged 15–44 were enrolled in Medicaid, compared with 16% of white women").
- 11 *Id.*
- 12 S. Ruggles, K. Genadek, R. Goeken, J. Grover, M. Sobek, *Integrated Public Use Microdata Series*, Minneapolis: University of Minnesota (Mar. 16, 2017), <https://usa.ipums.org/usa/>.
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- 18 Elizabeth Nash, Rachel B. Gold, Lizzanne Mohammed, Zahra Ansari-Thomas, and Olivia Cappello, *Policy Trends in the States*, 2017, Guttmacher Institute (Jan. 2, 2018), <https://www.guttmacher.org/article/2018/01/policy-trends-states-2017>.
- 19 *Id.*
- 20 Center for Reproductive Rights, *Abortion Clinic Shutdown Cases at The Supreme Court*, Center for Reproductive Rights (2016), <https://www.reproductiverights.org/sites/crrcivactions.net/files/documents/SCOTUS-Media-Kit-04-26-2016.pdf>.



**House Committee on Appropriations
Subcommittee on the Departments of Labor, Health and
Human Services, Education, and Related Agencies
Hearing on "The Impact on Women Seeking an Abortion but
are Denied Because of an Inability to Pay"**

December 8, 2020

Statement Submitted by
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Introduction and summary

Chairwoman DeLauro, Ranking Member Cole and Members of the Subcommittee, thank you for the opportunity to submit this statement for the record. The National Partnership for Women & Families is a nonprofit, nonpartisan organization that has fought for decades to advance the rights and well-being of America's women and families, including the right to access abortion care free of shame, stigma or barriers.

This hearing is an important step in bringing to light the impact that abortion coverage restrictions have on those denied abortion and reproductive health care, and to affirm the right of all people to have access to the care that they need, free of barriers, shame or stigma.

We commend the Chairwoman for holding today's hearing and urge the House to take seriously the very real, devastating impacts that restrictions on abortion coverage have on people's health, well-being, and economic security.

Abortion is an essential part of health care and a basic human right

Nearly one in four women in the United States will have an abortion by age 45.¹ Access to abortion care facilitates people's autonomy, dignity and ability to make decisions about their bodies, their lives and their futures. It also enables people to adequately care for themselves and their families and to fully contribute to American society. Abortion is fundamental to women's equality, and all people deserve access to abortion care and to comprehensive reproductive health care, no

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matter how much they earn, where they live or where they get their health insurance.

Yet since 1976, the Hyde Amendment has withheld federal funds from covering abortion care for people enrolled in Medicaid. In addition, many states restrict abortion coverage even further, for example by prohibiting private insurance coverage of abortion care.² As a consequence, abortion care is pushed out of reach for millions of people – with the burden falling heaviest on people with low incomes, people of color and young people.³

The EACH Woman Act is critical for people to consider all of their options, regardless of their economic status

The *Equal Access to Abortion Coverage in Health Insurance* (EACH Woman) *Act* is groundbreaking legislation that would restore abortion coverage to people who receive health care or insurance through the federal government, and would prohibit political interference with health insurance companies that decide to offer coverage for abortion care. The *EACH Woman Act* would help ensure that, when it comes to deciding whether to become a parent, each person will be able to consider all their options, regardless of their income or where they get their health insurance.

Lack of access to abortion care negatively impacts people's health outcomes

Approximately one in four Medicaid-eligible women with an unintended pregnancy is forced to carry that pregnancy to term because of restrictions on Medicaid funding for abortion.⁴ People who are denied access to an abortion have been found to suffer adverse physical and mental health consequences. For example, according to a longitudinal study that is frequently cited in peer-reviewed journals, women denied abortion care are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy; more likely to remain in relationships where interpersonal violence is present; and more likely to suffer anxiety.⁵

In addition to health outcomes, having access to abortion care also impacts the economic security of individuals and families

The ability to decide if and when to have a child is inextricably connected to a person's ability to support themselves and their family, especially for those who already live at the edge of or in poverty. Restrictions on abortion coverage target and harm people struggling to make ends meet. Research has shown that women who seek but are denied abortion care are worse off financially and significantly more likely to fall into poverty than women who are able to get the care they need.⁶ Additionally, women who are denied an abortion had more than three times greater odds of being unemployed six months later than women who were able to access an

abortion.⁷ Access to abortion is linked with greater workforce attachment and higher lifetime earnings; in one study, women who were able to have an abortion were six times more likely to have positive life plans – most commonly related to education and employment – and were more likely to achieve them than women denied an abortion.⁸

People of color disproportionately bear the burden of abortion coverage restrictions such as the Hyde Amendment

Women of color live at the intersection of multiple disparities and structural barriers that lead to a higher likelihood of being Medicaid-eligible and therefore, subject to the Hyde Amendment. The high out-of-pocket costs only increase when care is delayed due to barriers imposed on those seeking abortion, such as TRAP laws (Targeted Restrictions on Abortion Providers), mandatory delays, biased counseling laws, ultrasounds requirements and more. This means that people of color are too often unable to afford abortion care and may be forced to decide between paying for things like rent or groceries and paying for an abortion. Additionally, abortion coverage restrictions exacerbate the existing health disparities people of color face, including maternal health and maternal mortality disparities.⁹

People who can't afford abortion care face compounded harm and economic hardship

People must have the freedom to decide if and when to have families, or to expand their families. This is especially important to their economic security in light of the lack of policy supports for expecting and new parents. Many people do not have the workplace supports they need during and after pregnancy. An estimated quarter of a million women have been denied reasonable pregnancy-related workplace accommodations each year, and many more are not asking for the accommodations they need.¹⁰ Just over one in five worksites offer paid maternity leave to all workers.¹¹ And women of color bear a disproportionate burden, as they are more likely to work in jobs that fail to provide paid parental leave or other supportive workplace policies.¹²

Conclusion

We urge the House to reject efforts to undermine access to abortion care, and to stand up for the health, security and dignity of America's women and families. Following this hearing, the House should reject appropriations bills that perpetuate the harmful Hyde Amendment and swiftly pass the *EACH Woman Act*. The House should also promptly pass the *Women's Health Protection Act* (WHPA), which would protect abortion access across the country.

Thank you for the opportunity to submit this statement. If you have questions, please contact Jessi Leigh Swenson, Director of Congressional Affairs – Health Justice, at jswenson@nationalpartnership.org or 202-986-2600.

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**Fatima Goss Graves
President and CEO
National Women's Law Center**

**House Appropriations Subcommittee on the
Departments of Labor, Health and Human Services, Education, and Related Agencies**
**"The Impact on Women Seeking an Abortion but are Denied Because of an Inability to
Pay"**

December 8, 2020

Dear Chairwoman DeLauro, Ranking Member Cole, and Members of the Subcommittee,

The National Women's Law Center fights for gender justice – in the courts, in public policy, and in our society – working across the issues that are central to the lives of women and girls, including child care and early learning, education, reproductive rights and health, income security, workplace justice, and addressing sexual harassment or assault.

Access to reproductive health care – including abortion – is vital to gender justice. The ability to make decisions about whether to have an abortion, and the ability to access abortion, is a key part of a person's liberty, equality, and economic security. As the U.S. Supreme Court affirmed in its 1992 *Planned Parenthood of Southeastern Pennsylvania v. Casey* decision: "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."ⁱ

Yet despite this truth – or because of it – lawmakers continue to pass restrictions on a person's ability to make this fundamental decision. One of the most pernicious restrictions lawmakers have passed over the years is the Hyde Amendment. This restriction, a rider that Congress has attached to the annual appropriations bill since 1977, denies abortion coverage to individuals enrolled in the federal Medicaid program. Medicaid covers 25 million adult women in the U.S.,

two-thirds of whom are in their reproductive years (19 to 49), meaning that millions of individuals enrolled in Medicaid must pay out-of-pocket for abortion care except in very narrow circumstances.ⁱⁱ Over the years, Congress has extended the harmful reach of the Hyde Amendment to apply to many federal programs that provide health care including those serving in the U.S. military and Peace Corps, residents of the District of Columbia, veterans, federal employees, individuals in federal prisons and those detained in federal immigration facilities, individuals covered by the Indian Health Service, and young people who rely on the State Children's Health Insurance Program.

Although legislators opposed to reproductive health, rights, and justice have waged a decades-long systemic attack on the constitutional right to abortion, they have thus far been unsuccessful in overturning the right and polling shows that the majority of people in the U.S. do not want it to be overturned.ⁱⁱⁱ And yet, many still are denied access to abortion – making it a right in name only – because of restrictions like the Hyde Amendment. Representative Henry Hyde, the amendment's original proponent and namesake, made clear that this was the exact goal of his amendment: to use the federal government's role in providing health coverage as a way to deny people access to abortion: “I would certainly like to prevent, if I could legally, anybody having an abortion: a rich woman, a middle class woman, or a poor woman. Unfortunately, the only vehicle available is the... Medicaid bill.”^{iv} For too long and for too many women in this country, the Hyde Amendment has furthered that goal.

The Hyde Amendment is pernicious precisely because it targets the very people who struggle to make ends meet, disproportionately impacting Black and Hispanic women, single parents, and women who have not completed a high school education.^v In 2014, nearly half of abortion

patients were women with family incomes below the Federal Poverty Level (FPL); women whose families earned less than 200% of the FPL made up an additional quarter of abortion patients,^{vii} and women at this income level were more likely to be enrolled in Medicaid.^{viii} The cost of abortion care can consume the monthly budget of a person with low income; even before the COVID-19 pandemic, nearly four in ten (37%) adults in the U.S. would have difficulty paying an unexpected \$400 expense.^{viii} This means that a person struggling to make ends meet would have to forego paying for basic necessities in order to pay for the procedure,^{ix} a situation that is simply untenable for many. Indeed, studies show that when legislators restrict Medicaid coverage of abortion, it forces one in four lower-income women seeking an abortion to carry an unwanted pregnancy to term.^x Moreover, the Hyde Amendment cruelly compounds existing barriers to health care, including maternal and other reproductive health care, particularly harming Black and Indigenous women,^{xi} those who live in rural areas, and LGBTQ individuals.^{xii}

Being denied an abortion can further deepen an individual's economic insecurity and has long-lasting and harmful effects on a person's well-being, job security, and workforce participation. Compared to women who received an abortion, women denied an abortion were more likely to have household incomes below the FPL, more likely to be in a position where they will need support from external sources, including the government, and more likely to be without a full-time job six months later.^{xiii} Women who were denied abortions, compared to women who are able to have an abortion, are more likely to owe debt and be forced to incur negative "public records" (such as bankruptcy or eviction) on their credit reports after giving birth.^{xiv} They are also more likely to be tethered to an abuser and to be at risk for continued violence, even if they end the romantic relationship.^{xv}

Some Medicaid enrollees are able to overcome the coverage denial imposed by the Hyde Amendment to obtain an abortion. But the Hyde Amendment's harmful impact still reaches them. Some people who are denied coverage of abortion will be forced to postpone an abortion – inherently time-sensitive medical care – while attempting to find the necessary funds. In one study, more than one-third of women who had an abortion in the second trimester would have preferred to have the procedure earlier but could not because they needed to raise the necessary funds.^{xvi} Without insurance coverage, individuals are caught in a vicious cycle of raising money while abortion care costs increase.

It is important to note that prohibitions on insurance coverage of abortion do not exist in a vacuum. Denials of abortion coverage operate alongside a range of other medically unnecessary barriers erected by lawmakers who want to prevent individuals from making the decision that is best for them. In the last decade, state lawmakers have passed more than 450 restrictions on abortion access meant to shutter clinics and shame women from seeking an abortion.^{xvii} These restrictions have resulted in fewer abortion providers and increased travel times and distances for individuals seeking care. Even if a person is ultimately able to reach a clinic, they are likely to face significantly longer wait times and increased costs, including the costs of travel, lodging, child care, and more expensive procedures. The many state restrictions – including those that require multiple trips or additional unnecessary procedures – also add to out-of-pocket costs. These costs all add up, making it harder for a person to access abortion care, especially when the Hyde Amendment denies them coverage for the medical care they need.

People who have made the decision to seek abortion care – but who are delayed, blocked, shamed, or judged by politicians who impose unnecessary restrictions and barriers – need greater access to the care they are seeking, not less. These restrictions do nothing to make abortion – an

already extremely safe procedure – safer. We urge Congress to focus its attention on lifting barriers and restrictions and ensuring that those who are deciding if and when to have a child are supported – not deliberately undermined – by our federal programs.

This is more true now. It is no accident that the historic reckoning on racial injustice comes amid a pandemic and economic crisis that has taken the lives and livelihoods of millions, who are disproportionately Black, Indigenous, and people of color. These crises have exposed deep-seated inequities and structural racism across our institutions and in our government. But the crises also give us an opportunity for change and to address longstanding harmful policies rooted in injustice. We urge Congress to take that opportunity now, by recognizing that the Hyde Amendment is one in a web of racist, sexist, and classist abortion restrictions.

The first step is for Congress to break the tradition of adding the Hyde Amendment to its annual appropriations bills and instead swiftly act to pass the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act that would lift bans that restrict coverage of abortion. While the repeal of the Hyde Amendment will not reverse all of the barriers to abortion access that have been imposed on people seeking an abortion, eliminating it is a key piece to supporting people who need abortion care.

It is also a key piece of responding to the COVID-19 pandemic and related economic insecurity. At a time when people are struggling in so many ways and many are wanting to delay or prevent pregnancy,^{xviii} policymakers must ensure that protecting access to reproductive health care is part of any effort to comprehensively address economic and health insecurity inflicted by both the pandemic and recession.

In taking the important step of eliminating the Hyde Amendment, Congress will be recognizing that access to reproductive health care, including abortion, is part of economic justice, racial justice, and any effort to ensure the success and well-being of every community. We call on Congress to put an end to the Hyde Amendment in the next annual appropriations bill so that no one is denied abortion coverage because of how much money they have or how they get their health insurance.

Thank you.

ⁱ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 835 (1992).

ⁱⁱ Kaiser Family Foundation, Medicaid's Role for Women (2019), available at <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.

ⁱⁱⁱ Sixty-nine percent of Americans say *Roe v. Wade* should not be completely overturned and this share of Americans with this view has increased over recent years. See Hannah Fingerhut, *About seven-in-ten Americans oppose overturning Roe v. Wade*, PEW RESEARCH CENTER (January 3, 2017), <https://www.pewresearch.org/fact-tank/2017/01/03/about-seven-in-ten-americans-oppose-overturning-roe-v-wade/>.

^{iv} 123 CONG. REC. 19,700 (1977) (statement of Rep. Henry Hyde).

^v Kaiser Family Foundation, Medicaid's Role for Women (2019), available at <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.

^{vi} Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1906 (2017).

^{vii} Kaiser Family Foundation, Medicaid's Role for Women (2019), available at <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.

^{viii} BD GOVERNORS FED. RESERVE SYS., REPORT ON THE ECONOMIC WELL-BEING OF U.S. HOUSEHOLDS IN 2019, FEATURING SUPPLEMENTAL DATA FROM APRIL 2020, at 22 (May 2020), <https://www.federalreserve.gov/publications/files/2019-report-economic-well-being-us-households-202005.pdf>.

^{ix} One study found that one-third of women getting an abortion had to delay or forgo paying bills, food, and even rent. One-half relied on financial assistance from others, but such assistance is never assured. See Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1906 (2017). See also M Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, BMC WOMEN'S HEALTH, July 2013, at 6, and Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES e173, e176 (2013).

^x Stanley K. Henshaw et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, GUTTMACHER INSTITUTE (July 2009), <https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review>.

^{xi} Nat'l' P ship for Women & Families, Black Women's Maternal Health (2018), available at <http://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf>; Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, NEW YORK TIMES (May 7, 2019), <https://www.nytimes.com/2019/05/07/health/pregnancy-deaths.html>.

^{xii} AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION: HEALTH DISPARITIES IN RURAL WOMEN (2014), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/c0586.pdf?dmc=1&ts=20191112T0114132450>; BIXBY CTR. FOR GLOB. REPRODUCTIVE HEALTH, *LGBTQ Patients Face Discrimination and Erasure When Seeking Reproductive Health Care*, <https://bixbycenter.ucsf.edu/news/lgbtq-patients-face-discrimination-and-erasure-when-seeking-reproductive-health-care> (last visited on Nov. 11, 2019).

^{xiii} Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AMERICAN JOURNAL OF PUBLIC HEALTH 407, 412-413 (2018).

^{xiv} Sarah Miller, Laura R. Wherry, & Diana Greene Foster, *The Economic Consequences of Being Denied an Abortion*, NATIONAL BUREAU OF ECONOMIC RESEARCH WORKING PAPER NO. 26662 (2020).

^{xv} Women in abusive relationships who sought and obtained abortion care experienced a decrease in physical violence from the man involved in the pregnancy; women who sought but were denied care were not so fortunate. Pregnant women in abusive relationships are also at risk of being killed by their abusers. Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC MED., Sept. 2014, at 5; see also id. (women denied abortion were more likely to have sustained contact with the man involved in pregnancy); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 672 (2006).

^{xvi} Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

^{xvii} Elizabeth Nash, *Unprecedented Wave of Abortion Bans is an Urgent Call to Action*, GUTTMACHER INSTITUTE (May 22, 2019), <https://www.guttmacher.org/article/2019/05/unprecedented-wave-abortion-bans-urgent-call-action>.

^{xviii} Laura D. Lindberg, *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences*, GUTTMACHER INSTITUTE 4–5 (June 2020), https://www.guttmacher.org/sites/default/files/report_pdf/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.pdf.

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STATEMENT FOR THE RECORD

OF THE

HEARING TITLED "THE IMPACT ON WOMEN SEEKING AN ABORTION BUT ARE
DENIED BECAUSE OF THE INABILITY TO PAY"

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON APPROPRIATIONS

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES
SUBCOMMITTEE

DECEMBER 8, 2020

BY

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

409 12TH ST SW

WASHINGTON DC, 20024

Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the Labor, Health and Human Services, Education, and Related Agencies Subcommittee, thank you for the opportunity to submit this statement for the Subcommittee's record of its hearing titled "The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay."

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading organization of physicians providing health care for women. With more than 60,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care.

ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care. Policy related to reproductive health care must be based on medical evidence and scientific facts. The government can serve a valuable role in making health policy when its purpose is to improve patient health and advance medical and scientific progress.¹

Abortion is an essential component of women's health care.² Like all medical matters, decisions regarding reproductive health care, including abortion care, should be made by patients in consultation with their clinicians and without undue interference by outside parties.³ Like all patients, individuals seeking abortion are entitled to privacy, dignity, respect, and support.⁴

The federal Hyde Amendment, which is the primary focus of the Subcommittee's hearing today and denies federal funds from being used to pay for abortions except when a patient's life is endangered or in cases of rape or incest, and other federal and state restrictions on public and private insurance coverage of abortion should be eliminated. Public and private insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens. The harms of the Hyde Amendment are well documented during ordinary times; they are even more troubling during this time of pandemic and economic downturn when many people throughout the country face increased access barriers to care. The Subcommittee's hearing today could not come at a more pivotal time. Abortion, although legal, is increasingly out of reach because of mounting government-imposed restrictions targeting women, physicians, and other clinicians who provide abortions.⁵ Particularly germane to this hearing are the substantial barriers to abortion access and heightened reproductive health inequities created by insurance coverage restrictions.⁶ Legislative restrictions, including those that prevent coverage for essential health care, such as abortion,

¹ *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*. The American College of Obstetricians and Gynecologists. Available at <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship> (reaffirmed July 2019)

² *Abortion Policy*. Statement of Policy. The American College of Obstetricians and Gynecologists. Available at <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy> (Nov. 2020)

³ *Id.*

⁴ *Id.*

⁵ *Increasing access to abortion*. ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e107–15.

⁶ *Id.*

fundamentally interfere with the patient-clinician relationship and decrease access to abortion, particularly for those with low incomes and those living long distances from health care practitioners.⁷ These restrictions also impede the ability of physicians and medical professionals to provide care consistent with their medical judgment, standards of care, and their patients' needs. This is a crisis for both patients and their physicians that warrants urgent scrutiny and swift action by Congress.

When considering testimony today, ACOG urges the Subcommittee to rely on this statement to generate a dialogue informed by science and medical facts.

Impact of Insurance Coverage Restrictions on Access to Abortion

Insurance coverage restrictions, which take many forms, constitute a substantial barrier to abortion access and increase reproductive health inequities. The Hyde Amendment severely limits coverage of abortion for low-income individuals under Medicaid and significantly harms access to abortion for many patients who rely on other federal programs for coverage. Hyde restrictions on abortion coverage also exist for military personnel, retirees, and their dependents through the TRICARE military health care system, for federal employees and their dependents insured through the Federal Employees Health Benefits Program, and for those receiving care through the Indian Health Service. The Veterans Health Administration and Peace Corps further impose restrictions that extend beyond the Hyde Amendment and do not provide abortion coverage under any circumstances; veterans and those who have engaged in foreign service through the Peace Corps receive less coverage than others. All of these coverage restrictions impede access to safe abortion, and in some cases function as a de facto ban on abortion. Legislative bans on private insurance coverage of abortion further marginalize abortion and represent a departure from the insurance industry's usual practice of covering abortion services equitably with other procedures.

ACOG has received numerous accounts from our obstetrician-gynecologist members sharing their lived experiences and what these restrictions, including the Hyde Amendment, mean for their patients. One ACOG Fellow recounted how restrictive policies with limited exceptions force physicians to wait until a patient's health has so deteriorated she would die without abortion care. Another ACOG Fellow practicing in Pennsylvania noted how the combined restrictions of the Hyde Amendment and state insurance prohibitions have limited or delayed access to lifesaving abortion care. ACOG physicians also have recounted the ways in which their patients accessed abortion care to save their lives, protect their health, attain their educational goals, and to take care of their children. These stories reinforce that as with many one-size-fits-all government mandates, proffered "exceptions" are often unworkable in practice. The so-called "exceptions" to the Hyde Amendment's prohibitions are overly narrow, burdensome, and severely restrict access to care. Again and again, our physicians' experiences demonstrate that every patient's circumstance is unique, and why mandates, like the Hyde Amendment, combined with medically inaccurate rhetoric and stigma about abortion, are profoundly harmful.

Insurance coverage restrictions are not medically justified and they create sometimes insurmountable barriers for women across the United States. It cannot be overstated that the patients disproportionately harmed by these restrictions are people of color, patients who must travel long

⁷ *Id.*

distances to access care such as those living in rural or other underserved areas, and individuals with low incomes. We commend the Chairwoman for inviting witnesses to participate in the hearing who can shed light on the lived experiences of patients and the role that legislative restrictions have in indefensibly limiting their access to care.

ACOG affirms that public and private insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens.⁸ The Hyde Amendment and other federal and state restrictions on public and private insurance coverage of abortion should be eliminated.⁹

The COVID-19 Pandemic is Exacerbating Health Inequities

Our country is in an unprecedented time. The COVID-19 pandemic presents extreme challenges to individuals and their health care professionals; the pandemic has highlighted the obstacles to care that many face in ordinary times and that are exacerbated during this time of pandemic and economic downturn. Such obstacles are especially prevalent for people seeking abortion care. Many people may be experiencing new or enhanced challenges during this pandemic, such as loss of employment and insurance coverage, food insecurity, difficulty accessing needed supplies, and intimate partner violence.¹⁰ For those who already face the most barriers, the access divides presented by the public health crisis are even more pronounced and widening every day. As the nation's unemployment rate rises to historic levels, these barriers threaten to affect larger numbers of persons.

The COVID-19 pandemic compounds our nation's crisis of systemic racism and highlights the consequences of persistent inequities and disparate outcomes in health care. Racism and racial bias are a women's health crisis. ACOG works to educate clinicians about delivering patient-centered respectful care. Most recently, ACOG, along with more than 20 organizations, released a document outlining collective and sustained, intentional actions that ACOG and our partner organizations in health care will take to eliminate racism and racial inequities that lead to disparate health outcomes, including within the culture of medicine.¹¹ Congress can and must play a role in addressing racism as a public health crisis by committing to policies promoting equity across the spectrum of women's health and health care. This includes collectively advocating for public policies that seek to eliminate racial and other inequities in the delivery of health care and in health outcomes. The Hyde Amendment, which is discriminatory and has a disproportionate negative impact on people of color, represents an unacceptable driver of inequity that perpetuates structural racism. It is incumbent upon Congress to rectify this by eliminating the Hyde Amendment and any other restrictions on public and private coverage of abortion.

⁸ *Increasing access to abortion*. ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e107–15

⁹ *Id.*

¹⁰ *Addressing Health Equity During the COVID-19 Pandemic*. Position Statement. American College of Obstetricians and Gynecologists. Available at <https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2020/addressing-health-equity-during-the-covid-19-pandemic> (May 2020)

¹¹ *Joint Statement: Obstetrics and Gynecology: Collective Action Addressing Racism*. <https://www.acog.org/news/news-articles/2020/08/joint-statement-obstetrics-and-gynecology-collective-action-addressing-racism> (Aug 2020)

Clinical Guidance and Medical Research Regarding Reproductive Health Care

Politics should never outweigh scientific evidence, override standards of medical care, or drive policy that puts a person's health and life at risk.¹² Reproductive health care is essential to the health of people throughout the country.

ACOG issues evidence-based clinical practice guidelines and develops official statements of policy regarding women's health care, including reproductive care, through a thorough, deliberative, collaborative process among leading experts, practitioners, and scholars. Pertinent today for the Subcommittee's consideration is our robust body of clinical guidance that spans information regarding first trimester abortion that can be accomplished through medication,¹³ abortion training and education,¹⁴ abortion access,¹⁵ and clinical management of second trimester abortion procedures.¹⁶ ACOG's clinical materials specifically call for elimination of the Hyde Amendment as an unacceptable barrier to access that harms patients' health.

Abortion is extremely safe. It has complication rates that are lower than other routine medical procedures and its complication rates are substantially lower than childbirth.¹⁷ In the United States, 90 percent of abortions occur within the first trimester, when abortion is safest. Serious complications from abortions at all gestational ages are rare. Advances in medical science have expanded safe options for pregnancy termination. For example, medical abortion, which involves the use of medications rather than a procedure to induce an abortion, is a safe, effective option for women who seek termination of a first-trimester pregnancy.¹⁸

Notwithstanding the safety of abortion, the provision of abortion is highly regulated. Particularly relevant to today's hearing is ACOG's Committee Opinion 815, *Increasing Access to Abortion*, which examines the impact that restrictions on abortion access have on women's health.¹⁹ The Committee Opinion cites certain factors that may influence or necessitate a patient's decision to have an abortion. These factors include but are not limited to contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, illness during pregnancy, and exposure to teratogenic medications. Pregnancy complications, including placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, and cardiac or renal

¹² The American College of Obstetricians and Gynecologists and Physicians for Reproductive Health. (2019, September 25). *Abortion Can Be Medically Necessary* [Press release]. Available at <https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary>.

¹³ *Medication abortion up to 70 days of gestation*. ACOG Practice Bulletin No. 225. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e31–47.

¹⁴ *Abortion training and education*. Committee Opinion No. 612. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;124:1055–9.

¹⁵ *Increasing access to abortion*. ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e107–15.

¹⁶ *Second-trimester abortion*. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;121:1394—1406.

¹⁷ National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* (2018) ("Safety and Quality of Abortion Care"); see also Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (2012).

¹⁸ *Medication abortion up to 70 days of gestation*. ACOG Practice Bulletin No. 225. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e31–47.

¹⁹ *Increasing access to abortion*. ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e107–15.

conditions, may be so severe that abortion is the only measure to preserve a woman's health or save her life. All abortions are considered medically indicated.²⁰

ACOG's Committee Opinion 815 specifically calls for the elimination of the Hyde Amendment and notes its harmful effects. It further considers the substantial damage abortion restrictions may impose on women's health care, stating that "legislative restrictions fundamentally interfere with the patient-clinician relationship and decrease access to abortion, particularly for those with low incomes and those living long distances from health care practitioners" and calling for advocacy to oppose and overturn restrictions, improve access, and integrate abortion as a component of health care. Obstacles such as government restrictions result in the "marginalization of abortion from routine medical care," the Committee Opinion concludes, and "are harmful to people's health and well-being." This conclusion is consistent with a recent study published by the National Academies of Sciences, Engineering, and Medicine that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations on abortion.²¹ In its assessment, the report cited that these threats impact all six attributes of health care quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.²²

Moreover, ACOG, along with representatives from the National Partnership for Women & Families, American College of Physicians, American Academy of Family Physicians, American College of Nurse-Midwives, National Association of Nurse Practitioners in Women's Health, and the Society of Family Planning recently led a rigorous review of the available evidence and guidelines that inform safe delivery of outpatient care.²³ The objective of this study was to inform policy regarding the provision of procedures in primary care and gynecology offices and clinics and to further health care quality, safety, affordability, and patient experience without imposing unjustified burdens on patients' access to care or on clinicians' ability to provide care within their scope of practice. In the published findings, the authors note that the safety of abortion is similar to that of other types of office- and clinic-based procedures, yet in policy and law, regulation of abortion is frequently treated differently from other health services.²⁴ The authors conclude that false concerns for patient safety are being used as a justification for promoting regulations that specifically target abortion.

Medically unjustified restrictions on abortion access have profoundly negative effects on the health of women, their families, and communities. Notably, the Turnaway Study, conducted by the University of California San Francisco, found that women denied a wanted abortion had almost four times greater odds of a household income below the federal poverty level and three times greater odds of being unemployed.²⁵ Women who were denied wanted abortions also reported more chronic headaches, joint pain, and gestational hypertension, illustrating the devastating health effects denial of abortion can have on an individual's health.²⁶ In contrast, women who sought abortions and received them were more financially stable, raised children under more stable conditions, and set

²⁰ *Id.*

²¹ National Academies of Sciences, Engineering, Medicine, *Safety and Quality of Abortion Care* (2018).

²² *Id.*

²³ Report from the project on facility guidelines for the safe performance of primary care and gynecology procedures in offices and clinics. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2019;133:255–60.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

more ambitious goals.²⁷ The Hyde Amendment causes people seeking abortions, especially those with low incomes, to face delays in accessing care or undermines their ability to access care at all. This Amendment is harmful to the long-term health and well-being of women, their families, and communities.

Historical and contemporary data show that where abortion is illegal, restricted, or otherwise rendered inaccessible, pregnant people may resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, and reliance on unqualified or predatory abortion providers.²⁸ Today, approximately 25 million women around the world resort to unsafe abortions each year, and complications from these unsafe procedures account for as many as 15 percent of all maternal deaths, approximately 44,000 annually.²⁹

As you consider today's testimony, we urge your discourse and questioning to be informed by this evidence-based research and guidance.

The Importance of Using Medically Accurate Terminology and Information

Public and political discourse regarding abortion is all too often inaccurate and not based on medical evidence and scientific facts. As the leading association of physicians who are dedicated to the health care of women, it is important for ACOG to ensure that the Subcommittee understand that false and inflammatory claims regarding abortion care undermine the public's trust in obstetrician-gynecologists and stigmatizes necessary health care. We urge members of the Subcommittee today to be aware that medically inaccurate and inflammatory language can contribute to or encourage hostility or violence toward doctors, other medical professionals, or individuals seeking or receiving health care.

ACOG also seeks to correct false claims that have been made in the public discourse that abortion is never, or rarely, medically necessary. This is a dangerous narrative, which ACOG appreciates the opportunity to clarify for the Subcommittee. Pregnancy imposes significant physiological changes on a person's body, is a high-risk time in a person's life, and decisions about continuing a pregnancy must be in the hands of the patient. These changes can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death. Severe medical conditions, or preeclampsia (high blood pressure due to pregnancy) can all threaten a woman's health and life. Determining a treatment approach for these conditions should be between a woman and her clinician. The Hyde Amendment indefensibly jeopardizes patients' health by imposing financial barriers to abortion access on patients.

Our obstetrician-gynecologist members are dedicated to protecting the health, lives, and well-being of their patients. Determining the appropriate medical intervention based on a patient's specific condition, without unjustified government mandates, is critical to their ability to provide quality

²⁷ *Id.*

²⁸ *Increasing access to abortion*. ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e107–15.

²⁹ *Id.*

care. This includes situations where abortion is the only medical intervention that can preserve a patient's health or save their life.³⁰ All abortions are considered medically indicated.³¹

Conclusion

The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being. To ensure that all women, regardless of income, have access to abortion, ACOG strongly urges Congress to eliminate the Hyde Amendment and assert that abortion care is an integral component of women's health care and should be covered by public and private insurance.

Thank you for the opportunity to highlight ACOG's clinical guidance regarding reproductive health care and the importance of evidence-based policies related to women's health. We look forward to continuing our work together to protect access to comprehensive reproductive health care.

³⁰ The American College of Obstetricians and Gynecologists and Physicians for Reproductive Health. (2019, September 25). *Abortion Can Be Medically Necessary* [Press release]. Available at <https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary>.

³¹ *Increasing access to abortion*. ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;136:e107–15.



December 8, 2020

United States House of Representatives Committee on Appropriations

Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Hearing Entitled "The Impact on Women Seeking an Abortion but are Denied Because
of an Inability to Pay"

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") submit these comments concurrent to and in consideration of this subcommittee hearing examining "The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay." Planned Parenthood is one of the nation's leading providers of high-quality, affordable health care and the nation's largest provider of sex education. With more than 600 health centers across the country, Planned Parenthood health centers provide affordable birth control, vaccinations, lifesaving cancer screenings, testing and treatment for sexually transmitted infections, HIV screenings, and other essential care to 2.4 million patients each year. Planned Parenthood's services and education are critical for underserved communities, specifically communities of color and communities with low-incomes, facing limited access to reliable and affordable health care. The Action Fund is backed

by more than 16 million activists, donors, and other supporters working to advance access to sexual health care and defend reproductive rights. Through our international arm, Planned Parenthood Global, we provide financial and technical support to over 100 innovative partners in nine countries in Africa and Latin America for service delivery and advocacy to expand access to reproductive health care and empower people to lead healthier lives.

Planned Parenthood and the Action Fund strongly oppose any and all bans on abortion coverage, including the Hyde Amendment. We strongly urge Congress to enact future annual appropriations bills without Hyde in all its forms.

Since 1976, the Hyde Amendment — a legacy rider of the annual Labor, Health and Human Services, Education, and Related Agencies bill — has blocked federal Medicaid coverage of most abortion services.¹ Since then Congress has enacted additional similar “Hyde-like” restrictions in other appropriations measures that prohibit abortion coverage for federal employees and their families, military personnel and their families, Native Americans, Alaskan Natives, and inmates in federal prisons. While these may technically be different legal provisions and policies, the consequences are the same: penalizing people seeking abortion, and forcing them to pay out-of-pocket in order to access safe, legal care — even if they cannot afford to do so.

¹ Since 1994, there have been three extremely narrow exceptions: when continuing the pregnancy will endanger the patient's life, or when the pregnancy results from rape or incest.

Approximately one in four women in this country will have an abortion by age 45. People choose to have abortions for a variety of interrelated health, familial, economic, and personal reasons. A majority of women having abortions (61%) already have at least one child, while most (66%) also plan to have a child or additional children in the future.²

The single most important thing to understand is - **by design** - the Hyde amendment is discrimination in action. It targets the Medicaid program and people with low incomes, who are more likely to be women of color, young people, transgender, and non-binary people who have been systemically barred from health care — from using their health insurance to access safe, legal abortion. Women of color are more likely to use Medicaid for their health coverage because of the longstanding structural inequalities in our country that link racism, sexism, and economic inequality. The Hyde Amendment disproportionately hurts Black and Latinx communities and is a symptom of the same systemic racism that has driven millions to protest over the past many months.

The Hyde Amendment directly hurts the 60 percent of Planned Parenthood patients who rely on public health programs like Medicaid for preventive and primary care. Unless their state agrees to fund their care, they are blocked from using their public health coverage to receive medically necessary health care.

² For more information, please see Guttmacher Institute. (2019, September 30). September 2019 - Fact Sheet. Induced Abortion in the United States. Retrieved December 7, 2020, from <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>

The Hyde amendment puts the federal government in charge of people's personal medical decisions. When policymakers deny a woman insurance coverage for abortion, she is either forced to carry the pregnancy to term or pay for care out of her own pocket. Like any other medical expense, the consequences of the Hyde amendment can be severe. If someone has made the personal decision to end a pregnancy but cannot afford the medical care, they may forgo basic necessities such as heat and electricity in order to save the required funds. They may even resort to obtaining an abortion from an untrained or unlicensed practitioner.

Everyone — no matter how much money they make or who provides their insurance — should be able to access the full-range of reproductive health care services, including abortion. Everyone should be able to make their own decisions about pregnancy based on their own unique circumstances, and have the resources they need to exercise that decision with autonomy and dignity. **Abortion is health care.** Politicians should not be able to deny anyone's access to health services, including abortion, just because of their income or their insurance provider. It is our urgent hope that this Congress will eliminate this longstanding, discriminatory policy so that we can instead work together on proactive, comprehensive policies — like the Equal Access to Abortion Coverage (EACH Woman) Act (H.R. 1692) — which is aimed at addressing reproductive and other health inequities.

We strongly urge Congress to enact all future appropriations bills without these harmful
abortion ban legacy riders, including the Hyde amendment.

Sincerely,



Jacqueline Ayers
Planned Parenthood Action Fund
Planned Parenthood Federation of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005



Statement of NARAL Pro-Choice America

**U.S. House of Representatives Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Hearing on the Impact on Women Seeking an Abortion but are Denied Because of an
Inability to Pay
December 8, 2020**

Thank you for the opportunity to submit a statement to the Committee on this important issue. NARAL Pro-Choice America (NARAL) is a national advocacy organization, dedicated since 1969 to supporting and protecting, as a fundamental right and value, an individual's freedom to make personal decisions regarding the full range of reproductive choices through education, organizing, and influencing public policy. NARAL and our 2.5 million member activists work to guarantee every individual the right to make personal decisions regarding the full range of reproductive choices. Recognizing a person's right to privacy, dignity, and bodily autonomy is crucial to that mission. NARAL strongly supports and advocates to ensure that reproductive freedom, including the right to access abortion, is a reality for every body, regardless of their income or source of insurance. For this reason, we are submitting this statement to call on Congress to end the Hyde amendment and all other bans on insurance coverage of comprehensive reproductive health care, which includes abortion.

The importance and urgency of ending inequitable and discriminatory abortion coverage bans like the Hyde amendment are even more clear in light of the COVID-19 pandemic and national protests against a system that upholds white supremacy and perpetuates life-threatening racial disparities in health care, criminal justice, education, and more. Over 270,000 people have died this year in the United States from COVID-19, millions are struggling with hunger, housing, and joblessness, and communities of color have been disproportionately affected. We all must be more committed than ever to ending barriers to healthcare like the harmful Hyde Amendment that disproportionately impacts those who

already face significant obstacles to care, Black and Brown women and families, and those with low incomes.

I. Abortion coverage bans disproportionately harm people of color, low-income individuals, and others already failed by our health care system

For over four decades, unable to make abortion illegal, anti-choice legislators have tried to make the procedure nearly impossible for individuals to obtain. One of their most aggressive tactics has been to put abortion services financially out of reach for as many people as possible through coverage bans such as the Hyde amendment. Since 1976, this harmful policy, which has passed annually as an anti-choice rider to many appropriations bills, has banned federal funding for abortion with only very narrow exceptions (i.e. life endangerment, rape, and incest). For far too long, politicians have allowed the appropriations process to be used as a vehicle to impose restrictions on abortion coverage for a growing segment of the population, including: Medicaid, Medicare and Children's Health Insurance Program enrollees; federal employees; Native Americans; women in federal prisons and detention centers, including immigration detention centers; Peace Corps volunteers; and low-income women in the District of Columbia. These coverage bans disproportionately impact people of color, low-income individuals, immigrants, young people, transgender and gender nonconforming people, and others already facing barriers to healthcare.

The effect is that the constitutional right to abortion is out of reach for far too many communities. Pregnant people may struggle to afford abortion care or be forced to delay care because of their income, zip code, or source of insurance. Currently, 34 states and the District of Columbia fail to correct for discriminatory federal policies and restrict low-income people's access in almost all cases, and one state restricts access to abortion without exception for people who rely on Medicaid for health care coverage, in violation of federal law.¹ On the other hand, 16 states have filled the gap left by the federal government by using state funds to cover

abortion services for low-income people, with nine states funding abortion services beyond cases of life endangerment, rape, and incest, and seven states imposing no restrictions on coverage of abortion services². This state by state variation in the availability of abortion coverage leaves people's reproductive health in the hands of state legislatures or judges, and creates disparate access to a constitutional right.

The short-term and long-term consequences of these policies on real people are many and far-reaching. Studies show that when policymakers place restrictions on Medicaid coverage of abortion, it forces one in four Medicaid-eligible women to carry an unwanted pregnancy to term.³ Pregnant people whose insurance does not cover abortion care are forced to choose between receiving critical care and paying rent, food or other necessary expenses.⁴ When a woman wants to get an abortion but is denied, she is more likely to fall into poverty, less likely to have a full-time job, and twice as likely to experience intimate partner violence.⁵

II. A majority of Americans support health insurance coverage of abortion services

Americans have made it clear that at a time when the fundamental freedoms recognized in Roe are under attack, and when the constitutional right to abortion is not a reality for far too many women, support for reproductive freedom for all is not negotiable. Seventy-seven percent (77%) of Americans support access to safe and legal abortion.⁶ A majority of voters in battleground states believe abortion should be legal and that the government shouldn't prevent a woman from making that decision.⁷

According to polling conducted by our partners at All* Above All, a majority of voters also believe that all women should have health insurance that covers reproductive healthcare, including abortion.⁸ Roughly two in three (64%) voters believe women's health insurance should cover their reproductive healthcare, including abortion, and nearly three in four (76%) voters know that women having insurance coverage for the full range of reproductive

healthcare, including birth control, pregnancy tests, prenatal care, and abortion, is important to ensuring that they have equal economic opportunities.⁹

Reproductive justice groups led by women of color have tirelessly led the fight to repeal Hyde and other abortion coverage bans and we're proud to stand alongside them. Their efforts have shed light on the negative impact of these harmful policies and their disproportionate effects on people of color, resulting in politicians finally recognizing the importance of removing harmful limitations on insurance coverage of abortion. The Democratic Party included repealing the Hyde amendment in its platform for the first time in 2016, and reiterated that commitment in the 2020 Democratic platform.¹⁰ During the 2020 presidential election, the Democratic field coalesced around the Party's core values—support for abortion rights, and the basic truth that reproductive freedom is fundamental to the pursuit of equality and economic security in this country. As a part of this commitment to reproductive freedom, on the campaign trail, President-elect Joe Biden vowed to support the repeal of the racist and discriminatory Hyde Amendment. These are steps in the right direction to guaranteeing everybody can exercise their constitutional right to abortion care.

III. Congress must remove all language that restricts coverage of abortion care from annual appropriations and pass the EACH Woman Act

We applaud members of Congress who have stood up against the aforementioned attacks, including many members of this subcommittee. We call on you to introduce and pass clean appropriations bills that do not include the Hyde amendment and related abortion coverage restrictions, and block any attempts to insert these restrictions, thus ensuring that everyone has abortion coverage regardless of their income or source of health insurance. The legal right to abortion does not ensure access to abortion care; it has to be affordable as well.

NARAL Pro-Choice America strongly supports the Equal Access to Abortion Coverage in Health Insurance (EACH) Woman Act (H.R. 1692/S. 758), which was re-introduced last year for the third time in the U.S. House of Representatives by Reps. Barbara Lee (D-CA-13), Jan Schakowsky (D-IL-09), and Diana DeGette (D-CO-01), and introduced for the first time in the U.S. Senate by Sens. Tammy Duckworth (D-IL), Mazie Hirono (D-HI), Kamala Harris (D-CA), and Patty Murray (D-WA). The EACH Woman Act would end current bans on insurance coverage of abortion for women in government-administered healthcare programs including Medicaid, Medicare, the Indian Health Service, U.S. servicewomen and veterans, federal employees, low-income women in Washington, D.C., and others. The bill accomplishes this by ensuring that federal insurance programs cover abortion services. This legislation would also support access to private insurance coverage across the country by prohibiting state, local, and federal governments from interfering with coverage of abortion by private insurance companies. Studies show that, absent political interference, 87% of private insurance plans cover abortion services.¹¹ The EACH Woman Act would undoubtedly improve abortion access and, consequently, women's overall health. It is time to enact this critically important bill and end political interference with individuals' freedom to make private medical decisions.

IV. Conclusion

We urge you to lift the Hyde Amendment and all policy riders that restrict funding for abortion coverage and invite you to work with us to build a future where comprehensive reproductive health care is available to all. Doing so has the power to transform abortion access across the country and to bring us closer to a world in which all people have unencumbered access to affordable abortion services, no matter where they live, their income, or how they get their health coverage.

¹ NARAL Pro-Choice Am., WHO DECIDES? THE STATUS OF REPRODUCTIVE RIGHTS IN THE UNITED STATES, 18 (2020).

² *Id.* at 29.

³ Stanley K. Henshaw et. al., *Restrictions on Medicaid Funding for Abortions: A Literature Review* 26, (Jun. 2009), available at <https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review> (last visited Dec. 7, 2020).

⁴ Ibis Reprod. Health, THE HYDE AMENDMENT: FREQUENTLY ASKED QUESTIONS ABOUT ITS IMPACT 1 (Sept. 2020).

⁵ *Id.*

⁶ Gretchen Frazee, *New Abortion Laws are too Extreme for Most Americans, Poll Shows*, PBS (June 7, 2019, 5:00 AM) <https://www.pbs.org/newshour/politics/new-abortion-laws-are-too-extreme-for-most-americans-poll-shows>.

⁷ Memorandum from Katherine Patterson, Public Policy Polling, NARAL Pro-Choice Am., to Interested Parties, Strong Majority of Battleground State Voters Support Reproductive Freedom, Reject Banning Abortion (Aug. 25, 2020) (on file with NARAL Pro-Choice Am.).

⁸ Memorandum from Hart Rsch. Assocs., to Interested Parties, *New Polling Shows Voters See the Impact of Abortion Coverage on Women's Economic Opportunities and Security* (Oct. 18, 2017) (on file with All Above All).

⁹ *Id.*

¹⁰ Gerhard Peters & John T. Wooley, *Democratic Party Platforms, 2016 Democratic Party Platform, AM. PRESIDENCY PROJECT* (July 21, 2016) <https://www.presidency.ucsb.edu/documents/2016-democratic-party-platform>.

¹¹ Adam Sonfield et. al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002 36 PERSPECTIVES IN SEXUAL & REPRODUCTIVE HEALTH* 2, 72-79 (2004), available at <http://www.guttmacher.org/pubs/journals/3607204.html> (last visited Dec. 5, 2020).

Statement for the Record of the Center for Reproductive Rights

**Hearing: "The Impact on Women Seeking an Abortion but are Denied Because of an
Inability to Pay"**

**U.S. House of Representatives Committee on Appropriations Subcommittee on Labor,
Health, and Human Services**

December 8, 2020

Chairwoman DeLauro, Ranking Member Cole, and Members of the House Committee on
Appropriations Subcommittee on Labor, Health and Human Services:

The Center for Reproductive Rights respectfully submits the following testimony to the U.S.
House of Representatives Committee on Appropriations Subcommittee on Labor, Health and
Human Services.

Since 1992, the Center for Reproductive Rights has used the power of law to advance
reproductive rights as fundamental human rights that governments around the world are
obligated to protect, respect, and fulfill. Reproductive freedom lies at the heart of the promise of
human dignity, self-determination, and equality embodied in both the U.S. Constitution and the
Universal Declaration of Human Rights. Our litigation and advocacy over the past 26 years have
expanded access to reproductive health care around the nation and the world. We have played a
key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa,
Asia, and Eastern Europe on issues including access to life-saving obstetrics care, contraception,
safe abortion services, and comprehensive sexuality information. We envision a world where

every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where every person can make these decisions free from coercion or discrimination.

We appreciate the Subcommittee's attention to the Hyde Amendment, a discriminatory ban on abortion coverage that has put abortion care out of reach for far too many for far too long. Reproductive health care, including access to, abortion, is a fundamental health care need. The Hyde Amendment's ban on abortion coverage, in combination with related abortion coverage bans, affects enrollees in Medicaid, Medicare, CHIP, federal employees and their dependents, military service members, veterans, Indigenous people, Peace Corps volunteers, immigrants, and residents of Washington, D.C. It is vital that the Appropriations Committee eliminates the Hyde Amendment, ensuring that members of these affected communities are able to make decisions about their own reproductive health care regardless of where they live, how much money they earn, and their employer.

Access to health care, including abortion, is a human right. Every person has the right to make their own decisions about having children regardless of their circumstances and without interference and discrimination. Abortion coverage bans like the Hyde Amendment are intentionally designed to put abortion care out of reach, especially for people struggling financially and those who are insured through the federal government. This particularly affects communities who are subjected to systemic racism and other forms of discrimination, and whose access to health care is already tenuous due to these barriers.

Lack of adequate reproductive health services can have profound impacts, including increased risk of financial insecurity, intimate partner violence, and maternal and neonatal deaths.¹ These impacts are disproportionately felt by communities in the U.S who have long faced systemic barriers to health care—including people with low incomes, rural populations, people of color, LGBTQ people, people with disabilities, and immigrants.² Access to timely, comprehensive essential health care including abortion is even more urgent and necessary as the country continues to endure the COVID-19 public health and economic crises.³

The Hyde Amendment Blocks Access to a Constitutional Right

Our Constitution protects the right of each of us to chart our own life path and to make the deeply personal decisions that impact our lives, our families, and our health, including whether and when to become a parent. One in four women in the United States will make the decision to have an abortion in the course of her life.⁴ Abortion is essential health care, a constitutional right, and a human right.

That right is meaningless unless individuals have access to abortion, and it rings especially hollow when it is the government intentionally preventing people from accessing it. The Hyde Amendment unjustifiably singles out abortion care, denying those subjected to the Hyde

¹ CTR. FOR REPROD. RIGHTS & COLUMBIA MAILMAN SCH. OF PUB. HEALTH, HEILBRUNN DEP'T OF POPULATION & FAMILY HEALTH, ABORTION IS ESSENTIAL HEALTHCARE: ACCESS IS IMPERATIVE DURING COVID-19 1 (2020), <https://reproductiverights.org/sites/default/files/documents/USP-COVID-FS-Interactive-Update.pdf>.

² *Id.*

³ *Id.*

⁴ Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) AM. J. PUB. HEALTH 1904, 1908 (2017), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042>.

Amendment—many of whom already face extensive barriers to accessing health care—health insurance for the care they need. As a result, they must cover the full cost of their abortion procedures out of pocket—or forego care entirely.

Abortion access is already at a precarious point in this country. The past decade has seen an escalating, coordinated attack on access to abortion care. Since 2011, more than 450 state laws restricting and banning abortion care have been enacted. These laws are designed to ensure that patients face often insurmountable financial and logistical barriers to care and clinics are forced to close.⁵ In a number of states, people accessing abortion care are forced to pay for medically unnecessary ultrasounds, travel and lodging for multiple trips to distant clinics and to comply with mandatory delay laws, and childcare costs during their absence—all while losing wages for the time they spend attempting to access care.

Five states—Mississippi, Missouri, North Dakota, South Dakota and West Virginia—have only one abortion clinic.⁶ Eighty-nine percent of counties in the United States do not have a single abortion clinic and some counties that have a clinic only provide abortion services on certain days of the week.⁷ In addition, many states require multiple, medically unnecessary provider

⁵ CTR. FOR REPROD. RIGHTS, WHAT IF ROE FELL? (2019), <https://reproductiverights.org/what-if-roe-fell>.

⁶ ABORTION CARE NETWORK, *Communities Need Clinics: The Essential Role of Independent Abortion Clinics in the United States* (2020) <https://abortioncarenetwork.org/wp-content/uploads/2020/12/CommunitiesNeedClinics-2020.pdf>.

⁷ NAT'L P'SHIP FOR WOMEN & FAMILIES, BAD MEDICINE: HOW A POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS 13 (3d ed. 2018), <http://www.nationalpartnership.org/our-work/resources/repro/bad-medicine-third-edition.pdf>.

visits or unnecessary medical services. These barriers both delay care and prolong the time it takes to receive care.⁸

Delays have the effect of increasing the cost of abortion care. Abortion in the first trimester is substantially less expensive than in the second trimester.⁹ The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure for lower-income women. And because fewer clinics offer second-trimester abortions, a patient who has been delayed into the second trimester will typically be required to travel farther to obtain an abortion, thereby incurring additional travel and related costs, including costs for child care, transportation, or hotel stays.¹⁰ As a result, denials of care that result in delays can significantly drive up the cost for a patient seeking abortion care, which can push care out of reach—particularly for people with low incomes and those residing in states with few abortion providers.

These barriers are compounded for people who are denied insurance coverage for abortion due to the Hyde Amendment. In the majority of states, the cost of a first or second trimester abortion is considered financially catastrophic for households earning their state's median monthly income.¹¹ Lack of insurance coverage due to the Hyde Amendment and other coverage

⁸ See *id.* at 21-22; see also VIRGINIA DEP'T OF HEALTH, REGULATIONS FOR LICENSURE OF ABORTION FACILITIES, PROPOSED REGULATION AGENCY BACKGROUND DOCUMENT 10 (2013), http://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\58\3563\6315\AgencyStatement_VDH_6315_v2.pdf.

⁹ Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground, and Supportive States in 2014*, 28 WOMEN'S HEALTH ISSUES 212, 215-16 (2018), [http://www.whijournal.com/article/S1049-3867\(17\)30536-4/abstract](http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract).

¹⁰ Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. WOMEN'S HEALTH 706 (2013).

¹¹ Carmela Zuniga, Terri-Ann Thompson & Kelly Blanchard, *Abortion as a Catastrophic Health Expenditure in the United States*, 30 WOMEN'S HEALTH ISSUES (2020).

restrictions forces individuals to make the choice between accessing health care, paying rent, or asking for money from friends and family.¹² It may take weeks to pull together sufficient funds, pushing people past gestational limits in places where they live and setting in motion a series of escalating financial hurdles. Due to prohibitive costs, many forego care entirely. A study conducted in Louisiana estimated that 29% of Medicaid-eligible pregnant women who would have had an abortion if they could receive Medicaid coverage, were unable to do so.¹³ The effect of these compounded costs is that people are unable to make decisions about their own lives, which is the express intent of the anti-abortion politicians behind these restrictions.¹⁴

Eliminating the Hyde Amendment therefore works hand-in-hand with bills such as the EACH Woman Act (S.758/ H.R. 1692), a federal bill to eliminate discriminatory coverage restrictions on abortion care, including the Hyde Amendment, and the Women's Health Protection Act (S.1645/ H.R. 2975), a federal bill to protect the right to access abortion by creating a nationwide safeguard against bans and medically unnecessary restrictions that single out abortion care.

People Who are Denied Access to Abortion Are More Likely to Fall into Poverty

Being denied an abortion can have serious consequences for people's physical, mental, and economic health and well-being, and that of their families. According to a recent longitudinal

¹² Id.

¹³ Sarah C. M. Roberts, Nicole E. Johns, Valerie Williams, Erin Wingo & Ushma D. Upadhyay, *Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion*, 19 BMC WOMEN'S HEALTH (2019).

¹⁴ See, for example 123 Cong. Rec. 32, 19700 (June 17, 1977) (quoting Henry Hyde on the passage of the Hyde Amendment in 1977: "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the...Medicaid bill.")

study, individuals who are denied a wanted abortion are more likely to experience economic insecurity than individuals who receive a wanted abortion. After following participants for five years, the study found that people who were denied abortion care were more likely to live in poverty, experience debt, and have lower credit scores for several years after the denial.¹⁵ Moreover, when people are denied a wanted abortion, their existing children are more likely to live below the federal poverty level and have lower mean child development scores than the children of women who received an abortion.¹⁶ Importantly, these findings demonstrate that when people have control over when to have children and how many children to have, their children benefit through increased economic security and better maternal bonding.

The Hyde Amendment Unfairly Punishes Already-Marginalized Communities

Programs such as Medicaid play an essential role for rural communities, LGBTQ people, people of color, and other groups who, due to structural inequities, experience elevated rates of poverty, unemployment or underemployment, and gaps in private insurance coverage. For instance, Black and Hispanic women are approximately twice as likely as white women to be insured by Medicaid.¹⁷ LGBTQ individuals also rely heavily on Medicaid—in 2014, Medicaid covered 29% of low and middle-income LGBT Latinx individuals, and 37% of Black LGBT individuals who

¹⁵ ANSIRH, *Fact Sheet: Introduction to the Turnaway Study*, March 2020, <https://www.ansirh.org/sites/default/files/publications/files/turnawaystudyannotatedbibliography.pdf>.

¹⁶ Diana Greene Foster, Sarah E. Raifman, Jessica D. Gibson, et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. PED. 183 (2018) [https://www.jpeds.com/article/S0022-3476\(18\)31297-6/fulltext](https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext).

¹⁷ Alina Salganicoff, Laurie Sobel, & Amrutha Ramaswamy, *The Hyde Amendment and Coverage for Abortion Services*, KAISER FAMILY FOUNDATION (Sept. 10, 2020) <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>.

were low and middle-income.¹⁸ Individuals in rural areas are less likely to have private insurance coverage than those in non-rural areas, and Medicaid covers nearly one quarter of nonelderly individuals living in rural areas.¹⁹ People with disabilities are also overrepresented among Medicaid beneficiaries, and comprise more than one in three adults under age 65 enrolled in Medicaid.²⁰

People with low incomes, people of color, young people, immigrants, people with disabilities, people who live in rural communities, and LGBTQ people already experience significant barriers to accessing quality health care, which are further exacerbated by the Hyde Amendment. Deeply entrenched racial and ethnic disparities in health outcomes disproportionately affect Black and Indigenous women of all socioeconomic backgrounds. Likewise, according to the U.S. Department of Health and Human Services (HHS) Healthy People 2020 Initiatives, “LGBT individuals face health disparities related to societal stigma, discrimination, and denial of their civil and human rights.”²¹ Many people experience discrimination due to multiple, intersecting identities (for instance, people of color with low incomes who are also transgender or disabled) that compound and intensify barriers to accessing abortion care. By targeting programs such as

¹⁸ Kellan Baker, Ashe McGovern, Sharita Gruberg, et al., *The Medicaid Program and LGBT Communities: Overview and Policy Recommendations*, CENTER FOR AMERICAN PROGRESS (August 9, 2016) <https://www.americanprogress.org/issues/lgbtq-rights/reports/2016/08/09/142424/the-medicaid-program-and-lgbt-communities-overview-and-policy-recommendations/>.

¹⁹ Julia Foutz, Samantha Artiga, & Rachel Garfield, *The Role of Medicaid in Rural America*, KAISER FAMILY FOUNDATION (Apr. 25, 2017) <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>.

²⁰ Center on Budget & Policy Priorities, *Medicaid Works for People with Disabilities* (Aug. 29, 2017) <https://www.cbpp.org/research/health/medicaid-works-for-people-with-disabilities>.

²¹ U.S. DEPT. OF HEALTH & HUMAN SERVS., LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited Feb. 9, 2020).

Medicaid, the Hyde Amendment erects yet another barrier for these and other marginalized communities, effectively denying them access to care.

In addition to economic insecurity, systemic discrimination, and the Hyde Amendment, these communities have also borne the most devastating impact of the COVID-19 pandemic, all while in the throes of a long-overdue reckoning with this country's history of systemic racism and structural discrimination. COVID-19 continues to lay bare many of the structural inequities that persist across the country, including the disparate impact of abortion bans. It is long past time to abolish the discriminatory Hyde Amendment.

Conclusion

By prohibiting coverage of abortion care in government programs, the Hyde Amendment makes accessing abortion care difficult or impossible for those who are already struggling to get by. Eliminating the Hyde Amendment is therefore a necessary step towards improving equitable access to abortion care. However, it is not a comprehensive fix. In order for abortion care to be truly accessible it must not be conditioned by a person's economic circumstances, nor by state and local attempts to ban or unnecessarily restrict access to abortion. Together, coverage bans, gestational bans, unnecessary ultrasound requirements, mandatory delays and more can create an insurmountable series of barriers that delay or entirely block access to care.

Congress has the opportunity to right this wrong. In addition to eliminating the Hyde Amendment, Congress should pass the EACH Woman Act and Women's Health Protection Act. Together these bills have the power to transform access to abortion care across the country.

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The Center for Reproductive Rights deeply appreciates the opportunity to submit its testimony to the Committee and commends the Committee for addressing this critical issue.



The National Abortion Federation (NAF) is the professional association of abortion providers. Our mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care. NAF's Hotline offers patients resources and assistance in accessing their abortion care, including medically-accurate information about pregnancy and abortion, referrals to quality abortion providers, and limited financial assistance for patients in difficult situations. Restrictions on insurance coverage of abortion care jeopardize both the health and economic security of patients, and fall hardest on low-income patients and patients of color. The NAF Hotline hears every day from patients whose access to safe abortion care is inhibited by the Hyde Amendment. Below are excerpts of a few these patients' stories.

Reese* spent almost three months attempting to raise enough money to cover the cost of her abortion care, struggling to keep up as the price increased with each passing week. Reese reached out to her family for help, only to be told by her mother that she would not support Reese in her decision. Reese eventually obtained funding assistance from not one, but two different funding organizations, which finally enabled her to access the abortion care she needed.

Peggy's* husband abandoned her and their two children. Subsisting on food stamps and relying on Medicaid for health care coverage, Peggy was in the process of applying for disability benefits but had no income coming into the home when she learned she was pregnant. Because of the Hyde Amendment, Peggy couldn't rely on her insurance to cover the cost of the abortion care she needed. She had significant difficulty even in borrowing gas money to travel to her nearest clinic; without the assistance of a private fund, there is no way Peggy would have been able to access her abortion care.

Barbara* relies on food stamps as her only current source of income. She borrowed as much as she could from family members to pay for her abortion care, but the process of collecting funds took so long that she was forced to get a different kind of care than she originally wanted. This doubled the cost of Barbara's abortion care. Because of the Hyde Amendment, Barbara wasn't able to rely on her insurance to cover those costs. She was forced her to seek assistance from a private fund to cover the cost of her care and her travel needs.

*All names have been changed to protect patient privacy.

December 7, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole:

The undersigned organizations are committed to ensuring all people can access reproductive health care, including abortion, no matter how much money they make, where they are born, or their race or gender. We believe that each of us should be able to make decisions about pregnancy and parenting that are best for our families without political interference. For 44 years the Hyde Amendment has banned coverage for people enrolled in Medicaid and has served as a perpetual reminder that the legal right to abortion has never been enough. Bans on abortion coverage, like the Hyde Amendment, have long disproportionately impacted Black, Indigenous and People of Color (BIPOC) communities. Equally, BIPOC communities have long bore the brunt of the racial and economic inequities that have both been exposed and exacerbated by the COVID-19 pandemic. We need healthcare, including abortion access, that works for everyone. To this end, we strongly support clean appropriations bills, free from all abortion coverage bans, allowing for insurance coverage of full spectrum reproductive health care, including abortion.

We know that access to reproductive health care services, including abortion, are crucial for economic security and should not be contingent on a person's income, insurance coverage, immigration status, or where they live. Withholding coverage for abortion care creates profound hardships for people across the country, particularly for those who already face significant barriers to receiving high-quality health care, such as low-income people, immigrants, young people, women of color, and transgender and gender nonconforming people. Still, since the passage of the Hyde Amendment in 1976, the appropriations process has been used as a vehicle to systematically deny access to full spectrum reproductive health care. The Hyde rider has since permeated other appropriations bills thereby expanding the reach of the rider, resulting in abortion coverage bans for: (i) Medicaid, Medicare, and Children's Health Insurance Program beneficiaries; (ii) federal employees and their dependents; (iii) Peace Corps volunteers; (iv) Native American people; (v) people in federal prisons and detention centers, including those detained for immigration purposes; and (vi) low-income residents of the District of Columbia.

While our Black and Brown communities, women, LGBTQ folks, immigrants and young people are trying to survive the pandemic, the Senate confirmed an anti-abortion Supreme Court Justice. The continued threats to reproductive health care, including abortion, have never been more present, as our nation faces an unprecedented public health emergency in parallel to a long-needed reckoning on how systemic racism permeates our society and institutions. Through the adversity and pain brought by this health crisis and national reckoning, we imagine a future in which we can control our own bodies and safely care for our families. We are reimagining a world in which each of us makes a living wage and everyone has access to the full spectrum of reproductive health care, including abortion.

We commend the members of Congress who time after time have taken a stand against coverage bans. Representatives Barbara Lee, Jan Schakowsky, and Diana DeGette have introduced the Equal Access to Abortion Coverage in Health Insurance (EACH) Woman Act (H.R. 1692) each Congress since 2015. The bill now holds over 180 cosponsors in the House of Representatives and support doesn't stop there. Recent polling shows that the majority of national voters support Medicaid coverage for abortion, even more so in battleground districts.¹ 84% of women of color voters say it's extremely important that candidates support women making their own decisions about their reproductive health.² Women of color have been saying for decades, and the majority of national voters agree that – however we feel about abortion, no one should be denied access to it just because they are struggling to make ends meet.

Our movement is strong and the public is with us. We urge the Committee to lift the abortion coverage bans that have harmed our families, our communities, and our health. We urge you to draft and pass future appropriations bills free from abortion coverage bans. We invite the committee to reimagine what it looks like to go forward together and end policies that perpetuate economic and healthcare inequities. After 44 years, it's time to put an end the Hyde Amendment so that no one is denied abortion coverage because of how much money they have or how they get their health insurance.

Sincerely,

All* Above All
 Abortion Access Front
 Abortion Care Network
 ACCESS REPRODUCTIVE JUSTICE
 Advocates for Youth
 American Civil Liberties Union
 American Medical Student Association

¹ New polling shows that a significant majority of the American electorate supports Medicaid coverage of abortion services; support in battleground congressional districts is even stronger.
<https://allaboveall.org/press/national-poll-shows-tide-is-turning-on-43-years-of-restricting-abortion-coverage/>

²Intersections of Our Lives (2019). Fact Sheet On Perspectives Of Black Women Voters. p.3.

Catholics for Choice
Center for American Progress
Center for Reproductive Rights
Cobalt Advocates
Eastern Massachusetts Abortion Fund
EMAA Project
Forward Together Action
Holler Health Justice
Hope Clinic for Women
Ibis Reproductive Health
If/When/How: Lawyering for Reproductive Justice
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Indigenous Women Rising
Ipas
National Latina Institute for Reproductive Justice
Mabel Wadsworth Center
National Abortion Federation
NARAL Pro-Choice America
NARAL Pro-Choice Maryland
National Asian Pacific American Women's Forum (NAPAWF)
National Center for Lesbian Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Institute for Reproductive Health
National Network of Abortion Funds
National Partnership for Women & Families
National Women's Health Network
Nationsl Organization for Women
National Women's Law Center
PAI
Planned Parenthood Federation of America
Population Institute
Power to Decide
Pregnancy Options WI: Education, Resources & Support (POWERS)
Physicians for Reproductive Health
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
The Women's Centers: The Advocacy Center, Atlanta Women's Center, Cherry Hill Women's Center, Delaware County Women's Center, Hartford GYN Center, Philadelphia Women's Center
Union for Reform Judaism
URGE: Unite for Reproductive & Gender Equity
We Testify

Women of Reform Judasim
Women's Health Center of West Virginia
Women's Medical Fund- PA
Women's Medical Fund, Inc. (WI)
Yellowhammer Fund

Congress of the United States
Washington, DC 20515

December 8, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor, Health and
Human Services, Education, and
Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor, Health and
Human Services, Education, and
Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole:

As leaders of the Pro- Choice Caucus, we are committed to ensuring that all people can access reproductive health care, including abortion, no matter how much money they make, where they are born, or their race or gender. For 44 years, the Hyde Amendment has banned coverage for people enrolled in Medicaid and has served as a perpetual reminder that the legal right to abortion has never been enough. Bans on abortion coverage, like the Hyde Amendment, have long disproportionately impacted Black, Indigenous and People of Color (BIPOC) communities. Equally, BIPOC communities have long bore the brunt of the racial and economic inequities that have both been exposed and exacerbated by the COVID-19 pandemic. We need health care, including abortion access, that works for everyone. To this end, we strongly support ending the Hyde Amendment and are ready for Congress to pass appropriations bills without this harmful rider.

Withholding coverage for abortion care creates profound hardships for people across the country, particularly for those who already face significant barriers to receiving high -quality health care, such as low-income people, immigrants, young people, women of color, and transgender and gender nonconforming people. Still, since the passage of the Hyde Amendment in 1976, the appropriations process has been used as a vehicle to systematically deny access to the full spectrum reproductive health care. The Hyde rider has since permeated other appropriations bills thereby expanding the reach of the rider, resulting in abortion coverage bans for: (i) Medicaid, Medicare, and Children's Health Insurance Program beneficiaries; (ii) federal employees and their dependents; (iii) Peace Corps volunteers; (iv) Native American people; (v) people in federal prisons and detention centers, including those detained for immigration purposes; and (vi) low-income residents of the District of Columbia.

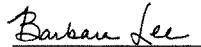
As our nation faces an unprecedented public health emergency, threats to reproductive health care, including abortion, have never been more present. This year we saw multiple states exploit

the coronavirus pandemic to try to ban abortion and cut patients off from care. The pandemic has exposed long-standing structural racism and inequities in our health care system, with communities of color, particularly those in the Black, Latinx, and Pacific Islander communities, and Indigenous people facing disproportionately high rates of infection and death from COVID-19. We know that same systemic racism is at the core of abortion coverage bans like the Hyde amendment and disproportionately impacts the same communities as the pandemic.

Still, recent polling shows that the majority of national voters support Medicaid coverage for abortion, even more so in battleground districts.¹ 84% of women of color voters say it's extremely important that candidates support women making their own decisions about their reproductive health.² Women of color and the majority of national voters agree that – however we feel about abortion, no one should be denied access to it just because they are struggling to make ends meet. With the EACH Woman Act, politicians will no longer be able to deny a woman abortion coverage based on her income, type of insurance, or zip code.

The public is with us. We urge the committee to lift the abortion coverage bans that have for far too long harmed our families, our communities, and our health. We urge you to draft and pass future appropriations bills free from abortion coverage bans. We invite the committee to reimagine what it looks like to go forward together and end policies that perpetuate economic and healthcare inequities. After 44 years, it's time to put an end to the Hyde Amendment so that no one is denied abortion coverage because of how much money they have or how they get their health insurance.

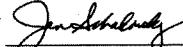
Sincerely,



Barbara Lee
Member of Congress



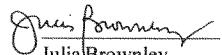
Diana DeGette
Member of Congress



Jan Schakowsky
Member of Congress

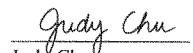
¹ New polling shows that a significant majority of the American electorate supports Medicaid coverage of abortion services; support in battleground congressional districts is even stronger. <https://allaboveall.org/press/national-poll-shows-tide-is-turning-on-43-years-of-restricting-abortion-coverage/>

² Intersections of Our Lives (2019). Fact Sheet On Perspectives Of Black Women Voters. p.3.

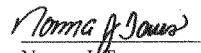

Julia Brownley
Member of Congress

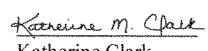

Jackie Speier
Member of Congress

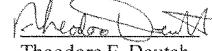

Ayanna Pressley
Member of Congress


Judy Chu
Member of Congress


Suzan DelBene
Member of Congress


Norma J. Torres
Member of Congress


Katherine Clark
Member of Congress


Theodore E. Deutch
Member of Congress



Statement for the Record of We Testify

Hearing: "The Impact on Women Seeking an Abortion
but are Denied Because of an
Inability to Pay"

U.S. House of Representatives Committee on
Appropriations Subcommittee on Labor, Health, and
Human Services

December 8, 2020

As people who had abortions, we know what it is to make the decision to terminate a pregnancy more intimately than anyone. We know what it is to contemplate what's next for our futures, we know what it is to make the decision to not grow our family beyond its current size, and we know what it is to go through the experience with *and* without the support of our government. Together, we've experienced financial, logistical, and legal barriers to abortion care, as well as support, compassion, and care from our loved ones, providers, and community. We know what abortion care should look like in the United States, which is why we have joined together to speak out against the Hyde Amendment, a policy that has harmed us and our right to abortion care for too long.

The Hyde Amendment has existed as a discriminatory policy enforcing an economic caste in this nation, ensuring that people with no or low-incomes are unable to afford abortions as soon as we want care. When former Congressman Henry Hyde of Illinois

lobbied for the harmful policy that bears his name, he used hurtful and degrading imagery and descriptions about those of us who have abortions, particularly those of us who receive our health insurance through public support systems. This racist and classist language has thrived for too long, keeping those of us who need care from being able to access it safely. The majority of us—people who have abortions—are people of color, so these restrictions harm us the most. It is long past time for the Hyde Amendment to be ended.

As abortion storytellers with We Testify, an organization dedicated to the leadership and representation of people who have abortions—particularly at the intersection of race, class, and gender identity, we are opposed to any bans on insurance coverage for abortion. We know the unnecessary financial struggle and the stigmatizing climate these bans create. We dream of a world where every single person who wants abortions is able to receive care, without stress, worry, or harassment. One of the first critical steps to this liberated world would be to lift all coverage bans on abortion and ensure that we are able to access care, freely. We know the difference that Medicaid coverage of abortion can make for our families.

Everyone loves someone who had an abortion. We had abortions and we deserve to be heard. Thank you for listening to our voices on the impact of the Hyde Amendment.

Denied Medicaid-funded Abortion**HK Gray, 20, Texas**

When I was fifteen years old I found out I was pregnant with my daughter. I was ecstatic. I struggled to get on Medicaid since I was a minor and my parents were unable to help; my dad was homeless and my mother was incarcerated. I was unable to go to an Ob/Gyn for almost three months because I had to jump through so many hoops to get my application approved. Once it was approved, I was able to start getting the prenatal care I should've had all along. I also had the opportunity to go to the doctor and dentist for the first time in years. Medicaid paid for everything from ultrasounds to the birth of my daughter. This allowed me to spend my money on baby clothes, toys, and nursery supplies.

I was still on Medicaid three months postpartum when I started having what I thought was a very heavy period. I made an appointment with my Ob/Gyn just in case it was anything serious. It was a spontaneous abortion, commonly known as a miscarriage. I didn't even know I was pregnant before I went in. I was given some medication (the same as a medication abortion) and Medicaid covered it all.

When my daughter was nine months old, I realized I was pregnant again. This time I knew that I was going to have an abortion. I was seventeen, so in Texas, I had to get my parents' consent, but this was something I couldn't do because my parents were still homeless and incarcerated. I had to wait to get permission from a judge through a

judicial bypass. This entire process made me go to the clinic multiple times, forced me to stay pregnant for an extra 12 weeks, and made my abortion more expensive. I had Medicaid but I couldn't use it. Luckily, I was supported by Texas Equal Access Fund and Jane's Due Process through the process. Despite the funding support, I still had to raise \$350 and that was difficult. It was unfair that Medicaid covered everything I needed for my daughter's birth and my miscarriage, but not my abortion.

Makayla Montoya Frazier, 21, Texas

I found out I was pregnant on my 19th birthday while inside of an anti-abortion crisis pregnancy center. I told them I did not want my ex-partner in the room for the ultrasound, but they invited him in any way. I told them I was in constant pain and that I was losing weight. Rather than medical advice, they gave me a blue onesie and a bottle of prenatal vitamins.

I had an extremely difficult few weeks after that. Gestational diabetes made my blood sugar low every few hours leaving me in cold sweats and vomiting all day. My body continued to struggle heavily and I knew that I could not continue my pregnancy while keeping myself healthy. I called my CHIP case manager and was told that I couldn't be helped because Texas bans insurance coverage of abortion. I was told that I wasn't going to die; I only *felt* like I was.

I was then forced to resume my job as an erotic dancer while 14 weeks pregnant in order to pay for the abortion care I needed. I wasn't able to raise the full \$700 within the

time crunch I was on, so a few friends pitched in what they could to help me. I owe them everything and more. I feel like they saved my life. Sex work and solidarity did more for me than the State ever could. Every person should have unrestricted access to medical care, regardless of circumstance.

Brittany Mostiller, 35, Illinois

When I was 22, I was a mama to three daughters and holding down a part-time job at a grocery store, and I realized I was pregnant again. I couldn't afford another child then — physically, emotionally, or financially. The decision to have an abortion was the easy part — but I couldn't afford it.

When I gave birth to my three daughters, Medicaid covered every aspect of my pregnancy and the delivery of my daughters. So I assumed it would cover my abortion, but because of the Hyde Amendment, it didn't. I had to figure out how to pay \$900 for the abortion out-of-pocket. That was more money than I made in a month. It took me several weeks to save up, which meant that while I tried to get my abortion during the first trimester, I was pushed to later in my pregnancy before I could finally afford the procedure. This was a really challenging and disheartening experience.

Thankfully, the law has changed in Illinois and people enrolled in Medicaid now have abortion coverage. Unfortunately, that is not the case in more than half of the states, and it is doubly difficult when combined with the thousands of abortion restrictions.

Millions of people live in states that are hostile to abortion. I experienced first hand the panic and worry of not being sure of whether I'd be able to get the abortions I wanted because I couldn't afford them. Medicaid insurance has been a healthcare lifeline for me and my family—including when I chose to become a parent. We need to make sure that everyone on Medicaid is able to decide if, when, and how to grow their families without fear of that decision being taken away from them simply because insurance won't cover it.

Angel Robinson, 22, Texas

At the time of my abortion, I was 20 years old and I had Texas Medicaid for my health insurance. In Texas, Medicaid will not cover abortions unless it is a medical emergency, which was not the case for me. I ended up traveling to New Mexico because it was closest, and in Texas, there is a 24-hour waiting period. I had a strict time limit to get the abortion done.

Since abortions are not covered by Medicaid you must either pay out of pocket and or find funding, if you're lucky some people may be able to get their full procedure covered, but it's very rare. Thankfully, in my case, I was able to get my full procedure covered, fuel, and lodging between two abortion funding organizations. It would have been easier if my insurance could have covered it, so I could have had the procedure in my home city or at least within the state of Texas.

Medicaid does not cover abortions, but they do cover alternative services such as prenatal medical care and adoption. Texas Medicaid prenatal assistance includes counseling, mentoring, informational brochures about pregnancy, and a family nurse program. They give information on adoption and how it works, but they do not give any information, counseling for services for abortion. I have had Medicaid for all of my pregnancies, including the last two I carried to term and it was so important to me. When I see how much my medical bill actually is, there is no way I could even come close to affording to have my children. I am so thankful that I was able to go see a doctor and not be forced to go through my pregnancy without it because I can't afford to pay. There is so much medication that I have to have, like lab work, sonograms, and weekly injections due to my anemia. Even the nausea medication is too expensive for me to afford on my own. I am thankful that Medicaid does cover a lot of it because there is just no way that I could have prepared for a baby and pay the medical bills at the same time. It is just impossible. What I wish, however, is that Texas would support me in my decision to not have another child, too. I wish all of my pregnancy healthcare was covered—including my abortion.

CoWanda Rusk, 21, Texas

When I needed an abortion, like a lot of young people, I experienced a lot of barriers, including a Medicaid coverage ban and parental involvement law. I lived independent of my parents but was receiving Medicaid tied to my parents' state benefits. Because I was under 18, I needed my parents' permission to get an abortion, but I couldn't go to them

for support and instead had to ask a judge for permission. The way Medicaid was set up it wouldn't have allowed me to navigate health care systems using pubic assistance (Medicaid) until I became 18 and could apply for services on my own.

Unfortunately, even if Texas' Medicaid covered abortions, I still would've been pushed out of accessing care because of my age. It's so complicated. Eventually, I had to see a judge to get permission for my abortion, which was granted. Ending Hyde is a necessary step to expanding Medicaid and abortion access. What I imagine is a process that works to include young peoples access and ability to navigate their healthcare independent from stagnant age and parental involvement regulations that only exploit their bodies and freedoms, including and independent from the lack of insurances like Medicaid and that only exacerbates financial barriers to the health needs of young people.

Kay Winston, 26, Ohio

I have had Medicaid health insurance throughout all of my pregnancies, but was only able to use it for the pregnancies I wanted to continue when I had my two children. I didn't even try to use my Medicaid because I was told early on that it doesn't cover abortion services before I even got my abortion. It was crystal clear. That makes the barrier just that much more of a barrier. People are on Medicaid because they qualify for it because they can't afford private insurance. It just creates another barrier. I had Medicaid during my first and second abortion. I also had private insurance through my

job, but the deductible on abortion is so high I had no option other than to pay for it out of pocket. It's extremely unfortunate. They don't even acknowledge that abortion services are even part of healthcare and that the same Black folks who need abortion care are also on Medicaid. It's unfortunate that you can use Medicaid to have a baby but not any form of abortion services. That's astounding. It's unfair, just like the fifty thousand other issues we fight for so our families can be healthy. It keeps us unable to have the services that we need. We get judged for having children and having food stamps, but then government assistance doesn't allow you to have abortions you need to decide if you want another child. It's hypocritical.

I have Medicaid for both of my children and it's like night and day when it comes to Medicaid supporting doctors appointments, prescriptions, surgeries, having the baby, and everything when it comes to healthcare. It covers so much that sometimes when I go into the pharmacy and get a prescription for my kids, Medicaid covers more than my private insurance through my job so I use it more. It's wild how Medicaid supports any other healthcare procedure but treats abortion so differently.

Esmarie, 19, Texas

The day I found out I was pregnant, I saw all over Facebook that Texas was going to be shutting down the clinics. I thought 'I'm not going to be able to have this abortion.' I thought that I didn't have a choice—I was going to have to just live with it. It was very scary because I couldn't tell anybody. I was trying to get as many hours of work as I

could. It was also scary because of everything going on. Everything was closed. I wasn't making enough money. The restaurants were giving me only 10 hours a week, so I couldn't make enough to support myself. I was scared I would get COVID-19 because I was pregnant. I didn't have a car, so I had to walk in the heat. No transportation, no work—I couldn't meet my basic needs.

The abortion clinics were closed at that time, but the CPCs, the crisis pregnancy centers, were open. When I was making phone calls, trying to see which clinics were open for abortion, they were the only ones who answered. They said, "We don't do abortions, but you can get an ultrasound and we can talk to you about your choices." But they really only give you two choices—adoption or parenting. I was definitely not going to do adoption because I was adopted and it just didn't go well. But I knew I couldn't raise my child at this time.

The first time I had an abortion, I was eight weeks along. I had Medicaid and was under 18, so I had to get help from an organization to get a judicial bypass and pay for my abortion. The first time, it was not that bad—I was able to handle the pain, I guess. But the second time, it was so bad. I couldn't move, I had chills, and my stomach was hurting. It was so bad I brought my blanket into the restroom just so I could be next to the tub, be next to the toilet. I feel like this wouldn't have happened if I could have just gotten the help earlier.

I had forgotten my mask—that was not on my mind at all. I was nervous. I didn't want to touch anything. I think I was having a panic attack because I couldn't tell them I was

having a miscarriage. They were asking me what was wrong and what I needed, but I couldn't breathe because I was in shock. I just remember holding my stomach because it was hurting and I was crying because I was scared. I told them, "I'm bleeding and I was pregnant." I told them I was having a miscarriage because I was scared that I could get arrested for doing my own abortion and because Medicaid insurance pays for miscarriage care.

Then I lost so much iron from bleeding that I passed out on the floor. I'm 4'11" and I weigh about 98 pounds. I later found out that I have an iron deficiency and was able to get medication for it. I remember a receptionist told me to go put hand sanitizer on. I walked to go get hand sanitizer and I woke up on the floor. They put me in a wheelchair. It was kind of embarrassing—I was bleeding all over the wheelchair, all over the floor and the restroom.

They gave me morphine for pain through an IV. I was on anesthesia because I guess they had to finish taking out whatever was left, so I was asleep. When I woke up, I felt better and everything was fine. The pregnancy was over, and honestly, they did the same procedure, but Medicaid covered it because it was considered a miscarriage and not an abortion. I should have been able to have it covered without going through this.

Received Medicaid-funded Abortion**Sally Alves, 35, Massachusetts**

At the age of 24, I found myself unemployed, struggling with an active addiction, and in poor mental health. It was at this time that I discovered that I was six-weeks pregnant. I knew growing my family was not in my best interest, so I wanted an abortion without hesitation. However, I was extremely scared and unsure of my options as someone with limited income. The silver lining during this very scary moment in my life was that I was on Medicaid and living in the state of Massachusetts. My state—unlike so many others—makes it possible for many on Medicaid to access abortion services without financial barriers. If it were not for Medicaid, I do not know how I would have saved up over \$500 to afford the medication abortion. Perhaps, if I sold some of my things, I would have needed four or more weeks to raise it all, but honestly, I do not think I would have been able to raise it in time. I didn't have anyone to turn to because everyone around me either didn't support my decision or—like me—also had limited income and didn't have the cash to spare.

I do not hesitate to say that my abortion saved my life. It was truly the access to comprehensive healthcare that provided me a second chance. My abortion allowed me the opportunity to re-direct my life towards stability, and thankfully I can say that I am ten years sober today. I do not doubt my trajectory would have been much different if I had not had my abortion. What I wish to stress is that I am privileged to live in a part of

the country where my abortion experience was possible without financial stress, especially when Medicaid abortion coverage is not an option for many people across this country.

It's shameful to think that a legal right to an abortion is continuously hindered because one has limited income and/or lives in a region that makes it logically impossible to access one. Medicaid is a viable and appropriate route for many who wish to seek an abortion, and if we're truly serious about upholding abortion rights in this country, then we must secure all resources for the 1 and 4 who will choose to rightfully have one.

Lexis Dotson-Dufault, 22, Ohio (via Massachusetts)

Nearly every factor surrounding my abortion experience was traumatizing-- except the fact that I was no longer pregnant, which was made possible only because my insurance covered my abortion care in its entirety. Growing up poor and part of the foster care system, I had been a MassHealth (the Massachusetts state Medicaid plan) member my whole life until I graduated college. As a full-time student at the time, I was not working as many hours as I needed already. Then once I became pregnant, I quickly became sick to the point of being bedridden, and could no longer work at all. I barely had enough money to put gas in my car to make it to the clinic. If MassHealth had not covered my abortion care entirely, I would have had no choice but to unwillingly continue my pregnancy due to my financial status. I can't imagine how long it'd have taken me to raise the funds to pay for my abortion. I wasn't in a safe position to tell anyone who had the means to help and I was too sick to work. I probably would have

had to wait at least an additional two months until my school refund check came through.

Massachusetts has a long way to go in terms of reproductive justice, specifically abortion access, but just allowing state dollars to be used to pay for abortions elevates a number of barriers for specifically for low-income individuals trying to make personal reproductive decisions. By banning Medicaid dollars from covering abortion care, America continues to perpetuate reproductive coercion, specifically targeted against poor people, Black people, people of color, and young people. It will never be enough to just make abortion legal, unless this country switches its focus to accessibility, abortion might as well be illegal to people with marginalized identities and from disadvantaged backgrounds.

Monica Edwards, Federal Policy Manager
URGE: Unite for Reproductive & Gender Equity

Jasmine Yunus, If/When/How Reproductive
Justice Policy Fellow
Advocates for Youth

December 8, 2020
The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole:

We the 27 undersigned local, state, and national organizations dedicated to ensuring reproductive health, rights, and justice for all strongly demand that you ensure access to reproductive healthcare for young people including abortion, free from unnecessary restrictions and political interference.

Young people, especially young queer, trans, and nonbinary Black, Indigenous, and other people of color (BIPOC), are disproportionately impacted by the actions of those in power. From the lack of a second COVID-19 relief package, to college campuses reopening during the height of the COVID-19 pandemic, to the criminalization of Black and brown youth, to bans on abortion and other restrictions on access to reproductive health, young people have been uniquely impacted from a failure of those in power to prioritize their health, safety, and bodily autonomy.

Dec 08, 2020

Honoring and prioritizing young people's health is inherent to achieving Reproductive Justice. A framework and movement started by 12 Black women in 1994, Reproductive Justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we do have in safe and sustainable communities.¹ Our communities are not safe and sustainable when young Black and brown people, are policed, criminalized and subject to state sanctioned violence and murder. Our communities are not safe and sustainable, and young people cannot maintain personal bodily autonomy when they face barriers to accessing reproductive healthcare, including abortion.

Young people already face extreme barriers to accessing abortion care, from unnecessary restrictions like forced parental involvement, greater challenges with finding transportation to care and waiting periods, to limitations on their ability to obtain confidential care using family health insurance, to the inability to pay because of federal and state restrictions on abortion insurance coverage. The average cost of an abortion is around \$500, which can often be prohibitively expensive. This disproportionately impacts young people: more than 40% of youth and children under age 19 and almost a quarter of young people age 19 to 25 have health insurance through government programs.² These barriers are magnified for BIPOC, and queer, trans, and nonbinary

¹ Reproductive Justice. (n.d.). Retrieved November 24, 2020, from <https://www.sistersong.net/reproductive-justice>

² The Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act. (2016, September 08). Retrieved December 1, 2020, from [https://advocatesforyouth.org/resources/policy-advocacy/the-equal-access-to-abortion-coverage-in-health-insurance-each-woman-act#:~:text=or%20zip%20code-,The%20Equal%20Access%20to%20Abortion%20Coverage%20in%20Health%20Insurance,Woman%20Act%20of%202015%20\(H.R.&text=Ending%20bans%20on%20insurance%20coverage,%2Drelated%20care%2C%20including%20abortion](https://advocatesforyouth.org/resources/policy-advocacy/the-equal-access-to-abortion-coverage-in-health-insurance-each-woman-act#:~:text=or%20zip%20code-,The%20Equal%20Access%20to%20Abortion%20Coverage%20in%20Health%20Insurance,Woman%20Act%20of%202015%20(H.R.&text=Ending%20bans%20on%20insurance%20coverage,%2Drelated%20care%2C%20including%20abortion)

Dec 08, 2020

youth. As of February 2020, 37 states require that young people under 18 seeking abortion notify or obtain consent from a parent or guardian.³ These mandates deny young people's right to bodily autonomy and can force young people to encounter an abusive parent or guardian, ignores trusted relationships young people may have with adults other than a parent or legal guardian, and in the case of the judicial bypass process, may force young people of color to interact with a legal system that has historically targeted and caused harm to communities of color.⁴

Young people are also heavily impacted by coverage bans and face obstacles paying for abortion. The Hyde Amendment was passed in 1976 and bans federal funding of abortion.⁵ Specifically, the Hyde Amendment prohibits federal funding for abortion in programs such as Medicare, Medicaid, Indian Health Services, Federal Employees Health Benefits Programs, peace corps volunteers and in the healthcare of those in the military.⁶ Millions of young people across the United States rely on Medicaid for insurance coverage and sixty percent of those enlisted in the military are under the age of 25.⁷ Abortion restrictions like the Hyde Amendment creates additional barriers for many young people already struggling to access affordable reproductive healthcare.

³ Naide, S., & Guttmacher Institute. (2020, February 19). "Parental Involvement" Mandates for Abortion Harm Young People, But Policymakers Can Fight Back. Retrieved November 24, 2020, from <https://www.guttmacher.org/article/2020/02/parental-involvement-mandates-abortion-harm-young-people-policymakers-can-fight-back>

⁴ Id.

⁵ Fact Sheet: About the Hyde Amendment. (2020, September 25). Retrieved November 24, 2020, from <https://allabovetheall.org/resource/hyde-amendment-fact-sheet/>

⁶ Abortion and Young People in the United States. (n.d.). Retrieved November 24, 2020, from <https://advocatesforyouth.org/resources/fact-sheets/abortion-and-young-people-in-the-united-states/>

⁷ Id.

Dec 08, 2020

There is no Reproductive Justice without young people being able to access abortion and other reproductive health care services free from interference and coverage bans like the Hyde Amendment which further complicates access for young people. Those in power, however, can choose to take action to prioritize young people's health and safety. **Passing legislation like the EACH Woman Act (EACH), is one way those in this committee and Congress can work to protect young people's bodily autonomy.** If passed, EACH would work to reverse the Hyde Amendment and prohibit political interference with private health insurance companies to offer coverage of abortion.⁸

Those in power should also draft and pass appropriation bills free from coverage bans. Budgets are moral documents, and the repeated inclusion of Hyde into annual appropriation bills continues an unfortunate yet intentional legacy of depriving people, especially young people with low incomes and young people of color from the constitutional right to abortion care. Make no mistake, these bans are racist and perpetuate systems of oppression, anti-Black racism, and white supremacy and were intentionally created that way by design.

Members of Congress have continued to insert coverage bans into appropriations bills despite the efforts of Black women leaders to end them. For more than 40 years, the Hyde Amendment has continued to deny BIPOC their inherent human right to maintain

⁸ EACH Woman Act Fact Sheet. (2020, August 26). Retrieved November 24, 2020, from <https://allabovetheall.org/resource/each-woman-act-fact-sheet/>

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bodily autonomy and make decisions about if, when and how to start families. Young BIPOC continue to face the brunt of these coverage bans.

Young people are not waiting to be heard, honored or respected. From the wave of young people who turned out to vote,⁹ to the continued uprisings demanding racial justice led by Black youth, to the young Black and brown people demanding an end to forced sterilization and ICE, we are not just sitting back. We are here, and demanding the human rights, and respect we deserve. **We call on you to pass the EACH Woman Act and to put an end to the inclusion of coverage bans in the annual Fiscal year budgets.** Improving young people's access to health care is one step towards ensuring Reproductive Justice for young people.

We demand this committee and those in Congress take the outlined steps to support, not undermine, young people and their autonomy. We're telling you what we need, it is time for you to listen and act accordingly.

In liberation,

Advocates for Youth

URGE: Unite for Reproductive & Gender Equity

American Atheists

⁹ 2020 Election Report Series. (2020, November 23). Retrieved November 24, 2020, from <https://urge.org/ElectionReport2020/>

Dec 08, 2020

American Humanist Association
American Medical Student Association
American Sexual Health Association
Center for Reproductive Rights
Equality North Carolina
Generation Progress
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Ipas
Mazzoni Center
NARAL Pro-Choice America
National Asian Pacific American Women's Forum (NAPAWF)
National Council of Jewish Women
National Equality Action Team (NEAT)
National Latina Institute for Reproductive Justice
National LGBTQ Task Force Action Fund
National Organization for Women
National Women's Health Network
National Women's Law Center
Physicians for Reproductive Health
Planned Parenthood Federation of America
Positive Women's Network-USA
SIECUS: Sex Ed for Social Change
Silver State Equality - Nevada
Women's Emergency Network

**VIA ELECTRONIC TRANSMISSION**

December 7, 2020

To: Representative Mark Pocan

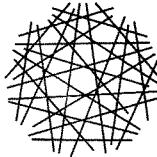
RE: House Hearing on Hyde: "Impact on Women seeking an abortion and are denied because of an inability to pay"

The National Network of Abortion Funds (NNAF) is a non-profit organization that builds power with members to remove financial and logistical barriers to abortion access by centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice. With over 80 member organizations across the United States and abroad, NNAF advocates for all people to have the power, autonomy, and resources to care for and affirm their bodies, identities, and health for themselves and their families in all areas of their lives. We believe that abortion access should be publicly supported as a basic human right. We engage an active grassroots base of people who have abortions and are directly affected by abortion coverage bans, as well as those who provide them compassionate financial and logistical support. **We vehemently oppose the Hyde Amendment and urge you to pass the EACH Woman Act as well as commit to clean budgets that do not include coverage bans.**

Abortion is a common health procedure: one in four women in the U.S. will have an abortion by age 45. Since 1976, the Hyde Amendment has systematically presented unfair barriers to people with low incomes needing abortions, including for the 1 in 7 Americans who use Medicaid. Along with other abortion barriers, the Hyde Amendment threatens the health, well-being, and economic security of more than a million individuals across the country. Many of those who are uninsured, underinsured, or who use Medicaid and are barred from abortion funding under Hyde restrictions will seek support from an abortion fund in our network. Of the patients we directly supported through our George Tiller Memorial Abortion Fund (Tiller Fund), the majority were African American, in their 20s, and already parenting more than one or more child.

Abortion funds leverage grassroots leadership and fundraising in order to redistribute wealth and privately fund the abortion care that should in fact be funded by all types of health insurance, including those with government funds. In addition to financial support, people who have abortions consistently report that our member funds provide invaluable compassionate, one-on-one support that cannot be monetized. Drawing on a vast mutual aid network and knowledge, abortion funds are a political response against the access gap created by federal and state governments unjustly withholding the health service of abortion care. In fiscal year 2019, member abortion funds directly supported 56,155 people to access an abortion through direct funding or through critical practical support--including transportation, child care payment, lodging, translation services, abortion doulas, meals, and more.

While abortion funds step in to cover the cost of abortion and serve as a critical line of defense for many to secure abortion access, funds alone are unable to meet the demand for abortion services--nor is it their responsibility to do so alone. Access to abortion is a human right, and as such, should be supported by



NATIONAL NETWORK OF
ABORTION FUNDS

government resources. The Hyde Amendment does the opposite by making access to abortion contingent on how much money a person has and punishing those enrolled in federally funded healthcare. Abortion funds fielded 215,573 calls in 2019, which - even after accounting for people who contacted multiple funds - represents a large unmet need. Each person should have healthcare coverage that provides full access to reproductive health care, including abortion. For the past four decades, the Hyde Amendment has made it difficult or impossible for scores of people with low incomes to access the abortions they need and deserve.

For people who call abortion funds, an unexpected pregnancy is an event that, for some, can be a crisis. Abortion care after the first trimester can cost anywhere from \$500 to over \$10,000. According to data from our Tiller Fund, people seeking abortion during their second trimester travel three times farther on average than those in their first semester, potentially incurring additional costs to obtain healthcare. **The massive hurdles to accessing abortion care compound the impact of an intricate web of accelerated cutbacks to public services that our communities depend on.**

Until we have full insurance coverage for abortion, those most impacted by racial and economic injustice will still face immense hurdles. In 2017, we published data based on the calls to the Dr. George Tiller Memorial Abortion Fund, an abortion fund previously operated by NNAF that prioritized awarding financial assistance to those who are seeking later abortion care.¹ The report,² representing an analysis of the Tiller Fund's 2010-2015 cases, and subsequent peer-reviewed publications^{3 4 5} based on this data, indicates that people with low incomes and experiencing precarity in the face of multiple systems, particularly Black people and other people of color residing in the Southeast and Midwest, who received financial assistance from the Tiller Fund are unduly burdened with the responsibility of procuring resources to cover out-of-pocket abortion related expenses. They are facing dire circumstances as they work to overcome these burdens to try and access abortion services that are virtually unaffordable to them in a timely manner. These economic burdens contribute to delays in abortion access, resulting in costlier and riskier procedures. They illustrate the real-world impacts of the Hyde Amendment

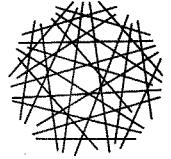
¹ The National Network of Abortion Funds created the George Tiller Memorial Abortion Fund, also referred to as the Tiller Fund less than eight hours after abortion provider Dr. George Tiller's assassination in 2009 by anti-abortion extremists in response to many inquiries, and the resulting request from Dr. Tiller's own office. In 2019, we transitioned this national abortion fund into one, called the Collective Power Fund, that redistributes dollars directly to local abortion funds to augment their capacity for directly meeting the funding and practical support needs of people calling them.

² Kotting, J. & Ely, G. E. (2017). The undue burden of paying for abortion: An examination of abortion fund cases. Data from the National Network of Abortion Funds' Tiller Memorial Abortion Fund. Chicago: National Network of Abortion Funds. ABORTIONFUNDS.ORG/TILLER-REPORT-2017. DOI: 10.13140/RG.2.2.15205.40162

³ Ely, G. E., Hales, T. W., Jackson, D. L., Maguin, G., & *Hamilton, G. (2017b). Where are they from and how far must they go? Examining location and travel distance in U.S. abortion fund patients. International Journal of Sexual Health, 29(4), 313-324. doi.org/10.1080/19317611.2017.1316809

⁴ Ely, G. E., Hales, T. W., Jackson, D. L., Maguin, G., & *Hamilton, G. (2017a). The undue burden of paying for abortion: An examination of abortion fund cases. Social Work in Health Care, 56(2), 99-114.

⁵ Ely, G. E., Hales, T.W., Jackson, D. L., Bowen, E. A., Maguin, E. & *Hamilton, G. (2017). A trauma-informed examination of the hardships experienced by abortion fund patients in the United States. Health Care for Women International, 38(11), 1133-1151. DOI:10.1080/07399332.2017.1367795



NATIONAL NETWORK OF
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and other access barriers imposed by politicians that disproportionately harm people of color and those with lower incomes. Some specific highlights include:

- In 2015, Tiller patients had, on average, just over \$500 to contribute to the costs of their abortion care, about one-fourth the amount required to fund an abortion that costs an average of \$2000. **For people with low incomes, especially in second trimester and later abortions, personal financial resources are severely limited and fall pointedly short of meeting the expense of the abortion. Many also experience significant economic burdens prior to accessing an abortion, including unemployment, inadequate housing or homelessness, and the costs of being a student.**
- Racial demographics of callers show that nearly half of the callers served are Black (48%), notably higher than abortion patients nationally (38%). 23% of callers were white, considerably lower than patients nationally (54%). **The fact that more Black people and people of color call the Tiller Fund than the national average suggests that the financial burdens imposed by existing policy restrictions on abortion are adversely impacting patients who are single, Black, and people of color at greater rates.**
- 80% of people who sought support from the Tiller Fund reside in states that prohibit coverage of abortion in public or private insurance plans. **That so many people who might otherwise be eligible for insurance coverage of abortion need help paying for an abortion demonstrates the vast inequity created by the Hyde Amendment and any insurance coverage ban.**
- 20% of Tiller Fund recipients were young people ages 11-19. In contrast, only about 14% of national abortion patients are in this age range. **Regressive abortion policy is disproportionately burdening young people.**

For the foregoing reasons, we vehemently oppose the Hyde Amendment and urge you to pass the EACH Woman Act as well as commit to clean budgets that do not include coverage bans.

In justice,

Cynthia Lin

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National Network of Abortion Funds
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United States House of Representatives
Committee on Appropriations
Subcommittee on the Departments of Labor, Health and Human Services, Education, and
Related Agencies

Hearing:
The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay

Testimony Submitted for the Record by LGBTQ Organizations

December 8, 2020
Washington, DC

I. The Hyde Amendment is Discriminatory and Harmful

As organizations committed to the equal dignity of all persons, including the right of all to make their own personal decisions regarding their health and their families, we submit this testimony in support of ending the Hyde Amendment and all other discriminatory restrictions on abortion coverage.

Access to comprehensive reproductive health care is essential to people's health, well-being, and ability to participate equally in their communities. And the U.S. Supreme Court has repeatedly affirmed—including earlier this year—that abortion is a fundamental right and that undue burdens on access violate the Constitution. But even a fundamental right is without meaning to someone who cannot afford care.

Each of us should be able to make decisions about pregnancy and parenting that are best for our families without political interference. But for decades policymakers have enacted bans on insurance coverage of abortion that push this decision out of reach for many, particularly those struggling to make ends meet. Such restrictions on coverage have a far-reaching impact on people enrolled in Medicaid and Medicare, federal employees and their dependents, Peace Corps Volunteers, Native Americans, women in federal prisons and immigration detention centers, and residents of the District of Columbia.

Access to reproductive health care services, including abortion, is crucial for personal dignity and economic security and should not be contingent on a person's income, insurance coverage, immigration status, or where they live. Withholding coverage for abortion care creates profound hardships for people across the country, particularly for those who already face significant barriers to receiving high-quality health care, such as low-income people,

immigrants, young people, women of color, and transgender and gender nonconforming people.

For many, insurance coverage for abortion care means the difference between getting the health care they need and being denied that care. Research has shown that approximately one in four Medicaid-eligible women who would have had an abortion if funds were available must instead carry the pregnancy to term against their wishes because they are unable to afford the cost of that care.¹

A recent study found that out-of-pocket costs for second trimester abortion would be catastrophic for households earning the state's median monthly income in all 50 states and D.C.² The impact of abortion coverage bans can have long-term effects on a family's future. Denial of abortion care can have serious long-lasting consequences on a person's health and well-being, including increasing the risk of experiencing poverty, physical health impairments, and intimate partner violence.³

¹ Henshaw, S.K., Joyce T., Dennis, A., Finer, L.B., and Blanchard, K. "Restrictions on Medicaid Funding for Abortions: A Literature Review." Guttmacher Institute. Jul 2009. Available at <http://bit.ly/2dh6DIY>.

² Zuniga, C., Thompson, T., Blanchard, K. (2020) Abortion as a Catastrophic Health Expenditure in the United States. Women's Health Issues. Retrieved from: [https://www.whijournal.com/article/S1049-3867\(20\)30066-9/fulltext](https://www.whijournal.com/article/S1049-3867(20)30066-9/fulltext).

³ Foster DG, Ralph LI, Biggs MA, Gerdts C, Roberts SCM, Glymour MA. "Socioeconomic outcomes of women who receive and women who are denied wanted abortions. American Journal of Public Health." (2018) Mar; 108(3):407-413. Advancing New Standards in Reproductive Health. "Turnaway Study: Long-term study shows that restricting abortion harms women." Bixby Center for Global Reproductive Health. Retrieved from: https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf.

II. Why the LGBTQ Community Supports Elimination of the Hyde Amendment

There are many reasons that our organizations, representing millions of LGBTQ people across this country, support the elimination of the Hyde Amendment and related abortion coverage restrictions.

First, many queer-identified and transgender people can and do become pregnant, and some will need abortion care if they face an unwanted pregnancy. Medicaid is of critical importance to the health of LGBTQ people, who experience negative health outcomes linked to stigma and discrimination.⁴ Our community also disproportionately experiences poverty,⁵ making programs such as Medicaid essential to securing access to health care. Coverage bans like the Hyde Amendment therefore fall particularly hard on our community.

Second, many abortion and family planning clinics have expanded their services to include cancer and STI screening and various wellness services and have become trusted providers of reproductive and other medical care to the LGBTQ community. Many queer people, and especially those who are transgender, avoid medical care based on legitimate fears of being turned away or facing discrimination and ignorance. Members of the LGBTQ community have historically struggled to access basic health care because of stigma arising from social and political beliefs about sex, gender roles, and childbearing. This stigma has led the LGBTQ population to experience significant health disparities compared to other populations.⁶ In response, many clinics that provide abortion and other reproductive health

⁴ See <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>.

⁵ LGBTQ Poverty in the United States, October 2019, <https://williamsinstitute.law.ucla.edu/publications/lgbt-poverty-us/>; LGBTQ Poverty Agenda Project, <https://thevaidgroup.com/project/lgbtq-poverty-agenda-project/>.

⁶ The National Institutes of Health formally designated sexual and gender minorities as a health disparity population in 2016. See Director's Message, "Sexual and Gender Minorities Formally Designated as a Health

services now offer affirming, judgment-free care to members of this community, providing critical medical services for those who would otherwise go without. The LGBTQ community looks to these clinics to provide contraception and abortion services, as well as wellness services, examinations, STI testing and treatment, hormone replacement therapy, and insemination services. These clinics provide these healthcare services in a safe, nurturing, and affirming environment—free from the discrimination and mistreatment often faced by LGBTQ individuals in the larger health care system. Abortion coverage restrictions make abortion care unaffordable for many, which in turn threatens the financial viability of these essential health care providers. When these facilities are thus forced to close or limit services, it is not only abortion care that is lost.

Third, the movements for reproductive freedom and LGBTQ equality share deeply linked interests and values. We are all seeking control over our own bodies – the freedom to decide whether to become or remain pregnant, whether and with whom to have intimate relationships, and whether to seek medical care to help our bodies align with our gender identities. We seek the freedom to form our families on our own terms – to partner with and marry whom we love, to have children or not, and to live as our true selves as determined by us, not by someone else. Discriminatory policies like the Hyde Amendment, along with the myriad restrictions placed on abortion care by many states, undermine our fundamental right to self-determination.

Disparity Population for Research Purposes,” Oct. 6, 2016, https://www.nimhd.nih.gov/about/directors-corner/messages/message_10-06-16.html.

III. Congress Must Act

It is critical that the next Congress eliminate the Hyde Amendment and other discriminatory insurance restrictions in federal appropriations bills. But it can also do more.

Over the past 10 years, a movement led by Millennials, communities of color, and reproductive and economic justice advocates rose up and demanded an end to these extraordinary obstacles to abortion care. In 2015, members of the House of Representatives, led by Congresswoman Barbara Lee (D-CA13), joined this movement and took a significant step forward by introducing the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act (H.R. 1692) – legislation to end the Hyde Amendment and related abortion coverage restrictions. Senators Duckworth, Hirono, Harris, and Murray made history in 2019 when they introduced the EACH Woman Act in the Senate (S. 758). With the EACH Woman Act, politicians will no longer be able to deny a woman abortion coverage based on her income, type of insurance, or zip code.

We applaud the Subcommittee for holding this important hearing and setting the stage for a new era in which harmful and discriminatory policies like the Hyde Amendment are but a relic of the past.

Sincerely,

Athlete Ally
Equality California
Equality Federation
Family Equality
GLBTQ Legal Advocates & Defenders
GLMA: Health Professionals Advancing LGBTQ Equality
Human Rights Campaign
Lambda Legal
Modern Military Association of America

National Center for Lesbian Rights
National Center for Transgender Equality
National Equality Action Team (NEAT)
SIECUS: Sex Ed for Social Change
Silver State Equality-Nevada
The Reunion Project
Transgender Legal Defense & Education Fund
U.S. People Living with HIV Caucus

AYANNA PRESSLEY
7TH DISTRICT, MASSACHUSETTS

Congress of the United States
House of Representatives
Washington, DC 20515

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December 8, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole,

As our nation continues to face a moment of reckoning and transformation, it is absolutely critical that we remain unapologetic in our efforts to dismantle systems of oppression and stand against racist and discriminatory policies that push comprehensive health care—including abortion care—out of reach for our nation’s most vulnerable. As Chair of the Abortion Rights and Access Task Force of the Pro-Choice Caucus, I unequivocally support eliminating the Hyde Amendment and all other harmful abortion coverage bans, so that every person can benefit from the full spectrum of reproductive health care and the right to make decisions over their own bodies.

For more than four decades now, the Hyde Amendment has banned access to abortion care for low-income people who receive health insurance coverage through Medicaid. These abortion coverage bans have disproportionately impacted low-income people, immigrants, Black, Latinx, Indigenous communities, and transgender and gender-nonconforming people, perpetuating cycles of poverty and economic inequality. It is clear that the legal right to an abortion has never been enough and it is incumbent upon us to ensure that our policies and our budgets affirm the dignity and worth of all people, no exceptions.

Access to comprehensive health care and specifically abortion care is both an economic and racial justice issue. Through its policies and institutions, our nation has exacted precise hurt and harm on people of color and other historically marginalized communities since its inception. These structures have dictated who has access to critical healthcare, economic opportunity and the ability to exercise one’s bodily autonomy. Since the passage of the Hyde Amendment in 1976, the annual appropriations process has served as a vehicle to systematically deny access to the full spectrum of reproductive health care. Withholding coverage for abortion services creates profound hardships for people across the country and throughout the globe, particularly for those who already face significant barriers to high-quality health care. Currently, an estimated 30 percent of Black women and 24 percent of Latina women of reproductive age (15-44 years old) are covered by Medicaid — in comparison to just 14 percent of white women.

As our Black and brown communities continue to bear the disproportionate brunt of connected crises—an unprecedented public health crisis exacerbated by systemic racism, an economic crisis that has pushed workers and families further towards the brink of economic despair, and the plague of police brutality disproportionately robbing us of Black and brown lives—the Trump Administration and anti-choice politicians across the country have enacted an all out assault on reproductive health care. Furthermore, the rushed and unjust confirmation of Justice Amy Coney Barrett to the Supreme Court demonstrates that reproductive rights and justice have never been more at risk. Congress has a responsibility to proactively legislate racial and reproductive justice and meaningfully advance policies that affirm that abortion care is health care and that health care is a fundamental human right.

Over the course of my first term serving in the House of Representatives, I have twice filed amendments that would strike the Hyde Amendment from the Labor, Health and Human Services, Education, and Related Agencies funding bills. I commend Chairwoman Rosa DeLauro and Congresswoman Barbara Lee for their leadership on these issues and for holding today's important hearing on the impact of these coverage bans and the critical need to pass clean appropriation bills to ensure that comprehensive reproductive health care is available to all. I stand ready to work alongside you to ensure that Congress right the wrongs of the past and makes reproductive autonomy a guaranteed right for everyone.

Sincerely,



Ayanna Pressley
Member of Congress

Shannon Russell
Legislative Counsel
National Council of Jewish Women
2055 L Street NW, Suite 650
Washington, DC 20036

Glenn Northern
Domestic Program Director
Catholics for Choice
1436 U Street NW, Suite 301
Washington, DC 20009

December 8, 2020

The Honorable Nita Lowey
Chair
House Committee on Appropriations
H-307 The Capitol
Washington, DC 20515

The Honorable Kay Granger
Ranking Member
House Committee on Appropriations
H-307 The Capitol
Washington, DC 20515

The Honorable Rosa DeLauro
Chair
House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
2358-B Rayburn House Office Building
Washington, DC 20515

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
2358-B Rayburn House Office Building
Washington, DC 20515

**Faith-Centered, Values-Based, & Religious Organizations
Express Support for the EACH Woman Act**

Dear Representatives Lowey, Granger, DeLauro, and Cole:

The undersigned religious, religiously-affiliated, values-based, and faith-centered organizations and communities represent millions of people of faith and conscience committed to securing universal access to affordable health coverage, including coverage for abortion care. We write to express our strong and unequivocal support for HR 1692, the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act.

For over 40 years, the Hyde Amendment has pushed time-sensitive, essential abortion care out of reach for countless Americans by discriminating against those struggling to make ends meet. Now, the measure not only denies abortion coverage through Medicaid, Medicare, and the Children's Health Insurance Program (CHIP), but also extends to federal employees and dependents, military personnel and dependents, Peace Corps volunteers, indigenous peoples

receiving care from federal or tribal programs, pregnant individuals in federal prisons and detention centers, pregnant individuals receiving care from community health centers, and survivors of human trafficking. The EACH Woman Act would permanently end Hyde and related coverage bans while prohibiting political interference in private insurance coverage of abortion at all levels of government, ensuring that everyone is able to live safely, to make our own decisions about our health care and futures, and to thrive in our communities with dignity.

Indeed, coverage bans further enshrine systemic racism in our federal laws and regulations and strip the poor of access to abortion, disproportionately impacting those struggling financially; Black, Indigenous, and People of Color (BIPOC) communities; young people; people living with disabilities; rural communities; immigrants; and LGBTQ individuals. People in the United States are facing severe economic duress compounded by a growing health crisis and firmly institutionalized racism; we cannot afford to further wrong the most vulnerable. As people of faith and conscience, we believe in the inherent dignity and equal worth of all people. We are, therefore, called to treat all individuals with respect, no matter their income, insurance, gender, race, or other factors.

We also believe in the power of compassion to build a just and fair society. Our nation is at its best when our laws match our compassion. A compassionate nation ensures that every single person can access quality, timely medical services from trusted providers when they seek abortion care — regardless of how much they earn, how they are insured, or where they live. Because of our faith traditions, consciences, and deep respect for an individual's moral agency, we support policies grounded in compassion that protect each person's right to care for their own body, health, and well-being and to ensure all others can do the same.

Finally, religious freedom is an essential shared principle undergirding our support of policies that ensure equitable access to abortion. The United States is home to people of many different faiths as well as people with no religious affiliation. We cannot limit an individual's religious liberty by enshrining one set of beliefs into law and restricting their ability to make personal decisions about their pregnancy, health, and family according to their own religious or moral beliefs and conscience. No government committed to human rights and democracy can privilege one religion over another.

Eschewing insurance coverage bans is a moral good. No one should be denied an abortion because of who they are, where they live, or how much they earn. It is long past time for our elected officials to eliminate the Hyde Amendment and all bans that interfere with people receiving the care they need.

Respectfully,

National Council of Jewish Women
Catholics for Choice
African American Ministers In Action
American Jewish World Service
Avodah
Bend the Arc: Jewish Action
Carolina Jews for Justice
Central Conference of American Rabbis
Clergy Advocacy Board of Planned Parenthood Federation of America
Feminist Agenda Network
Florida Interfaith Coalition for Reproductive Health and Justice
Habonim Dror North America
Interfaith Voices for Reproductive Justice
Jewish Alliance for Law and Social Action
Jewish Community Action
Jewish Women International
Jewtina y Co.
Just Texas: Faith Voices for Justice
Keshet
Lab/Shul
Methodist Federation for Social Action

Michigan Unitarian Universalist Social Justice Network (MUUSJN)
National Council of Jewish Women, Arizona Section
National Council of Jewish Women, Atlanta Section
National Council of Jewish Women, Austin Section
National Council of Jewish Women, Bergen County Section
National Council of Jewish Women, Chicago North Shore Section
National Council of Jewish Women, Cleveland Section
National Council of Jewish Women, Colorado Section
National Council of Jewish Women, Columbus Section
National Council of Jewish Women, Essex County Section
National Council of Jewish Women, Greater Dallas Section
National Council of Jewish Women, Greater Houston Section
National Council of Jewish Women, Greater Miami Section
National Council of Jewish Women, Greater New Orleans Section
National Council of Jewish Women, Louisville Section
National Council of Jewish Women, Maryland Action Team
National Council of Jewish Women, Massachusetts State Policy Advocate
National Council of Jewish Women, Michigan Section
National Council of Jewish Women, Minnesota Section
National Council of Jewish Women, Nashville Section
National Council of Jewish Women, Northern Virginia Action Team
National Council of Jewish Women, Peninsula Section
National Council of Jewish Women, Sacramento Section
National Council of Jewish Women, Saddleback Section
National Council of Jewish Women, Sarasota-Manatee Section
National Council of Jewish Women, South Cook Section
National Council of Jewish Women, St. Louis Section
National Council of Jewish Women, Washington State Policy Advocate
New Mexico Religious Coalition for Reproductive Choice
Rabbinical Assembly
Reconstructionist Rabbinical Association
Religious Coalition for Reproductive Choice
Society for Humanistic Judaism
Truah: The Rabbinic Call for Human Rights
Texas Freedom Network
Union for Reform Judaism
Women of Reform Judaism
Women's Alliance for Theology, Ethics, and Ritual (WATER)

December 7, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro, Ranking Member Cole, and Subcommittee Members:

We, the undersigned 77 organizations who advocate for and/or support reproductive health, rights and justice, express our strong support for removing the discriminatory Hyde Amendment and for today's hearing, "The Impact on Women Seeking an Abortion but are Denied Because of Inability to Pay." Reproductive Justice is a human right that can and will be achieved when all people, regardless of income, sexual orientation or gender identity/expression, age, immigration status, and ability have the economic, social, and political power and resources to define and make decisions about our bodies, health, sexuality, families, and communities in all areas of our lives, with dignity and self-determination. Every individual should have the right to make their own decisions about having children regardless of their circumstances and without interference and discrimination.

It is for this reason that as our nation grapples with the deeply rooted institutional racism that has plagued communities most impacted by health disparities for generations and especially now, **we call upon Congress and elected leaders at every level to end the Hyde Amendment and all discriminatory barriers to reproductive health care**, while undertaking this mission as an urgent act of racial and social justice.

This year we have all been impacted by and witnessed the most devastating pandemic of our lifetimes and an uprising for Black lives and racial justice. Yet still, people of color and those who experience multiple and intersecting forms of oppression have been left behind. Black people in particular have endured the concentrated and compounded effects of racism in every aspect of their lives from police violence to a lack of access to basic and life-saving health care, to disproportionate housing, food, and employment insecurity during the COVID-19 pandemic, to higher rates of COVID-19 diagnosis and mortality. Politicians are also exacerbating these racial disparities by passing "emergency" abortion bans in the states where Black, Indigenous, and other people of color (BIPOC) already face the greatest barriers to care.¹ Unfortunately,

¹ Kaiser Family Foundation, State Action to Limit Abortion Access During the COVID-19 Pandemic, <https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/>, (August 10, 2020).

discriminatory and systemic barriers to reproductive health and rights are not a new reality for BIPOC communities.

Despite the 1973 landmark victory of *Roe v. Wade*, which affirmed a pregnant person's right to abortion and effectively legalized abortion nationwide, this right has only existed in theory. Immediately after this decision, legislators passed the Hyde Amendment in 1976, a federal appropriations rider that bars the provision of federal funds for abortion care primarily for those enrolled in Medicaid. Since then, the Hyde Amendment has been applied to all federally funded healthcare programs, which disproportionately impacts communities of color and other historically marginalized communities by restricting access to needed abortion services.

In 2018, 30.7 percent of Black women and 27 percent of Hispanic women of reproductive age were enrolled in Medicaid, compared with 15.5 of white women.² Nearly one in five Asian American and Pacific Islander (AAPI) women rely on Medicaid on average, with higher rates of enrollment among certain ethnic subgroups: 60 percent of Bhutanese women, 56 percent of Burmese women, and more than 40 percent of Hmong and Bangladeshi women were estimated to use Medicaid in 2015.³ Approximately 1,171,000 LGBTQ+ adults have Medicaid as their primary source of health insurance.⁴ Medicaid is the largest source of coverage for persons living with HIV, who are disproportionately Black and Latino/x, covering more than 40 percent of individuals living with HIV in 2014.⁵ So while the right to abortion has existed for those who can afford one, for far too many Black, Latinas/xs, and AAPI people who disproportionately access coverage through Medicaid, Indigenous people who receive health care from Indian Health Services, and LGBTQ+ persons, the right to an abortion has never been a reality.

The reality is that barriers to Medicaid coverage of abortion force one in four people to carry a pregnancy to full term, resulting in further and lasting economic hardship and compromised health.⁶ Barriers to abortion coverage and care also contribute to and exacerbate health risks for marginalized communities. According to the Turnaway Study, women who are denied a wanted abortion and forced to carry to full term are not only four times as likely to live below the Federal Poverty line; they are also more likely to experience pregnancy-related complications from the

² Adam Sonfield, U.S. Insurance Coverage 2018: The Affordable Care Act Is Still Under Threat and Still Vital for Reproductive-Age Women, Guttmacher Institute, <https://www.guttmacher.org/article/2020/01/us-insurance-coverage-2018-affordable-care-act-still-under-threat-and-still-vital> (last visited November 27, 2020).

³ NAPAWF calculations based on American Community Survey (ACS) 2015 1-year using Ruggles, S., Genadek, K., Goeken, R., Grover, J., & Sobek, M. (2015). Integrated Public Use Microdata Series: Version 6.0 [dataset]. Minneapolis: University of Minnesota. Retrieved 16 March 2017, from <https://usa.ipums.org/usa/>

⁴ Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., LGBT Adults with Medicaid Insurance 1 (2018), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Medicaid.pdf> (last visited November 24, 2020)

⁵ Kaiser Family Found., Medicaid and HIV 1 (2016), <http://files.kff.org/attachment/Fact-Sheet-Medicaid-and-HIV> (last visited November 24, 2020).

⁶ Amanda Dennis and Kelly Blanchard, Abortion providers' experiences with Medicaid abortion coverage policies: a qualitative multistate study, *Health Services Research*, 2013, 48(1):236–252.

end of pregnancy, including preeclampsia and death.⁷ This study also found that women who are denied a desired abortion are more likely to stay with abusive partners, and more likely to suffer anxiety and loss of self-esteem.⁸

Furthermore, because of medical and environmental racism, embodied stress related to racism and disproportionate barriers to coverage and care, Black women who embark on the journey of carrying a pregnancy to full term are three to four times more likely to die from pregnancy-related causes, and more than twice as likely to experience severe maternal morbidity.⁹ It is hypocritical at best when lawmakers refuse to improve access to reproductive and maternal healthcare, including abortion, for communities most impacted by the maternal health crisis, yet continue to prioritize pushing standard abortion healthcare out of reach.

Young people are also impacted by these biased, political health care attacks that restrict access to health care. For so long, young people's health, safety, and rights have been ignored even while being forced to rely on adults and unrepresentative leadership to make decisions about their futures. The wave of young people who turned out to vote, the continued uprisings demanding racial justice led by Black youth, and the young Black and Brown leaders across the nation demanding an end to forced sterilization and ICE, all demonstrate that young people are not sitting back.¹⁰ Young people are politically engaged and are asserting their human rights, demanding health equity, and mobilizing for a more equitable future.

Political games with people's health and lives cannot continue.

For over 40 years, BIPOC communities have had to live in the reality that the legal right to abortion on paper is no guarantee to access that right. When you cut off communities from care, they die. Their families are driven deeper into poverty, and all of our communities suffer. **To ensure Reproductive Justice for all, we must remove the racist and discriminatory Hyde amendment and all restrictions on funding for abortion coverage and care.**

Sincerely,

In Our Own Voice: National Black Women's Reproductive Justice Agenda
 National Asian Pacific American Women's Forum
 National Latina Institute for Reproductive Justice
 URGE: Unite for Reproductive & Gender Equity

⁷ Foster, Diana Greene. "A Groundbreaking Study: Turnaway Study." University of California San Francisco, ANSIRH, 2020, Summary Accessed via www.ansirh.org/research/turnaway-study (last visited December 1, 2020).

⁸ Ibid.

⁹ In Our Own Voice: National Black Women's Reproductive Justice Agenda. *Addressing America's Black Maternal Health Crisis.* (2020) http://blackrj.org/wp-content/uploads/2020/04/6217-IOOV_Maternal_trifold.pdf, (last visited November 24, 2020).

¹⁰ URGE: Unite for Reproductive & Gender Equity. *2020 Election Report Series.* (2020). <https://urge.org/electionreport2020/> (last visited December 2, 2020).

Abortion Access Front
Access Reproductive Care (ARC)-Southeast
Access Reproductive Justice
Advocates for Youth
Advocating Opportunity
AIDS Foundation Chicago
American Medical Student Association
Amnesty International USA
AMPLIFY Georgia
Athlete Ally
Black Alliance for Just Immigration (BAJI)
Black Women for Wellness
Black Women's Health Imperative
Bold Futures
Chicago Women's Health Center
Colorado Organization for Latina Opportunity and Reproductive Rights
Deeds Not Words
Desiree Alliance
EverThrive Illinois
Feminist Women's Health Center
Forward Together Action
Freedom Network USA
Fund Texas Choice
Hispanic Federation
Hope Clinic for Women
Ibis Reproductive Health
If/When/How: Lawyering for Reproductive Justice
Illinois Choice Action Team
Illinois National Organization for Women
Interfaith Voices for Reproductive Justice (IVRJ)
Ipas
Jacobs Institute of Women's Health
Jewish Women International
Medical Students for Choice
Men4Choice
Midwest Access Project
MomsRising
Mujeres Latinas en Acción
NARAL Pro-Choice Texas
National Birth Equity Collaborative
National Council of Jewish Women
National Health Law Program
National Institute for Reproductive Health
National Network for Immigrant & Refugee Rights

National Network of Abortion Funds
National Partnership for Women & Families
National Women's Health Network
New Voices for Reproductive Justice
Personal PAC
Physicians for Reproductive Health
Planned Parenthood Federation of America
Population Institute
Positive Women's Network-USA
Private Citizen
Progress Texas
Religious Coalition for Reproductive Choice
Religious Coalition for Reproductive Choice - IL affiliate
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
SisterLove, Inc.
SisterSong Women of Color Reproductive Justice Collective
SPARK Reproductive Justice NOW!, inc.
Texas Equal Access Fund
The Afiya Center
The Leadership Conference on Civil and Human Rights
Third Wave Fund
University of Pennsylvania Carey Law School
Voices for Progress
We Testify
WHARR, Womxn's Health and Reproductive Rights
Win Without War
Women's Foundation California
WV FREE



December 8, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole:

We the undersigned local, state, and national Black Reproductive Justice organizations and advocates are united in our commitment to ensuring that all people, but especially Black women, femmes, and girls, have unfettered access to the full spectrum of reproductive healthcare, including abortion. It is for this reason that we demand that the discriminatory Hyde Amendment never appear in another appropriations bill, and express our support for today's hearing, *"The Impact on Women Seeking an Abortion but are Denied Because of Inability to Pay."*

Each of our organizations is rooted in the Reproductive Justice framework which was founded by 12 Black women in 1994. They named themselves Women of African Descent for Reproductive Justice and developed the term "Reproductive Justice" because women with low incomes, women of color, LGBTQ+ women, including transgender, nonbinary, and gender non-conforming individuals felt neglected and misrepresented by the women's right movement, which had primarily focused on abortion rights as solely a white

woman's issue. The term is a combination of reproductive rights and social justice and it is also grounded in Black feminist theory and human rights. Reproductive Justice acknowledges that a pregnant person cannot freely choose what to do with a pregnancy when options are limited by oppressive circumstances or lack of access to services. Reproductive Justice is the human right to control our bodies, our sexuality, our gender, our work, and our reproduction. That right can only be achieved when all frequently marginalized communities have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives. This includes the right to choose if, when, and how to start a family. It is this vision that propels our concern about the increased barriers to abortion access we are seeing across the country today.

Reproductive Justice focuses on a myriad of issues, from economic justice and environmental justice, to voting rights and health equity. As it relates to reproductive health and rights, the Reproductive Justice frame focuses specifically on access rather than rights, asserting that the legal right to abortion is meaningless for pregnant people when they cannot access such care due to the cost, the distance to the nearest provider, child care needs, or other barriers placed on them by way of state legislatures.

It is important to take the time to fully appreciate the origins and definition of Reproductive Justice because of the irony of debating the harms of Hyde Amendment whilst addressing a global pandemic that disproportionately impacted Black communities and the nation collectively reconciles with its

history if inherent racism. None of these issues are mutually exclusive.

When Representative Henry Hyde (R-IL) proposed the Hyde Amendment in 1976 he was very clear that it was in direct response to the landmark Roe v. Wade decision, which struck down anti-abortion laws. Representative Hyde took up his own personal crusade to ensure that the right to abortion would be a right in name only for low income people. The Hyde amendment and related abortion coverage restrictions have decimated access for millions of Americans for over 40 years. During the amendment's original introduction, Henry Hyde stated, "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the... Medicaid bill."¹ He was clear on his intent then, and it has contributed to a widening gap between low- and middle-income individuals and those with unfettered access for decades upon decades. As Justice Ginsburg said, there will never be a day in this country when a rich woman can't get an abortion.

Approximately 17 million women of reproductive age in America are enrolled in Medicaid, of those 30% are Black women.¹ The Hyde Amendment creates an often insurmountable barrier to abortion for people across the country already struggling to get affordable health care, and disproportionately affects those who are low income, people of color, young, immigrants, or live in rural communities. As the Guttmacher Institute notes, "because of social and economic inequality linked to systemic racism and discrimination, women of

¹ Planned Parenthood Action Fund. "*Hyde Amendment*". Retrieved December 2020, [Hyde Amendment](https://plannedparenthoodaction.org) (plannedparenthoodaction.org).

color are disproportionately likely to be insured through Medicaid”²— therefore subject to the Hyde Amendment’s cruel ban on insurance coverage of abortion. The decision of when and how to have a family and start or grow a family is a decision that should only be made by a pregnant person and those they trust, not politicians.

Over time, the Hyde Amendment has been expanded across the federal government beyond Medicaid and CHIP to include federal employees, military personnel and veterans, those who receive health care through Indian Health Services, federal prisoners and detainees, Peace Corps volunteers, and low-income residents of the District of Columbia.³ Additionally, while 17 states have a policy that requires the state to cover abortion for people on Medicaid, almost 60% of women aged 15–44 enrolled in Medicaid and CHIP lived in the remaining 33 states in addition to the District of Columbia that do not cover abortion, except in very limited circumstances.⁴

The original intent of the Hyde Amendment has been achieved in spades. Over the last decade, abortion access in the U.S. has become increasingly fraught with restrictive laws. The Guttmacher Institute reports that between January 1, 2011 and July 1, 2019, states enacted 483 new abortion restrictions, accounting for nearly 40% of the abortion restrictions enacted by states since *Roe v. Wade*.⁵⁶ These restrictions significantly prohibit access to

² Donovan, Megan K. “EACH Woman Act offers bold path toward equitable abortion coverage.” Guttmacher Institute, March 12, 2019, <https://www.guttmacher.org/article/2019/03/each-woman-act-offers-bold-path-toward-equitable-abortion-coverage>.

³ Ibid.

⁴ Ibid.

⁵ “State policies on abortion.” Retrieved December 2020, [United States Abortion | Guttmacher Institute](https://www.guttmacher.org/statecenter/factsheets/state-policies-abortion).

abortion care for Black women, femmes, and girls in particular by placing reproductive healthcare out of reach for too many, with the end result being greater long-term economic hardship and poor health, including contributing to higher maternal mortality rates.⁶

Black women account for 28 percent of all U.S. abortions, although they make up just 13.4 percent of the U.S. female population.⁷ A variety of factors results in this disproportionately high abortion rate compared to women of other races and ethnicities. These include a greater likelihood of being low-income, unemployed, uninsured, and being insured by programs that restrict abortion coverage.

The UC San Francisco's Bixby Center for Global Reproductive Health has shown that women who are denied an abortion and then give birth report worse health outcomes up to five years later as compared to women who receive a desired abortion.⁸ Not only that, but as the country grapples with the maternal mortality crisis we face, one that disproportionately impacts Black women in particular, research has found that the states with higher numbers of abortion restrictions are the exact same states that have poorer maternal health outcomes.⁹

While it has been widely shown that abortion in the United States is an

⁶ University of California, San Francisco, Bixby Center for Global Reproductive Health. "Turnaway Study: A look into the consequences of unwanted pregnancy and abortion on women's lives." (2012). Retrieved December 2020, [The Turnaway Study](#).

⁷ In Our Own Voice: National Black Women's Reproductive Justice Agenda. "Ensuring safe abortion care for Black women." (2019). Retrieved December 2020, [6217-IQOV_Abortion.pdf](#) ([blackrj.org](#)).

⁸ Ralph, Lauren J., Eleanor Birnbaum Schwarz, Daniel Grossman, and Diana Greene Foster. "Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study." *Annals of Internal Medicine* (2019).

⁹ Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care, Black Mama Matters Alliance and Center for Reproductive Rights, 2016, [http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf](#).

extremely safe procedure, abortion restrictions themselves continue to put individual's health and well-being at risk regularly. When facilities are closed down or restricted in the services they provide, when people must travel further distances to obtain services, research shows that people report multiple barriers to obtaining safe health care, including increased travel time, longer waits, and greater costs.¹⁰ Additionally, when a person has no option but to obtain an abortion later in pregnancy or carry an unwanted pregnancy to term, these outcomes cause more danger to their health than the abortion itself.

Abortion restrictions can often also put a person's physical and emotional safety at risk. Decreased access to abortion care may lead a person to maintain unplanned or unwanted pregnancies keeping them in contact with violent or abusive partners. For example, 7 percent of women in the 2012 Turnaway study reported an incident of domestic violence in the last six months, compared to 3 percent of the women who obtained an abortion.¹¹ Although leaving an abusive relationship is never easy, women who accessed an abortion were able to leave while those who were forced to carry an unwanted pregnancy to term helped to keep the abusive partner in the women's life. This can often lead to lack of safety for entire families or communities.

The reality is that the Hyde Amendment is a racist and classist piece of legislation that has been knowingly voted upon, in the affirmative, for over 40

¹⁰ "Abortion restrictions put women's health, safety and well-being at risk," University of California San Francisco Bixby Center for Global Reproductive Health, last accessed November 10, 2019, <https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/Abortion%20restrictions%20risk%20women%27s%20health.pdf>.

¹¹ Hess, Amanda. "What Happens to Women Who Are Denied Abortions?" *Slate*, November 14, 2012, <https://slate.com/human-interest/2012/11/the-turnaway-study-what-happens-to-women-who-are-denied-abortions.html>.

years. That is, for over 40 years elected officials have knowingly restricted funding a bill that they knew would hurt Black, Latinx, Indigenous, low-income, LGBTQ+, and young people. The Hyde Amendment is a stain on the country and one of the most blatant and obvious examples of intentionally oppressive and discriminatory legislation. The hypocrisy is palpable as the country purports to want to address systemic racial hurts while at the same time debating whether Medicaid funds can be used to cover necessary and legal reproductive care for the largely poor and disenfranchised individuals and families. As Black women, femmes, and girls, and Reproductive Justice advocates we have had enough. It is our expectation that the Hyde Amendment and all other restriction on funding be removed.

Sincerely,

In Our Own Voice: National Black Women's Reproductive Justice Agenda
Black Alliance for Just Immigration (BAJI)
Black Mamas Matter Alliance
Black Women for Wellness
Black Women for Wellness Action Project
Black Women's Health Imperative
Interfaith Voices for Reproductive Justice
National Birth Equity Collaborative
New Voices for Reproductive Justice
SisterLove, Inc.
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 DOI: 10.1111/j.1475-6773.2012.01443.x
 RESEARCH ARTICLE

Abortion Providers' Experiences with Medicaid Abortion Coverage Policies: A Qualitative Multistate Study

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Objective. To evaluate the implementation of state Medicaid abortion policies and the impact of these policies on abortion clients and abortion providers.

Data Source. From 2007 to 2010, in-depth interviews were conducted with representatives of 70 abortion-providing facilities in 15 states.

Study Design. In-depth interviews focused on abortion providers' perceptions regarding Medicaid and their experiences working with Medicaid and securing reimbursement in cases that should receive federal funding: rape, incest, and life endangerment.

Data Extraction. Data were transcribed verbatim before being coded.

Principal Findings. In two study states, abortion providers reported that 97 percent of submitted claims for qualifying cases were funded. Success receiving reimbursement was attributed to streamlined electronic billing procedures, timely claims processing, and responsive Medicaid staff. Abortion providers in the other 13 states reported reimbursement for 36 percent of qualifying cases. Providers reported difficulties obtaining reimbursement due to unclear rejections of qualifying claims, complex billing procedures, lack of knowledgeable Medicaid staff with whom billing problems could be discussed, and low and slow reimbursement rates.

Conclusions. Poor state-level implementation of Medicaid coverage of abortion policies creates barriers for women seeking abortion. Efforts to ensure policies are implemented appropriately would improve women's health.

Key Words. Abortion, Medicaid, state policies, low-income, women

Medicaid, a jointly funded federal-state insurance program, was designed to provide comprehensive coverage of health care for low-income U.S. residents. Women make up three-quarters of the adult Medicaid population, and in 2005, almost 7.5 million reproductive-aged women were enrolled in the program (Guttmacher Institute 2007). Although women insured by Medicaid make up nearly one-third of annual abortion clients (Jones, Finer, and Singh

2010), federal and state policies limit their ability to use their insurance for abortion.

The Hyde Amendment, which prohibits the use of federal funds for abortion, was passed in 1976 and has been re-approved every year since. Currently, federal funds can only be used to cover abortion when the pregnancy is a result of rape or incest, or threatens the life of the woman (hereafter referred to as Hyde-qualifying cases). Thirty-two states and the District of Columbia follow the federal example and restrict the use of Medicaid funds to Hyde-qualifying cases. South Dakota, in direct violation of federal law, only covers abortion when a woman's life is endangered. Seventeen states use their own funds to cover all or most abortions (Guttmacher Institute 2011a).

Little is known about how Medicaid abortion coverage policies are realized in practice or influence service delivery. We compared abortion providers' experiences securing Medicaid reimbursement in states with policies that limit abortion coverage to Hyde-qualifying cases to states with policies indicating broad coverage of abortion. We then investigated how the daily workings of these policies impacted abortion providers and women.

MATERIALS AND METHODS

We recruited abortion providers in 10 states that restrict Medicaid funding for abortion to Hyde-qualifying cases (Florida, Idaho, Iowa, Kansas, Kentucky, Maine, Pennsylvania, Rhode Island, Wisconsin, and Wyoming) and in five states where policy indicates that Medicaid funding should be broadly available for abortion in all or most cases (Arizona, Illinois, Maryland, New York, and Oregon). We purposively selected states for geographic diversity, and variation in the number of facilities that provide abortion and the number of publicly funded abortions reported in each state. Within states, we purposively selected for diversity in facility size and type (abortion clinic, hospital, nonspecialized clinic, or private physician's office).

We mailed introductory letters to all known facilities in selected study states and followed up with a phone invitation to participate in an in-depth telephone interview. Because of the sample's diversity of facility structures, we

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asked front-line staff to direct us to the person who could best answer questions about Medicaid coverage of abortion. We then screened that individual for eligibility and interest in participation. We stopped recruitment within individual states once we reached saturation of state-level themes and stopped recruitment overall once this occurred across study states.

Initially, participants were eligible for interview if they reported they had sought Medicaid coverage of a Hyde-qualifying abortion in the last 5 years. After recruiting the first third of study participants and finding that many were ineligible because they did not work with Medicaid, we removed the requirement to collect information on why facilities no longer contracted with Medicaid. Participants were then eligible if they reported they had experience working with at least one woman seeking a Hyde-qualifying abortion. In all, the study team attempted to contact 225 potential participants by phone. Of these, 16 percent were unreachable, 18 percent declined to participate, 36 percent were ineligible,¹ and 30 percent were eligible and interested in participating.

Five interviewers, trained in qualitative data collection techniques, conducted all interviews. Interviews were semi-structured and primarily consisted of open-ended questions about participants' experiences seeking Medicaid coverage of abortion in Hyde-qualifying cases. Respondents were asked to describe the circumstances of these cases, the services provided, and the process and outcome of seeking Medicaid coverage. We also asked participants to estimate the number of claims their facility submitted in the previous year for Hyde-qualifying cases and the number of those cases ultimately reimbursed by Medicaid.

Interviews were conducted between October 2007 and March 2010. During this time, there were no changes to the Hyde Amendment or to study states' policies regarding Medicaid coverage of abortion.

Data were approached using framework analysis, a method well suited for applied qualitative research (Ritchie and Spencer 2002). All interviews were recorded, transcribed, and coded in ATLAS.ti version 5.2 or 5.5 (Scientific Software Development, Berlin, Germany). Codes were initially generated from research questions. Revisions to the codebook were made as new themes emerged. Research team members reviewed each other's coding to ensure inter-coder reliability. We then summarized individual and combinations of codes and identified patterns within and across codes, extracting illustrative quotes pertaining to identified themes. Microsoft Excel 2007 was used to develop basic descriptive statistics regarding demographics, participant and facility characteristics, and responses to close-ended questions.

The Western Institutional Review Board approved all procedures. Participants gave oral consent prior to participation and received \$75 remuneration. To protect the identities of abortion providers and facilities, we present quotes and results without identifying the states in which they are located, although we do provide the type of facility in which the participant worked and his or her self-identified role at the facility (administrator, clinical support staff, counselor, financial manager, multiple roles, or physician).

RESULTS

Facility and Participant Characteristics

We interviewed 68 participants representing 70 facilities. Two participants worked for two facilities and reported on both. One participant worked for three facilities and reported on all of them. In three cases, two participants worked for one facility and were interviewed separately because the participants felt they could only answer a portion of the interview questions.

Participants working in 15 states were interviewed; an average of five interviews was conducted in each state (range 1–9). On average, the facilities represented 32 percent (range 2–66 percent) of all known abortion facilities in each state and provided an average of 51 percent (range 4–98 percent) of annual abortions in each state (Table 1). Of the 70 facilities, most (74 percent) primarily or exclusively provided abortion services. The majority (72 percent) of facilities provided between 400 and 3,000 abortions annually. Participants had an average of 14 years of experience in abortion provision and most held administrative roles.

Participants' Estimates of Success Securing Medicaid Reimbursement for Hyde-Qualifying Cases

Participants estimated that in the year prior to interview, the facilities they worked in attempted to secure Medicaid reimbursement for 1,884 abortions provided in Hyde-qualifying cases (Table 2). Participants reported receiving Medicaid reimbursement in 58 percent ($n = 1,102$) of qualifying cases.

Participants' success securing Medicaid reimbursement differed in states with restrictive versus broad Medicaid abortion policies. In the 10 sampled states with restricted coverage, participants reported that 54 percent ($n = 398$) of Hyde-qualifying abortions were reimbursed by Medicaid, compared with 62 percent ($n = 704$) in the five sampled states where state

Table 1: Facility and Participant Characteristics

<i>Facility characteristics</i>	
Percentage of state abortion-providing facilities represented in the sample, mean (range)	32 (2–66)
Type of facility, n (%)	
Abortion clinic	52 (74)
Private physician's office	4 (6)
Nonspecialized clinic	9 (13)
Hospital	5 (7)
Number of abortions provided, past year, n (%)	
<400	8 (11)
400–999	17 (24)
1,000–2,000	18 (26)
2,001–3,000	15 (22)
>3,000	7 (10)
Refuse or do not know	5 (7)
Percentage of states' annual abortions that participants reported they provide, mean (range)	51 (4–98)
<i>Participant characteristics</i>	
Age in years, mean (range)	46 (22–82)
Position,* n (%)	
Administration	49 (71)
Clinical support staff	13 (19)
Counselor	14 (20)
Financial manager	10 (14)
Physician	7 (10)
Years in abortion care, mean (range)	14 (0.5–35)

*Participants could select more than one position.

Medicaid coverage of abortion should be available in most cases. Further, participants in restricted states almost universally expressed considerable challenges obtaining reimbursement from Medicaid. In the five states with nominally broad coverage of abortion, two divergent patterns emerged as follows: participants in two states reported consistent success obtaining coverage (97 percent, $n = 671$), but participants in the other three states reported securing reimbursement in only 7 percent ($n = 33$) of Hyde-qualifying cases (Table 2).

As participants experienced similar challenges in the 10 states with limited abortion coverage and in the 3 states where broad coverage should be available but largely was not, we grouped the states by participants' quantitative and qualitative assessments (explored below) of how likely they were to secure Medicaid coverage in Hyde-qualifying cases. In the two states where participants reported consistent success obtaining Medicaid reimbursement,

Table 2: Participants' Estimates of Abortions Provided and Covered by Medicaid in Cases of Rape, Incest, or Life Endangerment of the Woman in Year Prior to Interview

	<i>Total Sample</i>	<i>Subsample of Five Nonrestricted States</i>	
		<i>Subsample of 10 Restricted States</i>	<i>Policy Implemented Correctly</i>
Participants' estimates of abortions provided to Medicaid clients in Hyde-qualifying cases, <i>n</i>	1,884	742	695
Participants' estimates of abortions provided to Medicaid clients in Hyde-qualifying cases covered by Medicaid, <i>n</i> (%)	1,102 (58)	398 (54)	671 (97) 33 (7)

97 percent (*n* = 671) of cases were reimbursed, compared with only 36 percent (*n* = 431) in the 13 states where participants commonly experienced barriers obtaining Medicaid reimbursement (data not shown).

Participants' Reports of Success Securing Medicaid Reimbursement for Hyde-Qualifying Cases

In two study states, participants indicated that they consistently receive Medicaid reimbursement for abortion care. These participants described themselves as "lucky" that Medicaid functioned well in their state and recognized the difficulties other states face securing Medicaid coverage of abortion.

In both states, participants had recently moved from submitting paper claims to electronic billing systems, which led to streamlined, consistent, and relatively simple claims procedures. Although switching to the electronic process proved initially challenging, participants reported that over time it improved their experience and success obtaining reimbursement. The electronic system, often described as "user friendly," helped to eliminate billing errors that occurred when paper-based claims were submitted. One participant with multiple roles at an abortion clinic said, "When we used to do paper claims...often times there would be errors, and I'd have to resubmit a lot.... It's not usually an issue [now] since we have electronic billing." The electronic billing system also made it easier to confirm

women's eligibility and enrollment in Medicaid, regardless of whether a client had his or her insurance card; this system facilitated provision of care and helped participants feel confident that they would receive reimbursement. As one administrator at an abortion clinic said, "Most of the time we are very certain that the patient has that coverage and that they will cover the visit.... We rely on that database very heavily." In addition, the majority of participants found that electronic billing helped ensure that they would receive timely reimbursement.

Another component of success in these two states was participants' relationships with responsive Medicaid staff that were able to provide billing support. Participants in both states said that they were able to access a Medicaid staff person or department who was experienced in abortion billing and had held that position for a number of years, providing continuity of support.

Despite the positive aspects of working with Medicaid in these two states, participants reported that Medicaid managed care organizations (MCOs) complicated the process of applying for reimbursement because of the different claims procedures for each MCO. One hospital-based clinical support staff explained, "We have all these different sub-types [MCOs] of Medicaid...that makes things very complicated for our financial people because they all have different contact people; they have different eligibility criteria."

In addition, participants stated that reimbursement rates were consistently lower from MCOs than "straight" state Medicaid. Participants in these states said that state Medicaid programs reimbursed them an average of \$403 (range \$230–\$650) for an abortion regardless of the gestation of the abortion, but that MCO reimbursement rates were consistently lower. Few participants knew the exact reimbursement rate from the various MCOs; one participant with multiple roles at an abortion clinic reported specific rates, "We get \$174 for an abortion from a Medicaid managed care program even though [state] gives us \$230."

Participants' Reports of Challenges Securing Medicaid Reimbursement for Hyde-Qualifying Cases

Participants in all 10 states with restrictions on Medicaid coverage of abortion, and in the 3 states where state funding should be broadly available but largely is not, reported difficulties obtaining reimbursement in Hyde-qualifying cases.

The biggest challenge that participants in these states faced was consistent rejection of claims that they believed qualified for coverage. Applying for Medicaid reimbursement for abortion was described as "futile," "a big

runaround," "a huge rigmarole," or "a big fat circle of confusion." Most participants in these states said that they had never received reimbursement for Hyde-qualifying cases and did not know of any abortion providers who ever had. One participant with multiple roles at an abortion clinic described her experience being denied reimbursement, "We jump through every hoop they've asked us to jump through; I don't remember ever receiving a payment from them [Medicaid] for these procedures." Likewise, an administrator at an abortion clinic explained that obtaining reimbursement from Medicaid was not part of her institution's history: "The woman who trained me has been in the business for 28 years and they have never been able to get assistance from public aid for any part of an abortion."

Participants whose claims were rejected were generally unsure of Medicaid's reason for denying reimbursement. The lack of information about rejected claims prevented many participants from pursuing previously denied claims or correcting future claims. One abortion clinic administrator described trying to find out why a claim was rejected three times:

We took copious notes like you would in a science lab. This was the one factor that was different. It was done on this date. It was turned in on this date. It was rejected on this date. Next try. [We did this] to see if we could...experiment to find the magic pill. We did not get reimbursed. We stopped trying.

Some participants speculated that they received rejections because Medicaid disagreed with participants' assessment of the circumstances of women's abortions. Participants reported that it is not clear how Medicaid defines rape, and that women, providers, and Medicaid often have varying definitions. Likewise, participants reported that there is no clear definition of what characterizes a threat to a woman's life or whose certification of life endangerment is needed to secure Medicaid coverage. One abortion clinic administrator described the issue this way: "We...may believe an abortion is necessary to save the life of a pregnant woman. Oftentimes, when it goes to Medicaid, they don't agree with that assessment."

Given these challenges, many participants gave up on filing Medicaid claims. The few participants who reported continuing to apply for reimbursement described a complex, paperwork-heavy, and time-consuming billing process in which they repeatedly submit claims only to have them rejected for seemingly arbitrary or insignificant reasons.

Participants reported that they rarely seek help from Medicaid staff to resolve questions about reimbursement for a number of reasons. First, many

participants reported difficulty contacting an appropriate staff person. One abortion clinic administrator described her efforts: "You always leave a phone message. You never get a real person, and then of course you never have the right department.... It's grueling." In addition, some participants said that they have received misinformation about the availability of abortion coverage from Medicaid staff and therefore no longer reach out to Medicaid for billing support.

In the rare circumstance that participants were able to secure reimbursement for abortion after "fighting tooth and nail" for it, participants said that reimbursement rates were inadequate and turnaround time was slow. The few participants who received reimbursement for abortion reported that they received an average of \$235 (range \$60–498) from Medicaid regardless of the gestation of the abortion, meaning reimbursement rates were often lower than the cost of providing services. One hospital-based physician expressed the need to increase reimbursement rates: "Certainly, the procedure needs to be reimbursed in a very reasonable way.... Although they can check it off on the books, like, 'Oh, yes, public aid pays,' but, it's not nearly enough to make it worthwhile to do those procedures."

Similar to the two states where participants reported successfully receiving reimbursement, the complexity of working with Medicaid was increased by the presence of MCOs. Challenges included difficulties understanding which MCOs covered abortion, under what circumstances they offered coverage, and the different processes for securing reimbursement among MCOs. Participants in these states also reported that the reimbursement rate from MCOs was consistently lower than the rate paid when directly reimbursed by the state, although the exact rate of reimbursements from MCOs was not known.

When asked why they thought it was difficult to secure adequate Medicaid coverage in Hyde-qualifying cases, participants almost unanimously reported that they felt subtle antiabortion politics pervaded Medicaid. One provider said, "About, Medicaid—I think that there's a lot of politics going on.... They're all anti-abortion." Alternatively, a small number of participants, usually hospital-based providers, speculated that the difficulties they experienced securing reimbursement were "just the way the Medicaid system is set up," and that their difficulties were not related to the services they provide.

Participants' Reports of the Consequences of Challenges Working with Medicaid

Participants who worked in the two states where Medicaid practices appeared consistent with state law and the majority of Hyde-qualifying cases were

covered said that they experienced few, if any, service delivery challenges working with Medicaid. These participants also reported that their Medicaid-eligible clients were able to access abortion in a timely manner. However, participants working with Medicaid in the other 13 states experienced a number of challenges that had severe consequences for participants as well as their clients.

Participants who said that they experienced problems with Medicaid chose to either struggle to obtain some level of reimbursement or refused to work with Medicaid due to the "hassle level" of doing so. Some participants described feeling "extremely unenthused" about continuing to work with Medicaid, as it was becoming financially untenable to do so. In one extreme case, a participant reported that Medicaid owed the facility \$90,000 for past services and that because of Medicaid's slow reimbursement process the facility had to cut staff salaries by 20 percent. Other participants, who reported "giving up" on contracting with Medicaid, said that it was easier and less time-consuming to provide services at a discounted rate, rather than work with Medicaid. These participants had to "eat the cost" of providing care that should have been covered by Medicaid. We received mixed feedback about which strategy appeared to be most cost-effective.

Participants also reported that these challenges made it difficult to ensure low-income women could obtain timely abortion care. When Medicaid coverage of abortion was inaccessible or denied, participants reported that women scrambled to find other resources to cover the cost of the procedure, which led to delays in obtaining a desired abortion or the continuation of an unwanted pregnancy. One abortion clinic counselor explained as follows:

There are certainly women who have an unwanted pregnancy, and wish to terminate, and don't have the funds to. They may, out of necessity, continue the pregnancy because they don't even have \$340 dollars to do the termination at that early stage. I've certainly seen people that are as much as 20 weeks [gestation], and when we get to that point, our services are jumpin' to roughly \$2,000, and if they don't have \$340, they may not have the \$2,000.... That might be financially impossible for the patient to get in a timely manner.

Although many participants said that women often rely on family, friends, or partners to help raise money, and use their savings or credit cards, participants also reported that some women are forced to take more drastic measures. One financial manager at an abortion clinic noted, "Women sometimes take money out of their rent, selling their food stamps for cash, and we have even had cases where a woman admitted that she had sex for cash to raise money for her abortion."

A small number of participants reported working with women with life-endangering conditions. After being told that Medicaid would not provide abortion coverage, women were forced to delay treating their condition while they raised money for the procedure. In these few cases, most participants attempted to mitigate the challenges experienced by women by discounting the procedure or working with abortion funds.² One participant shared the story of a woman who needed an abortion to undergo life-saving cancer treatment:

It was a first pregnancy and she had a reoccurrence of throat cancer, and had to undergo chemo, and they had to withhold the chemo because they found out she was pregnant, so she had to terminate the pregnancy in order to have chemo, in order to treat the reoccurring throat cancer.... She was only 26 years old.

The participant sought Medicaid reimbursement for this case, but she was denied because Medicaid determined the woman's life was not sufficiently endangered.

DISCUSSION

Findings suggest that policies stipulating Medicaid coverage of abortion do not always translate into coverage of care. Abortion providers working in 13 of 15 sampled states reported experiencing considerable administrative burden when submitting Medicaid claims for abortion. Of concern, providers also reported that women in the majority of sampled states (including three states where broad abortion coverage should be available) have no, little, or extremely hard-won access to Medicaid coverage of abortion even in cases of rape, incest, and life endangerment.

Participants' reports about how lack of access to Medicaid coverage of abortion affects women are consistent with previous studies. A 2009 literature review of 38 studies examining the impact of Medicaid restrictions on abortion found that as many as 25 percent of low-income women are forced to carry pregnancies to term that they would have terminated if Medicaid coverage of abortion was available and that many other women delay their abortions by days or weeks while trying to raise money to cover the procedure. The review also found that Medicaid restrictions on abortion increase public costs for prenatal care, delivery services, and welfare, and have a potentially (although not well documented) adverse impact on child health (Henshaw

et al. 2009). There is a dearth of research about the psychological or social impact of being forced to continue a pregnancy or raise money for an abortion when Medicaid coverage is delayed or denied; more research is needed to investigate women's perspectives on the impact of inaccessible Medicaid coverage.

One potential solution to identified Medicaid challenges is to involve state-level Medicaid officials in providing Medicaid staff guidance about abortion coverage policies and appropriate implementation of such policies. In previous research, we found that one state-level coalition consisting of Medicaid officials, abortion providers, legal professionals, and women's health advocates was able to identify and implement solutions to state-level Medicaid challenges. As a result of the coalition's work, abortion providers and Medicaid staff were educated about qualifying circumstances for coverage, claims procedures were simplified, and the rate of qualifying claims reimbursed increased (Dennis, Blanchard, and Córdova 2011). State-level intervention may not be successful in some states for many reasons, including lack of political will or coalition partners, among other factors. In these circumstances, federal oversight of abortion claims may be needed.

However, at a time when more restrictions on abortion access have been passed than ever before (Guttmacher Institute 2011b), abortion providers may be wary of working with state or federal officials. Moreover, previous research has documented that some abortion providers are hesitant to advocate for state- or federal-level interventions due to negative experiences working with policy makers and fear that such interventions would ultimately be short won or inspire backlash against abortion providers (Kacanek et al. 2010; Dennis, Blanchard, and Córdova 2011). Therefore, interventions not focused on state or federal oversight of claims must also be considered to ensure that current Medicaid coverage of abortion policies meets their stated goals. The experiences of participants in the two states with well-functioning Medicaid systems provide evidence of other ways that state administration of abortion coverage can be improved.

One of the most readily replicable aspects of the two successful states' systems was the use of electronic billing, which streamlined billing procedures. Indeed, many health care facilities are converting to electronic records and claims and there are considerable benefits to doing so; research has shown that compared with paper-based claims, electronic claims reduce administrative burden, are more accurate, less expensive to file, and more quickly processed (Yoo and Harner 2006; Blanchfield et al. 2010). Moving to electronic claims could potentially benefit abortion providers working with Medicaid for

Hyde-qualifying abortion claims, as well as other reproductive health services. However, abortion providers would have to weigh these potential benefits against the complexity of transitioning staff to utilizing electronic claims, as well as the costs associated with converting to electronic claims; these are challenges that data suggest are more difficult for smaller or independent facilities (Resnick et al. 2009).

Access to responsive and educated Medicaid staff providing billing support facilitated reimbursement of claims in two states. Future state-level interventions should include training Medicaid staff about the availability of abortion coverage and the procedures for filing abortion claims. Given the relative rarity of Hyde-qualifying cases, trainings must incorporate regular ongoing reminders about state and federal policies regarding abortion coverage. In addition, we found in previous research that Medicaid staff do not always have access to up-to-date information about what should be covered by Medicaid (Dennis and Blanchard 2011). We therefore suggest that Medicaid officers work diligently to ensure that all materials provided to staff are current and accurately reflect state and federal policies. This will enable Medicaid staff to provide appropriate support to women seeking abortion care and abortion providers filing claims.

Despite these two states' overall success working with Medicaid, participants reported receiving low reimbursement rates for abortion, as did participants from all study states. Almost all of the participants recommended increasing the overall reimbursement rate for abortion and prorating reimbursement for termination services based on the gestation of pregnancy, as the complexity and provision cost of the procedure increase with gestation. These findings are consistent with the struggles that many health care providers face; nationwide, physicians report reluctance to work with Medicaid largely because of low reimbursement rates (Borchgrevink et al. 2008). Other scholars have noted that increasing Medicaid reimbursement rates is critical to improving access to a variety of health care services (Cohen and Spector 1996; Grabowski 2001; Intrator and Mor 2004; Yoo et al. 2010). State-specific strategies for increasing reimbursement must be developed as states establish their own Medicaid reimbursement rates, and there are no uniform procedures for ensuring the rates are adequate (Centers for Medicare & Medicaid Services 2011). Our findings suggest that this should be a priority for stakeholders working on improving abortion access, as increasing reimbursement levels may be an important incentive for abortion providers to participate in the Medicaid program.

Although some of the challenges abortion providers face when working with Medicaid are not specific to abortion care, we hypothesize that because abortion providers and the services they provide are heavily stigmatized and regulated, abortion providers face heavier bureaucratic requirements, stronger opposition, and greater scrutiny when working with Medicaid. However, more research is needed to test this hypothesis. Regardless of whether the Medicaid challenges abortion providers experience are unique to the services they provide or generally related to working with Medicaid, solutions to these challenges must be identified, tested, and shared to protect women's health.

Limitations

This qualitative study was conducted with a purposive sample of respondents; therefore, results may not be generalizable to other facilities that provide abortion in the states included or to other states where we did not conduct interviews. The limited generalizability of our findings is likely particularly true within states where a small number of abortion-providing facilities are represented. However, this article focuses on patterns that occurred across states, and not on individual state analyses.

In addition, the effects of nonparticipation bias are not known and the experiences of hospital-based providers and private physicians are underrepresented. However, a 2011 study found that hospitals and private physicians' offices provided only 5 percent of abortions provided between 2007 and 2008, whereas specialized abortion clinics provided 70 percent of procedures in those years and 24 percent of abortions occurred in nonspecialized clinics (Jones and Kooistra 2011). The same study also found that most abortion providers have annual caseloads between 1,000 and 4,999. Therefore, the types of facilities represented in our sample and the number of abortions provided annually reflect national abortion provision trends.

Another limitation of this study is that participants' estimates of the number of submitted or reimbursed Hyde-qualifying abortions may be imprecise due to recall challenges. We did not confirm the number of cases submitted or reimbursed with Medicaid claims data or with abortion providers' client files and therefore cannot verify the accuracy of participants' self-reports. We are confident that participants' reports are reasonably accurate because many participants reported that they reviewed their client files and Medicaid records prior to the interview and a small number did so in real time during the interview. In addition, because of the extreme nature of qualifying cases and the rarity of receiving Medicaid reimbursement, participants were more likely to

recall those events. Next, estimates of percent of cases reimbursed and reported relationships with Medicaid were remarkably consistent across providers within individual states, suggesting that reimbursement experiences were similar among providers within a state. We did not interview Medicaid officials about their perspectives on the submission of abortion claims, or review Medicaid claims data, and believe future research in this area is necessary.

Despite these limitations, this study provides in-depth data about abortion providers' experiences under policies regarding Medicaid coverage of abortion and how the implementation of such policies affects provision of and access to care, an area lacking rigorous empirical research.

CONCLUSION

The Affordable Care Act will expand Medicaid coverage to nonelderly individuals with incomes up to 133 percent of the federal poverty level. With this expansion, more women will become eligible for Medicaid and more women will be affected by Medicaid abortion policies. Our findings highlight that state-level variances in how, or if, state-level policies are implemented play a critical role in access to and the provision of Medicaid-covered abortion care. Our findings also suggest that restrictions on the circumstances under which Medicaid covers abortion effectively lead to prohibitions on coverage in all cases, even those "exempted" for coverage by the Hyde Amendment. Given that current policies are not meeting their stated goals, interventions are needed to ensure that state Medicaid programs meet their obligations to cover abortion as outlined by state and federal policy.

ACKNOWLEDGMENTS

Joint Acknowledgment/Disclosure Statement: We thank the Compton Foundation and an anonymous foundation for their financial support of this project. We also acknowledge Denisse Córdova and Alicia Flanagan for their help in conducting interviews, Ruth Manski for her editorial assistance, and the Ibis Reproductive Health interns who provided excellent research assistance throughout the course of this study: Natalie Massenburg, Adrienne Nickerson, Christina Nikolakopoulos, Joanna Prager, and Madeline Taskier.

Disclosures: None.

Disclaimer: None.

NOTES

1. In most cases, individuals were ineligible because they had never worked with Medicaid and were contacted in the first phase of this study when experience working with Medicaid was a requirement for participation in the study. In a small number of cases, individuals reported that they had never worked with a woman seeking an abortion in Hyde-qualifying cases, and hence, they were not eligible at any point in recruitment.
2. Abortion funds are nonprofit groups, often volunteer led, which help women to raise money, or provide grants to women, to pay for abortion care.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

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Does Medicaid Coverage Matter? A Qualitative Multi-State Study of Abortion Affordability for Low-income Women

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Abstract: Medicaid is designed to ensure low-income populations can afford health care. However, not all health services are covered by the program. Most state Medicaid programs restrict abortion coverage, though a small number of state programs offer such coverage. Little is known about how low-income women are affected by differing Medicaid coverage policies regarding abortion. We conducted in-depth interviews with 98 low-income women who had abortions. We found that women's impressions about abortion costs and the availability of Medicaid coverage are generally accurate and that women rely predominantly on abortion facilities for confirmatory cost and coverage information. Additionally, when abortion is out of financial reach, women and the people in their lives experience numerous emotional and financial harms. Policies that aim to ensure abortion is affordable largely prevent these harms, though the availability of Medicaid coverage does not always guarantee access to affordable care. Findings can help advance evidence-based policies.

Key words: Medicaid, abortion, qualitative, women.

Over nine million women of reproductive age (aged 15–44) in the United States are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), income-qualifying government programs designed to provide health insurance for those that could otherwise not afford health care.¹ While such programs are a critical source of health care coverage for many services, they do not provide coverage for all health care needs.

Abortion is often excluded from coverage. Since 1976 the Hyde Amendment has prohibited federal Medicaid funding for abortion except in limited cases. Federal funding is supposed to be available for abortion when a pregnancy results from rape or incest, or endangers a woman's life. States can use their own funds to cover abortion in broader circumstances. Thirty-two states and the District of Columbia follow the federal example and restrict Medicaid coverage of abortion to cases of rape, incest, or life endangerment.² However, because of gaps between policy and practice, Medicaid

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coverage of abortion in these states is largely inaccessible, regardless of the circumstances.³ Only 17 states have policies indicating they provide broad abortion coverage.²

Policies that outline what health services are covered by Medicaid affect people insured by the program, who are more likely than the general population to be poor and members of racial or ethnic minority groups.⁴ These same populations have higher rates of unintended pregnancy and abortion compared with higher-income or non-Hispanic White women.⁵ Data show that most low-income women in the United States pay out of pocket for abortion care and find gathering funds for the time-sensitive procedure to be challenging.⁶

Abortions cost an average of \$470 in the first trimester,⁷ and the average pregnant woman on Medicaid has an income of approximately \$1,750 a month,⁸ meaning paying for an abortion would consume over 25% of a low-income woman's monthly income. However, not all low-income women pay for care out-of-pocket. A small portion of women on Medicaid use their insurance for coverage, with most of these women living in the few states where Medicaid provides broad abortion coverage.³ In 2010, the most recent year in which data are available, state Medicaid programs covered almost 181,000 abortions.⁹

There is a growing body of literature that shows that restricting Medicaid coverage of abortion can delay abortion access while women search for the funds to pay out-of-pocket for care, or can altogether impede abortion access when women are unable to gather the necessary funds.¹⁰⁻¹¹ We sought to build on this literature and draw comparisons between the knowledge and experiences of women living in states where Medicaid coverage is and is not available for abortion. This work is necessary as understanding the full impact of Medicaid coverage of abortion policies is critical for promoting state and federal policies that respond to the health care needs of low-income women.

We focus on answering the following questions: 1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? 2) Where do women obtain this information? and 3) What are women's experiences paying for care?

Methods

A qualitative study was selected for this investigation as it provided an opportunity to explore our research questions in-depth and to feature the voices of women themselves.¹² This exploratory step is critical as little is known about women's experiences with differing abortion coverage policies and hearing from the women most affected by these policies helps illuminate their full impact. Data were gathered from two similarly-focused studies which involved in-depth interviews with low-income women who had abortions. Two of the article's authors (AD and RM), collected all of the data for the two studies; both authors have extensive training in qualitative data collections methods.

In the first study, conducted between October 2010 and February 2011, we conducted interviews with low-income women who obtained abortions in four states. We chose to conduct interviews with women who obtained care in Arizona, Florida, Oregon, and New York because prior research shows that in two of these states (Oregon and New York) Medicaid coverage for abortion is readily available, whereas in the other two states (Arizona and Florida) Medicaid coverage for abortion is difficult to secure.³

A convenience sample of women was recruited through community-based websites such as Craigslist and Facebook. In order to be eligible for the study, a woman had to report she: 1) was age 18 or older, 2) had an abortion within the past two years, 3) resided in one of the four study states at the time of the abortion, and 4) was low-income, which we defined as meeting the Medicaid income qualifications of the state where she had the abortion (Table 1). As is best practice in qualitative research, we did not define our sample size for each state or for the entire sample *a priori*, but instead stopped collecting data once we obtained predictability and reached a saturation of themes for each state and for the overall sample.¹²

During interviews, a semi-structured in-depth interview guide was used, which allowed for exploring consistent themes across interviewers while also allowing enough flexibility to probe for emergent themes.¹² Major domains of the interview guide included: 1) knowledge of Medicaid policies regarding abortion; 2) attitudes and opinions regarding current abortion laws; and 3) experiences obtaining and paying for abortion. After the interviews, participants were sent a \$35 gift card in return for participation.

In the second study, conducted from December 2011 to June 2012, we conducted in-depth interviews with low-income women in Massachusetts. We chose to recruit women in Massachusetts because we viewed it as a state where abortion coverage is likely widely available given that almost all women in Massachusetts are insured¹³ and

Table 1.
MEDICAID INDICATORS RELATED TO ABORTION BY STATE AT THE TIME OF INTERVIEW

	Medicaid policy regarding abortion	Poverty level standards for pregnant women to enroll in Medicaid
Arizona	By law, abortion coverage should be available in all or most cases, but in practice is rarely ever covered.	150%
Florida	By law, abortion coverage is only available in cases of rape, incest, and life endangerment of the woman, but in practice is rarely ever covered.	185%
Massachusetts	By law, abortion coverage should be available in all or most cases, and in practice appears to be.	200%
New York	By law, abortion coverage should be available in all or most cases, and in practice appears to be.	200%
Oregon	By law, abortion coverage should be available in all or most cases, and in practice appears to be.	185%

that almost all public or subsidized insurance programs in the state provide abortion coverage.¹⁴ Women were again recruited through community based websites and similar eligibility criteria were used. To participate in the study a woman had to: 1) be age 18 or older, 2) have had an abortion within the past three years, 3) have resided in Massachusetts at the time of the abortion, 4) have been uninsured or on a public or subsidized health insurance plan at the time of abortion, and 5) be low-income, which again was defined as meeting the Medicaid income qualifications of the state (Table 1). As with the prior study, data collection was stopped when we obtained predictability and saturation of themes.

A semi-structured interview guide was also used for this study and the major domains of the interview guide were the participant's experiences: 1) enrolling in and staying on health insurance; 2) obtaining and paying for abortion; 3) obtaining and paying for contraceptives; and 4) knowledge of and attitudes towards laws affecting abortion and contraceptive coverage. Participants were given a \$50 gift card in return for participation.

Prior to participating in the interviews, women from both studies provided verbal informed consent. All study procedures were reviewed and approved by Allendale Institutional Review Board (IRB), a private IRB.

To analyze data from both studies, all interviews, which were digitally recorded, were transcribed verbatim. Data were uploaded into Atlas.ti (Scientific Software Development, Berlin, Germany), a qualitative software program. We developed a short list of codes based on our central research questions. The study team coded each transcript using the initial codes and adding new codes as additional themes emerged from the data. After coding each transcript, the study team conferred about proposed new codes and reviewed one another's coded transcripts for consistency in coding. This iteratively generated a standard codebook used across all transcripts and helped build consensus on how each transcript should be coded. Each code was then summarized and discussed in-depth within the study team which allowed for identification of the relationships between the codes and for the most salient themes within and across codes. We then searched for negative evidence of identified themes attempting to disprove our findings and refine our results. Last, after further sharpening of identified themes, we selected quotations which best illustrated study themes.¹⁵ We identify each quotation with a pseudonym, the state in which a participant sought an abortion, and key identifying demographic characteristics (age, race, and ethnicity).

Results

Demographic characteristics and abortion characteristics. Interviewees were fairly evenly distributed across the five study states (Table 2). Participants were on average 31 years of age. Fifty-seven percent of participants identified as White, with the remainder identifying as women of color. Sixty percent of participants had at least one child (data not shown), half were single, and 52% were not working at the time of interview.

Sixty-eight percent of women reported they had only had one abortion, with the remainder reporting two or more abortions (data not shown). Almost 90% of women reported their most recent or only abortion occurred within the first trimester (data not

Table 2.
PARTICIPANT CHARACTERISTICS

	Overall sample	Arizona	Florida	Massachusetts	New York	Oregon
Participants, n (%)	98 (100)	16 (16)	20 (20)	27 (28)	20 (20)	15 (15)
Age, mean (range)	31 (18–55)	30 (19–51)	31 (20–48)	34 (24–46)	29 (20–45)	28 (18–55)
Race and ethnicity, n (%)						
Asian	4 (4)	0 (0)	1 (5)	2 (7)	1 (5)	0 (0)
Black	15 (15)	1 (6)	3 (15)	10 (37)	1 (5)	0 (0)
Black, Hispanic	3 (3)	1 (6)	0 (0)	1 (4)	1 (5)	0 (0)
American Indian or Alaskan Native	3 (3)	1 (6)	0 (0)	1 (4)	1 (5)	0 (0)
White	56 (57)	8 (50)	11 (55)	12 (44)	10 (50)	15 (100)
White, Hispanic	15 (15)	5 (31)	5 (25)	1 (4)	4 (20)	0 (0)
Other	2 (2)	0 (0)	0 (0)	0 (0)	2 (10)	0 (0)
Relationship status, n (%)						
In a relationship	31 (32)	4 (25)	4 (20)	12 (44)	5 (25)	6 (40)
Married	16 (16)	3 (19)	5 (25)	4 (15)	3 (15)	1 (7)
Single	49 (50)	9 (56)	10 (50)	11 (41)	11 (55)	8 (53)
Missing	2 (2)	0 (0)	1 (5)	0 (0)	1 (5)	0 (0)
Current student, n (%)	18 (18)	7 (44)	3 (15)	4 (15)	2 (10)	2 (13)
Work status, n (%)						
Not working	52 (53)	7 (44)	11 (55)	17 (63)	9 (45)	8 (53)
Working part-time	33 (34)	8 (50)	5 (25)	6 (22)	9 (45)	5 (33)
Working full-time	11 (11)	1 (6)	4 (20)	2 (7)	2 (10)	2 (13)
Temporarily employed	2 (2)	0 (0)	0 (0)	2 (7)	0 (0)	0 (0)
Number of pregnancies, mean (range)	3.3 (1–24)	4.1 (1–24)	2.6 (1–7)	4.4 (1–11)	2.6 (1–7)	2.1 (1–5)
Number of children	1.2 (0–6)	0.9 (0–3)	1.2 (0–4)	2.1 (0–6)	0.8 (0–4)	0.8 (0–4)
Number of miscarriages	0.5 (0–20)	1.7 (0–20)	0.2 (0–2)	0.4 (0–3)	0.4 (0–1)	0.1 (0–1)
Number of abortions	1.5 (1–5)	1.4 (1–3)	1.3 (1–3)	1.9 (1–5)	1.5 (1–3)	1.1 (1–3)

shown) with the average abortion occurring at eight weeks gestation (Table 3). Overall, 63% reported having insurance at the time of their most recent or only abortion. Among insured women, most had public insurance. Women reported using multiple methods to pay for the procedure. Notable state differences emerged in relation to forms of payment for abortion; when considering Arizona and Florida together only 3% of women used public insurance to cover their procedures, whereas 60% of women did so when combining data from Massachusetts, New York, and Oregon.

Knowledge about abortion costs and coverage. We asked women to recall what they knew about abortion costs and coverage prior to obtaining an abortion. Across study states, regardless of the Medicaid policy regarding abortion coverage, women reported little concrete knowledge about abortion costs and the potential for coverage. However, they did have impressions informed by word-of-mouth discussions with other women in their lives who had abortions, past individual experiences with abortion, and past individual experiences with other health care services. Distinct state-level patterns emerged.

Prior to gathering information about the cost of abortion or potential for insurance coverage, women in Arizona and Florida, where Medicaid coverage is generally not available for abortion, almost universally believed that their insurer would not cover abortion. These views were most strongly informed by prior difficulties accessing insurance coverage for abortion and other reproductive health services, including emergency contraception and testing for sexually transmitted infections/diseases. Sally said,

Arizona doesn't cover any options for pregnant women. I mean, it doesn't wanna cover the costs of midwives. [...] It doesn't wanna cover the cost of birth control. It doesn't wanna cover the cost of abortion. It doesn't wanna cover the cost of a lot of prenatal things [Arizona, age 25, Non-Hispanic, White].

Women in these states also believed that obtaining an abortion is expensive and that the procedure must be paid for out-of-pocket at considerable personal costs. Helen summed this up when she said,

I know a lot of people that have had an abortion. Most of my friends and a lot of my family members have. I just know that every time I know somebody who has to go through that, it's a struggle having to come up with the money because they're very rarely ever covered by health insurance. So, even my friends that have insurance still have to pay out-of-pocket for their abortions, and you know it's unexpected. I mean, women don't know that they're going to have to have one, we don't plan for that. We don't put away a fund for it or anything. So it's really an unexpected expense, and I know a lot of people that have been really burdened by it [Arizona, age 24, Non-Hispanic, White].

On the other hand, women in Massachusetts, New York, and Oregon, states where Medicaid coverage of abortion is broadly available, commonly expected that abortion would be fully covered by their insurance. Again, women's impressions about the availability of coverage emerged predominantly from past positive experiences using Medicaid for other types of health care. Women in Massachusetts, for example, repeatedly stated

Table 3.
CHARACTERISTICS OF PARTICIPANTS' MOST RECENT ABORTION^a

	Overall sample (n = 98)	Arizona (n = 16)	Florida (n = 20)	Massachusetts (n = 27)	New York (n = 20)	Oregon (n = 15)
Abortion type, n (%)						
Medical	23 (23)	5 (31)	6 (30)	4 (15)	6 (30)	2 (13)
Surgical	75 (77)	11 (69)	14 (70)	23 (85)	14 (70)	13 (87)
Abortion gestation in weeks, mean (range)	8.3 (1.5–23.5)	8.5 (3–23.5)	8.7 (1.5–16)	8.7 (5.5–14)	7.1 (2–12)	8.5 (4–16.5)
Type of insurance at time of abortion, n (%)						
Public	54 (55)	6 (37)	6 (30)	20 (74)	11 (55)	10 (67)
Private	8 (8)	1 (6)	2 (10)	0 (0)	4 (20)	1 (7)
Uninsured	36 (37)	9 (56)	12 (60)	7 (26)	5 (25)	4 (27)
Method(s) of payment for abortion, ¹ n (%)						
Out of pocket	49 (50)	14 (88)	13 (65)	6 (22)	8 (40)	8 (53)
Private insurance	2 (2)	0 (0)	0 (0)	0 (0)	2 (10)	0 (0)
Public insurance	38 (39)	1 (6)	0 (0)	18 (67)	10 (50)	9 (60)
Abortion fund	2 (2)	0 (0)	1 (5)	0 (0)	0 (0)	1 (7)
Family/friend	39 (40)	8 (50)	16 (80)	6 (22)	4 (20)	5 (33)
Clinic discount	10 (10)	4 (25)	3 (15)	0 (0)	2 (10)	1 (7)

^aPercent may not add up to 100%; multiple methods of payment could be selected.

that they did not question if their Medicaid would cover abortion because it “covers everything” [Ciara, age 46, Non-Hispanic, Black] or, as Tracy stated, “They pay for abortions, they pay for teeth, they pay for everything” [age 36, Non-Hispanic, White].

Obtaining information about abortion costs and coverage. Women’s impressions of the cost of abortion and the potential for insurance coverage were supplemented by information gathered from (in order of reliance): abortion facilities, insurance providers, and other health care providers.

Women almost universally recalled that the cost of abortion and the availability of insurance coverage for abortion were explained to them upfront when they first called a facility to make an abortion appointment. Women perceived staff at abortion facilities as being able to provide this information quickly and accurately. Participants also spontaneously noted the importance of being able to access this information confidentially. Because a subset of interviewees did not want insurers or other health care providers to know about their abortion, they elected to rely exclusively on the abortion facilities for information. For example, Malie explained how she found out about the cost of her abortion: “[Clinic name] actually helped me out ‘cause it was a secret. I was still able to go to them and they told me my rights and everything and they spoke to me. That’s the only place I checked” [Arizona, age 19, White, Hispanic].

There were state-level differences in the information given to women by staff at abortion facilities. Women in Arizona and Florida said they were informed that the state Medicaid program does not cover abortion or that it would be extraordinarily difficult to obtain coverage. For example, Trina was told that Medicaid is “really uncooperative” [Florida, age 21, White, Non-Hispanic]. On the other hand, women in New York, Oregon, and Massachusetts were almost universally informed that coverage was available. Moreover, during these initial phone calls, women in these three states who were uninsured often reported being provided with information about enrolling in Medicaid, an issue that did not emerge in reports from women in Arizona or Florida. Hannah recalled being told about enrollment when she called an abortion facility: “Apparently, if I got all the paperwork together and qualified, then it would; the procedure would be paid for” [Oregon, age 25, White, Non-Hispanic].

The second most common source of information about abortion costs and coverage was insurance providers. Though some women feared being judged for calling to inquire about abortion benefits, no woman reported actually experiencing such judgment. Across study states women described calls to their insurance providers as matter of fact and straightforward requests for information about benefits. However, the state-level outcomes of these calls varied markedly. Women in Massachusetts, Oregon, and New York ended their calls satisfied with the information received whereas women living in states without accessible Medicaid coverage described feelings of devastation when they confirmed their suspicion that coverage was unavailable. Ana explained, “I did call it and they said they didn’t cover it. And then, and then, that’s it. I was just left alone. Like, I had, I had *no resources*” [Arizona, age 25, White, Hispanic, emphasis in the original].

A sizable minority of women, all in states where Medicaid coverage of abortion is available, reported receiving information from their regular health care providers dur-

ing routine health visits or when confirming the pregnancy and discussing pregnancy options. Overall, these women appeared comfortable talking with their regular health care providers because they were the providers with which they discussed all of their health issues. Megan explained,

I've been using my doctor for a long time. I went there for another reason and I figured I would get it [the pregnancy] verified while I was there. And he told me if I wanted to do that option [abortion] I could get help with it from insurance. [Oregon, age 23, White, Non-Hispanic].

Paying for care when Medicaid coverage is available. Women's experiences paying for abortion care varied widely and were almost entirely dependent on their home state's policies regarding Medicaid coverage. Insured women residing in Massachusetts, New York, and Oregon largely described a straightforward and "pretty easy" payment process. Participants reported that they either filled out a small amount of paperwork or simply showed their Medicaid identification card to abortion clinic staff and their payment was completed. Ciara explained: "Well, all I had to do was just show my card and they ran everything through the computer so it wasn't really no aggravation or anything." [Massachusetts, age 46, Black, Non-Hispanic].

Some women in these three states who were eligible for Medicaid, but uninsured at the time of their pregnancy, were able to quickly enroll in Medicaid in order to obtain coverage for their abortion. For uninsured women in New York, the enrollment process was facilitated by presumptive eligibility, a process where women can be considered presumptively eligible for Medicaid and quickly and temporarily enrolled in the program to cover the cost of an abortion.¹⁶ Women in New York spontaneously expressed that presumptive eligibility had a number of benefits, namely making the enrollment process easy and ensuring no unnecessary delays between when they confirmed their pregnancy and had an abortion. Lavona said that she obtained pregnancy confirmation and options counseling, enrolled in Medicaid, and obtained an abortion "all in one day." [New York, age 29, Black, Hispanic]. Later in the interview she further said, "I just signed a paper for them to process it through Medicaid and that was it. I never heard of a bill. Never saw a bill."

Most women in these three states who enrolled or were able to enroll in insurance at the time of their abortion reported that they would not have had the resources to pay for their care otherwise. Ali explained, "I really needed it [coverage]. I didn't have \$500 to spend on this. And I definitely didn't have thousands in order to raise a child" [Oregon, age 28, White, Non-Hispanic]. Similarly, Lilah related: "I didn't have \$600 at the time, so I would've had to figure out a way to put it on a credit card or borrow it or something. I was really relieved when I found out that my Medicaid would cover it" [New York, age 21, White, Non-Hispanic].

Although women in these three states largely had positive things to say about using Medicaid for abortion care, a minority of women reported challenges enrolling in Medicaid in time for the procedure, a challenge that led to delays obtaining care while waiting for insurance to become active or finding alternative resources to pay for care. Meg stated,

I did think about that [waiting until insurance came through] but I realized it was more important for me to do what I needed to do. I remember my partner was like, "Can we just wait? Can you just wait?" He didn't like the idea of spending so much money on it, but I said, "You know what? No. I really need to just do this. I need to really take care of it." So that was kind of a struggle but I just decided the most important thing was just make the appointment and just get it done. [Massachusetts, age 29, White, Non-Hispanic].

Additionally, for a sizable minority of insured women, concerns about leaving a "paper trail" led to women not using their insurance and paying out-of-pocket. For some of these women the concern was an abstract fear about anyone finding out about the abortion. Rita explained, "They asked me if I had insurance. I just said 'No.' I just didn't want that to be on my insurance 'cause I didn't know if that was private information or not. I don't know who had access to it, so just to be kinda safer than sorry" [Massachusetts, age 33, Black, Non-Hispanic]. For a smaller group of young women, the concern was about a parent finding out, since they were on a parent's insurance plan. Emily reported, "I didn't want my dad to find out so that [using insurance] wasn't even really an option for me" [New York, age 20, Black, Non-Hispanic].

Paying for care when Medicaid coverage is unavailable. Women living in Arizona and Florida, states where Medicaid coverage is largely not available, and women who were unable to access Medicaid coverage in Massachusetts, Oregon, or New York turned to a number of different resources to pay for care, including drawing from their own resources and borrowing money.

While a small number of women had savings that they could tap into, most women had to wait for their paychecks, work additional hours, juggle bills, cut back on personal and household necessities (usually food), take out loans, use credit cards, and/or sell personal possessions to gather the necessary funds for their abortion. Most often, women pulled from multiple resources, as described by Destiny:

I did a payday loan against my [pay] check. Some bills did not get paid. [...] I didn't send my daughter to preschool. [...] Whatever money I had to pay for other stuff, I was trying to save and hustle it. I actually pawned some of my jewelry as well. [Florida, age 27, Black, Non-Hispanic].

While women did their best to stretch their resources, some participants said they simply did not make enough money to make ends meet. For example, Trina explained how she found herself without electricity for 13 days, a situation which not only affected her but also her family:

I saved as much money as I could with still paying my rent and water and electric and car payment and child support and everything else that I have to pay. I ended up being late on my electric bill. [...] You can't have groceries when you don't have electricity. [...] Hot water heaters are electric. Little things like that that you take for granted until you don't have electricity, [you have] ice cold showers and no groceries in the fridge [Florida, age 21, White, Non-Hispanic].

Women reported that pulling from their limited resources only served to make the time leading up to having an abortion more emotionally difficult. Participants almost universally called the process of scrimping and saving for an abortion “stressful,” “hard,” “humiliating,” and “frustrating.”

Many women reported that saving for the abortion not only affected them before the procedure, but also after the procedure. Women described paying back loans, unpaid bills, and/or credit card debts for months after their abortion. For example, Carmen in Arizona took out a title loan on her car to pay for her abortion, which took her an estimated five months to pay back [age 26, White, Hispanic].

When their own resources were insufficient, women sought financial assistance from someone in their lives. Women related that because they lived in low-income families and communities, it was not easy for the gather this support. Vanessa received help from her mother and explained the emotional and financial impact on the family:

She just worked as much as she could for like a week. [...] That was basically all her money and she was completely broke after that and it was hard for her to get by. [...] It didn't just affect me, it affected her, and I have a little brother that we're living with too. [...] They felt the impact of not having as many groceries and the necessities that went with that [Oregon, age 18, White, Non-Hispanic].

A smaller portion of women received reductions in fees at the abortion clinic. Some women said they automatically qualified for the discount by having a Medicaid card; others said they had to provide the clinic with information about their financial circumstances. Women described the process as straightforward and easy to navigate. Monica related:

You just give them the paperwork that they asked for. And then they have a sheet they fill out and afterwards they tell you, “Ok your discount is this much. You qualify for this much discount. So you have to pay this much [Arizona, age 24, White, Hispanic].”

Least commonly, women reported obtaining financial support from abortion funds, non-profit organizations that help women pay for abortion care. Because only two women had experiences with abortion funds, it is difficult to determine a pattern of women's experiences with the funds.

Discussion

Our findings suggest that policies regarding Medicaid coverage of abortion affect the lives of women and their families in numerous ways. Restrictive coverage policies appear to force women to take measures to raise money for an abortion that may put their health and wellbeing at risk, promote short and longer-term financial instability, and increase the difficulty of implementing an abortion decision, thereby interfering with women's reproductive life plans. Restrictive Medicaid coverage policies also appear to have ripple effects on children, partners, and parents of women seeking abortion services.

Full coverage of abortion in the Medicaid program eliminates most of the above

challenges. When coverage is available, there is little to no need for women or others in their lives to make financial sacrifices, and there is rarely a scramble for money that provokes feelings of indignity or delays abortion care. However, gaps in access to affordable abortion care were present in states where Medicaid coverage was available. Women unable to enroll in Medicaid in a timely manner were forced to pay out-of-pocket for care. Presumptive eligibility for Medicaid for pregnant women helped resolve this access barrier. Additionally, some women did not use their Medicaid due to privacy concerns. State-level insurance statutes and regulations could help mediate the barrier to confidential care.¹⁷

Other important themes emerged from states where coverage of abortion was available. First, women reported that staff at abortion facilities directed them to enroll in Medicaid. This suggests that these staff and facilities are an underutilized resource for helping pregnant women enroll in public or subsidized insurance programs. Staff members' roles as facilitators in the enrollment process may become even more critical under the Affordable Care Act (ACA), when millions of women of reproductive age become eligible for insurance.¹⁸ This finding has practice implications for abortion facilities as under the ACA it will be paramount that front-line staff be well educated about new insurance coverage policies regarding abortion. We speculate that providing this information may be challenging under the ACA as more women are insured and more insurers emerge in the marketplace. This speculation is supported by research conducted in Massachusetts where after state-level reform health care providers reported limited knowledge about the specifics of abortion coverage in the then new health care landscape.¹⁹

Next, women in Massachusetts, New York, and Oregon reported comfort talking with their primary health care providers about their abortion care needs. This suggests that in states where Medicaid coverage of abortion is available discussions about abortion are not isolated to the abortion provision setting. It also suggests that there are a range of health care providers in these states providing pregnancy options counseling, offering information about costs and coverage, and directing women to abortion clinics. The referrals seen in this study in Medicaid coverage states—where staff at abortion facilities refer women to Medicaid and where primary care providers refer women to abortion providers—indicate a health system responding to women's comprehensive health needs.

Our results are consistent with prior research illuminating the harmful effects on women when Medicaid coverage of abortion is restricted.^{10–11} There is no identifiable research highlighting the benefits of providing Medicaid coverage of abortion to women, though prior research has shown that the existence of state-level Medicaid coverage of abortion does not always lead to access to coverage because of delays enrolling in Medicaid.¹⁴

We believe that a nationally representative study is needed to test our emergent hypothesis that low-income abortion clients in states without Medicaid coverage of abortion experience significantly more emotional and financial harm than clients in states where coverage is available. More research is needed to quantify the extent of emotional and financial duress placed on women and their families, and how this

duress affects individuals and families over time. Additionally, more work is needed to determine if our findings about the benefits of available abortion coverage hold true across the few states where this coverage is available and if there are other unidentified benefits. This work will be of particular importance under the ACA. Some data suggest that women will have access to abortion coverage in the few states where Medicaid coverage is available in all cases and states are electing to expand Medicaid coverage.⁹ However, because of the large number of women enrolling in Medicaid and the number of states enacting severe abortion coverage restrictions under the ACA, it likely that more women than ever will be subject to restrictions on abortion coverage.²⁰

Limitations and strengths. Qualitative methods are powerful for collecting rich, hypothesis-generating data.¹² However, our findings may not be generalizable to the population of low-income women who obtain abortions. Additionally, it is not known how women in our convenience sample differ from those who did not participate in the study. Another limitation is that this study relies on self-report and some details may suffer from recall bias. However, we recruited women who reported having obtained abortions in the recent past and viewed cautiously details women reported difficulty remembering.

Despite these limitations, our study provides new and insightful information about the effects of differing state Medicaid coverage of abortion policies, data that emerge from the individuals most affected by these policies. Additionally, data were gathered from states in which Medicaid coverage of abortion appears to be either widely or not at all accessible, providing a critical opportunity for drawing rich comparisons. Notably, interviews were conducted with a racially and ethnically diverse sample of low-income women. This is a notable strength to this paper as Black and Hispanic women have higher rates of abortion than non-Hispanic White women, just as low-income women have higher rates of abortion when compared with women with higher incomes.⁵

Conclusion. To the extent that federal and state abortion policies are informed by evidence, it is critical to consider the intended and unintended effects of differing Medicaid coverage policies regarding abortion. Restrictions on Medicaid coverage of abortion are common and have important effects, many deleterious for women and their families. State Medicaid coverage of abortion ameliorates many of the harms of coverage restrictions and should be a central component of any efforts to ensure abortion policies are responsive to the health care needs of women and their families.

Acknowledgments

We thank Sasha Albert, Sandrine Batonga, Bridgit Burns, Ana Sofia De Brito, Karen Connolly, Hilary Reid, and Caty Wilkey for their assistance with transcription of interviews. We also thank Sarah Roberts, Bhargavi Sampath, and Katherine Wang for their excellent assistance creating code summaries. This project would not have been possible without financial support from an Anonymous Foundation and the Society of Family Planning Research Fund; views and opinions expressed in this paper are those of the authors and do not necessarily represent the views of the Anonymous Foundation or the Society of Family Planning Research Fund.

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December 8, 2020

The Honorable Nita Lowey
Chair
House Committee on Appropriations
H-307 The Capitol
Washington, DC 20515

The Honorable Kay Granger
Ranking Member
House Committee on Appropriations
H-307 The Capitol
Washington, DC 20515

The Honorable Rosa DeLauro
Chair
House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
2358-B Rayburn House Office Building
Washington, DC 20515

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
2358-B Rayburn House Office Building
Washington, DC 20515

**Faith-Centered, Values-Based, & Religious Organizations
Express Support for the EACH Woman Act**

Dear Representatives Lowey, Granger, DeLauro, and Cole:

The undersigned religious, religiously-affiliated, values-based, and faith-centered organizations and communities represent millions of people of faith and conscience committed to securing universal access to affordable health coverage, including coverage for abortion care. We write to express our strong and unequivocal support for HR 1692, the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act.

For over 40 years, the Hyde Amendment has pushed time-sensitive, essential abortion care out of reach for countless Americans by discriminating against those struggling to make ends meet. Now, the measure not only denies abortion coverage through Medicaid, Medicare, and the Children's Health Insurance Program (CHIP), but also extends to federal employees and dependents, military personnel and dependents, Peace Corps volunteers, indigenous peoples

receiving care from federal or tribal programs, pregnant individuals in federal prisons and detention centers, pregnant individuals receiving care from community health centers, and survivors of human trafficking. The EACH Woman Act would permanently end Hyde and related coverage bans while prohibiting political interference in private insurance coverage of abortion at all levels of government, ensuring that everyone is able to live safely, to make our own decisions about our health care and futures, and to thrive in our communities with dignity.

Indeed, coverage bans further enshrine systemic racism in our federal laws and regulations and strip the poor of access to abortion, disproportionately impacting those struggling financially; Black, Indigenous, and People of Color (BIPOC) communities; young people; people living with disabilities; rural communities; immigrants; and LGBTQ individuals. People in the United States are facing severe economic duress compounded by a growing health crisis and firmly institutionalized racism; we cannot afford to further wrong the most vulnerable. As people of faith and conscience, we believe in the inherent dignity and equal worth of all people. We are, therefore, called to treat all individuals with respect, no matter their income, insurance, gender, race, or other factors.

We also believe in the power of compassion to build a just and fair society. Our nation is at its best when our laws match our compassion. A compassionate nation ensures that every single person can access quality, timely medical services from trusted providers when they seek abortion care — regardless of how much they earn, how they are insured, or where they live. Because of our faith traditions, consciences, and deep respect for an individual's moral agency, we support policies grounded in compassion that protect each person's right to care for their own body, health, and well-being and to ensure all others can do the same.

Finally, religious freedom is an essential shared principle undergirding our support of policies that ensure equitable access to abortion. The United States is home to people of many different faiths as well as people with no religious affiliation. We cannot limit an individual's religious liberty by enshrining one set of beliefs into law and restricting their ability to make personal decisions about their pregnancy, health, and family according to their own religious or moral beliefs and conscience. No government committed to human rights and democracy can privilege one religion over another.

Eschewing insurance coverage bans is a moral good. No one should be denied an abortion because of who they are, where they live, or how much they earn. It is long past time for our elected officials to eliminate the Hyde Amendment and all bans that interfere with people receiving the care they need.

Respectfully,

National Council of Jewish Women
Catholics for Choice
African American Ministers In Action
American Jewish World Service
Avodah
Bend the Arc: Jewish Action
Carolina Jews for Justice
Central Conference of American Rabbis
Clergy Advocacy Board of Planned Parenthood Federation of America
Feminist Agenda Network
Florida Interfaith Coalition for Reproductive Health and Justice
Habonim Dror North America
Interfaith Voices for Reproductive Justice
Jewish Alliance for Law and Social Action
Jewish Community Action
Jewish Women International
Jewtina y Co.
Just Texas: Faith Voices for Justice
Keshet
Lab/Shul
Methodist Federation for Social Action

Michigan Unitarian Universalist Social Justice Network (MUUSJN)
National Council of Jewish Women, Arizona Section
National Council of Jewish Women, Atlanta Section
National Council of Jewish Women, Austin Section
National Council of Jewish Women, Bergen County Section
National Council of Jewish Women, Chicago North Shore Section
National Council of Jewish Women, Cleveland Section
National Council of Jewish Women, Colorado Section
National Council of Jewish Women, Columbus Section
National Council of Jewish Women, Essex County Section
National Council of Jewish Women, Greater Dallas Section
National Council of Jewish Women, Greater Houston Section
National Council of Jewish Women, Greater Miami Section
National Council of Jewish Women, Greater New Orleans Section
National Council of Jewish Women, Louisville Section
National Council of Jewish Women, Maryland Action Team
National Council of Jewish Women, Massachusetts State Policy Advocate
National Council of Jewish Women, Michigan Section
National Council of Jewish Women, Minnesota Section
National Council of Jewish Women, Nashville Section
National Council of Jewish Women, Northern Virginia Action Team
National Council of Jewish Women, Peninsula Section
National Council of Jewish Women, Sacramento Section
National Council of Jewish Women, Saddleback Section
National Council of Jewish Women, Sarasota-Manatee Section
National Council of Jewish Women, South Cook Section
National Council of Jewish Women, St. Louis Section
National Council of Jewish Women, Washington State Policy Advocate
New Mexico Religious Coalition for Reproductive Choice
Rabbinical Assembly
Reconstructionist Rabbinical Association
Religious Coalition for Reproductive Choice
Society for Humanistic Judaism
Truah: The Rabbinic Call for Human Rights
Texas Freedom Network
Union for Reform Judaism
Women of Reform Judaism
Women's Alliance for Theology, Ethics, and Ritual (WATER)

December 7, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro and Ranking Member Cole:

The undersigned organizations are committed to ensuring all people can access reproductive health care, including abortion, no matter how much money they make, where they are born, or their race or gender. We believe that each of us should be able to make decisions about pregnancy and parenting that are best for our families without political interference. For 44 years the Hyde Amendment has banned coverage for people enrolled in Medicaid and has served as a perpetual reminder that the legal right to abortion has never been enough. Bans on abortion coverage, like the Hyde Amendment, have long disproportionately impacted Black, Indigenous and People of Color (BIPOC) communities. Equally, BIPOC communities have long bore the brunt of the racial and economic inequities that have both been exposed and exacerbated by the COVID-19 pandemic. We need healthcare, including abortion access, that works for everyone. To this end, we strongly support clean appropriations bills, free from all abortion coverage bans, allowing for insurance coverage of full spectrum reproductive health care, including abortion.

We know that access to reproductive health care services, including abortion, are crucial for economic security and should not be contingent on a person's income, insurance coverage, immigration status, or where they live. Withholding coverage for abortion care creates profound hardships for people across the country, particularly for those who already face significant barriers to receiving high-quality health care, such as low-income people, immigrants, young people, women of color, and transgender and gender nonconforming people. Still, since the passage of the Hyde Amendment in 1976, the appropriations process has been used as a vehicle to systematically deny access to full spectrum reproductive health care. The Hyde rider has since permeated other appropriations bills thereby expanding the reach of the rider, resulting in abortion coverage bans for: (i) Medicaid, Medicare, and Children's Health Insurance Program beneficiaries; (ii) federal employees and their dependents; (iii) Peace Corps volunteers; (iv) Native American people; (v) people in federal prisons and detention centers, including those detained for immigration purposes; and (vi) low-income residents of the District of Columbia.

While our Black and Brown communities, women, LGBTQ folks, immigrants and young people are trying to survive the pandemic, the Senate confirmed an anti-abortion Supreme Court Justice. The continued threats to reproductive health care, including abortion, have never been more present, as our nation faces an unprecedented public health emergency in parallel to a long-needed reckoning on how systemic racism permeates our society and institutions. Through the adversity and pain brought by this health crisis and national reckoning, we imagine a future in which we can control our own bodies and safely care for our families. We are reimagining a world in which each of us makes a living wage and everyone has access to the full spectrum of reproductive health care, including abortion.

We commend the members of Congress who time after time have taken a stand against coverage bans. Representatives Barbara Lee, Jan Schakowsky, and Diana DeGette have introduced the Equal Access to Abortion Coverage in Health Insurance (EACH) Woman Act (H.R. 1692) each Congress since 2015. The bill now holds over 180 cosponsors in the House of Representatives and support doesn't stop there. Recent polling shows that the majority of national voters support Medicaid coverage for abortion, even more so in battleground districts.¹ 84% of women of color voters say it's extremely important that candidates support women making their own decisions about their reproductive health.² Women of color have been saying for decades, and the majority of national voters agree that – however we feel about abortion, no one should be denied access to it just because they are struggling to make ends meet.

Our movement is strong and the public is with us. We urge the Committee to lift the abortion coverage bans that have harmed our families, our communities, and our health. We urge you to draft and pass future appropriations bills free from abortion coverage bans. We invite the committee to reimagine what it looks like to go forward together and end policies that perpetuate economic and healthcare inequities. After 44 years, it's time to put an end the Hyde Amendment so that no one is denied abortion coverage because of how much money they have or how they get their health insurance.

Sincerely,

All* Above All
 Abortion Access Front
 Abortion Care Network
 ACCESS REPRODUCTIVE JUSTICE
 Advocates for Youth
 American Civil Liberties Union
 American Medical Student Association

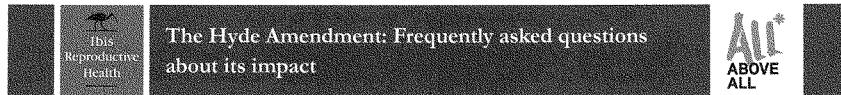
¹ New polling shows that a significant majority of the American electorate supports Medicaid coverage of abortion services; support in battleground congressional districts is even stronger.

<https://allaboveall.org/press/national-poll-shows-tide-is-turning-on-43-years-of-restricting-abortion-coverage/>

²Intersections of Our Lives (2019). Fact Sheet On Perspectives Of Black Women Voters. p.3.

Catholics for Choice
Center for American Progress
Center for Reproductive Rights
Cobalt Advocates
Eastern Massachusetts Abortion Fund
EMAA Project
Forward Together Action
Holler Health Justice
Hope Clinic for Women
Ibis Reproductive Health
If/When/How: Lawyering for Reproductive Justice
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Indigenous Women Rising
Ipas
National Latina Institute for Reproductive Justice
Mabel Wadsworth Center
National Abortion Federation
NARAL Pro-Choice America
NARAL Pro-Choice Maryland
National Asian Pacific American Women's Forum (NAPAWF)
National Center for Lesbian Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Institute for Reproductive Health
National Network of Abortion Funds
National Partnership for Women & Families
National Women's Health Network
National Organization for Women
National Women's Law Center
PAI
Planned Parenthood Federation of America
Population Institute
Power to Decide
Pregnancy Options WI: Education, Resources & Support (POWERS)
Physicians for Reproductive Health
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
The Women's Centers: The Advocacy Center, Atlanta Women's Center, Cherry Hill Women's Center, Delaware County Women's Center, Hartford GYN Center, Philadelphia Women's Center
Union for Reform Judaism
URGE: Unite for Reproductive & Gender Equity
We Testify

Women of Reform Judasim
Women's Health Center of West Virginia
Women's Medical Fund- PA
Women's Medical Fund, Inc. (WI)
Yellowhammer Fund



Issued September 2020

How does the Hyde Amendment restrict insurance coverage of abortion care?

- The Hyde Amendment is a policy that bans the use of federal funds to pay for abortion care except when a pregnancy endangers the life of the pregnant person, or when it results from rape or incest.¹ Since 1976 Congress has inserted the Hyde language in the annual appropriations bill.¹
- This restriction on federal funding has been expanded to a number of federally funded health insurance programs, including Medicaid, Medicare, the Children's Health Insurance Program, the Federal Employee's Health Benefits Program, and the Indian Health Service.¹
- US states may elect to use state-based funding to pay for the abortion care that the Hyde Amendment prohibits for individuals enrolled in Medicaid; however, as of April 2020 only 16 states do so.²

Who is affected by coverage bans on abortion?

- Abortion is a common and safe procedure with very few risks.³ In 2017, 18.4% of all pregnancies in the United States ended in abortion.⁴ In the same year, the US abortion rate was 13.5 abortions per 1,000 women of reproductive age.⁴
- In the United States, most women who have an abortion are struggling financially and already face significant barriers to health care. A majority pay out-of-pocket for their care.⁵
- Among US women aged 15–49, 19% were covered by Medicaid and one percent by Medicare in 2018. Both programs ban abortion coverage and Medicare recipients cannot have their abortion care covered by state funds because it is fully funded by federal dollars.⁶ Medicaid coverage is disproportionately higher among women living below the Federal Poverty Level (FPL), women of color, single parents, and women with lower educational attainment.⁷ In 2018, 14% of nonelderly adult women in the United States had incomes at or below the FPL.⁸
- Sixty-seven percent of all women enrolled in Medicaid were of reproductive age.⁷ Over half of women of reproductive age who were enrolled in Medicaid in 2018 lived in states that apply the Hyde restrictions to their state funds.¹
- Data on the number of women of reproductive age who rely solely on the Indian Health Service for their sexual and reproductive health care are not available. However, in 2018, there were 700,940 American Indian and Alaska Native women 15–50 years of age in the United States.⁹
- Most women who obtain abortion care are parents; 29% report that caring for their existing family is a primary reason for obtaining an abortion.¹⁰

How do abortion coverage bans impact pregnant people?

- *Pregnant people may be unable to find a local abortion provider.* The number of abortion-providing facilities in the United States decreased five percent between 2014 and 2017.⁴ Thirty-eight percent of reproductive-age women in the United States live in a county that lacks an abortion provider.⁴ A recent analysis of disparities in access to abortion care found that although the median distance to an abortion provider in the United States is 10.79 miles, 20% of US residents may have to travel up to 42.54 miles or farther to reach a provider.¹¹
- *Pregnant people may struggle to afford abortion.* Pregnant people residing in 33 states and the District of Columbia are unable to use their Medicaid health insurance to cover the cost of abortion care unless their pregnancy results from rape or incest, or is life-endangering.² Such a time-sensitive and unanticipated out-of-pocket expense can mean forgoing food, rent, or household bills for pregnant people whose insurance will not cover the cost of an abortion.^{12,13} Over half of the women in one study of abortion patients said such costs amounted to more than one-third of their personal monthly income.¹³ Individuals seeking abortion after 20 weeks in a pregnancy faced costs nearing two-thirds of their income per month.¹³
- *Pregnant people may be forced to delay care.* Even for those who are able to afford care, a lack of available or accessible care may result in additional delays. Many pregnant people are not able to obtain abortion care as early as they would like and attribute delays to the time it took to discover their pregnancy, arrange care, and to decide whether or not to continue the pregnancy.¹⁴

What are the impacts of being denied a wanted abortion?

- Women who do not obtain a wanted abortion are *more likely to subsequently live in poverty*.¹⁵ Women unable to obtain a wanted abortion may be more likely to be unemployed and less likely to have the financial resources to afford household essentials such as food and the cost of housing.¹⁵ The negative financial impacts of abortion denial have been found to persist for up to several years.¹⁶
- *Pregnant people can face risk of violence.* Carrying an unwanted pregnancy to term can slow a woman's separation from the man involved in the pregnancy.¹⁸ For women experiencing intimate partner violence, this can mean they and their children are at continued risk of violence from that partner.¹⁹

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December 7, 2020

The Honorable Rosa DeLauro
Chairwoman
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

The Honorable Tom Cole
Ranking Member
House Committee on Appropriations
Subcommittee on Labor Health and Human Services, Education, and Related Agencies

Dear Chairwoman DeLauro, Ranking Member Cole, and Subcommittee Members:

We, the undersigned 77 organizations who advocate for and/or support reproductive health, rights and justice, express our strong support for removing the discriminatory Hyde Amendment and for today's hearing, "The Impact on Women Seeking an Abortion but are Denied Because of Inability to Pay." Reproductive Justice is a human right that can and will be achieved when all people, regardless of income, sexual orientation or gender identity/expression, age, immigration status, and ability have the economic, social, and political power and resources to define and make decisions about our bodies, health, sexuality, families, and communities in all areas of our lives, with dignity and self-determination. Every individual should have the right to make their own decisions about having children regardless of their circumstances and without interference and discrimination.

It is for this reason that as our nation grapples with the deeply rooted institutional racism that has plagued communities most impacted by health disparities for generations and especially now, **we call upon Congress and elected leaders at every level to end the Hyde Amendment and all discriminatory barriers to reproductive health care**, while undertaking this mission as an urgent act of racial and social justice.

This year we have all been impacted by and witnessed the most devastating pandemic of our lifetimes and an uprising for Black lives and racial justice. Yet still, people of color and those who experience multiple and intersecting forms of oppression have been left behind. Black people in particular have endured the concentrated and compounded effects of racism in every aspect of their lives from police violence to a lack of access to basic and life-saving health care, to disproportionate housing, food, and employment insecurity during the COVID-19 pandemic, to higher rates of COVID-19 diagnosis and mortality. Politicians are also exacerbating these racial disparities by passing "emergency" abortion bans in the states where Black, Indigenous, and other people of color (BIPOC) already face the greatest barriers to care.¹ Unfortunately,

¹ Kaiser Family Foundation, State Action to Limit Abortion Access During the COVID-19 Pandemic, <https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/>. (August 10, 2020).

discriminatory and systemic barriers to reproductive health and rights are not a new reality for BIPOC communities.

Despite the 1973 landmark victory of *Roe v. Wade*, which affirmed a pregnant person's right to abortion and effectively legalized abortion nationwide, this right has only existed in theory. Immediately after this decision, legislators passed the Hyde Amendment in 1976, a federal appropriations rider that bars the provision of federal funds for abortion care primarily for those enrolled in Medicaid. Since then, the Hyde Amendment has been applied to all federally funded healthcare programs, which disproportionately impacts communities of color and other historically marginalized communities by restricting access to needed abortion services.

In 2018, 30.7 percent of Black women and 27 percent of Hispanic women of reproductive age were enrolled in Medicaid, compared with 15.5 of white women.² Nearly one in five Asian American and Pacific Islander (AAPI) women rely on Medicaid on average, with higher rates of enrollment among certain ethnic subgroups: 60 percent of Bhutanese women, 56 percent of Burmese women, and more than 40 percent of Hmong and Bangladeshi women were estimated to use Medicaid in 2015.³ Approximately 1,171,000 LGBTQ+ adults have Medicaid as their primary source of health insurance.⁴ Medicaid is the largest source of coverage for persons living with HIV, who are disproportionately Black and Latino/x, covering more than 40 percent of individuals living with HIV in 2014.⁵ So while the right to abortion has existed for those who can afford one, for far too many Black, Latinas/xs, and AAPI people who disproportionately access coverage through Medicaid, Indigenous people who receive health care from Indian Health Services, and LGBTQ+ persons, the right to an abortion has never been a reality.

The reality is that barriers to Medicaid coverage of abortion force one in four people to carry a pregnancy to full term, resulting in further and lasting economic hardship and compromised health.⁶ Barriers to abortion coverage and care also contribute to and exacerbate health risks for marginalized communities. According to the Turnaway Study, women who are denied a wanted abortion and forced to carry to full term are not only four times as likely to live below the Federal Poverty line; they are also more likely to experience pregnancy-related complications from the

² Adam Sonfield, U.S. Insurance Coverage 2018: The Affordable Care Act Is Still Under Threat and Still Vital for Reproductive-Age Women, Guttmacher Institute, <https://www.guttmacher.org/article/2020/01/us-insurance-coverage-2018-affordable-care-act-still-under-threat-and-still-vital> (last visited November 27, 2020).

³ NAPAWF calculations based on American Community Survey (ACS) 2015 1-year using Ruggles, S., Genadek, K., Goeken, R., Grover, J., & Sobek, M. (2015). Integrated Public Use Microdata Series: Version 6.0 [dataset]. Minneapolis: University of Minnesota. Retrieved 16 March 2017, from <https://usa.ipums.org/usa/>

⁴ Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., LGBT Adults with Medicaid Insurance 1 (2018), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Medicaid.pdf> (last visited November 24, 2020)

⁵ Kaiser Family Found., Medicaid and HIV 1 (2016), <http://files.kff.org/attachment/Fact-Sheet-Medicaid-and-HIV> (last visited November 24, 2020).

⁶ Amanda Dennis and Kelly Blanchard, Abortion providers' experiences with Medicaid abortion coverage policies: a qualitative multistate study, *Health Services Research*, 2013, 48(1):236–252.

end of pregnancy, including preeclampsia and death.⁷ This study also found that women who are denied a desired abortion are more likely to stay with abusive partners, and more likely to suffer anxiety and loss of self-esteem.⁸

Furthermore, because of medical and environmental racism, embodied stress related to racism and disproportionate barriers to coverage and care, Black women who embark on the journey of carrying a pregnancy to full term are three to four times more likely to die from pregnancy-related causes, and more than twice as likely to experience severe maternal morbidity.⁹ It is hypocritical at best when lawmakers refuse to improve access to reproductive and maternal healthcare, including abortion, for communities most impacted by the maternal health crisis, yet continue to prioritize pushing standard abortion healthcare out of reach.

Young people are also impacted by these biased, political health care attacks that restrict access to health care. For so long, young people's health, safety, and rights have been ignored even while being forced to rely on adults and unrepresentative leadership to make decisions about their futures. The wave of young people who turned out to vote, the continued uprisings demanding racial justice led by Black youth, and the young Black and Brown leaders across the nation demanding an end to forced sterilization and ICE, all demonstrate that young people are not sitting back.¹⁰ Young people are politically engaged and are asserting their human rights, demanding health equity, and mobilizing for a more equitable future.

Political games with people's health and lives cannot continue.

For over 40 years, BIPOC communities have had to live in the reality that the legal right to abortion on paper is no guarantee to access that right. When you cut off communities from care, they die. Their families are driven deeper into poverty, and all of our communities suffer. **To ensure Reproductive Justice for all, we must remove the racist and discriminatory Hyde amendment and all restrictions on funding for abortion coverage and care.**

Sincerely,

In Our Own Voice: National Black Women's Reproductive Justice Agenda
 National Asian Pacific American Women's Forum
 National Latina Institute for Reproductive Justice
 URGE: Unite for Reproductive & Gender Equity

⁷ Foster, Diana Greene. "A Groundbreaking Study: Turnaway Study." University of California San Francisco, ANSIRH, 2020, Summary Accessed via www.ansirh.org/research/turnaway-study (last visited December 1, 2020).

⁸ Ibid.

⁹ In Our Own Voice: National Black Women's Reproductive Justice Agenda. *Addressing America's Black Maternal Health Crisis.* (2020) http://blackrj.org/wp-content/uploads/2020/04/6217-IOOV_Maternal_trifold.pdf, (last visited November 24, 2020).

¹⁰ URGE: Unite for Reproductive & Gender Equity. *2020 Election Report Series.* (2020). <https://urge.org/electionreport2020/> (last visited December 2, 2020).

Abortion Access Front
Access Reproductive Care (ARC)-Southeast
Access Reproductive Justice
Advocates for Youth
Advocating Opportunity
AIDS Foundation Chicago
American Medical Student Association
Amnesty International USA
AMPLIFY Georgia
Athlete Ally
Black Alliance for Just Immigration (BAJI)
Black Women for Wellness
Black Women's Health Imperative
Bold Futures
Chicago Women's Health Center
Colorado Organization for Latina Opportunity and Reproductive Rights
Deeds Not Words
Desiree Alliance
EverThrive Illinois
Feminist Women's Health Center
Forward Together Action
Freedom Network USA
Fund Texas Choice
Hispanic Federation
Hope Clinic for Women
Ibis Reproductive Health
If/When/How: Lawyering for Reproductive Justice
Illinois Choice Action Team
Illinois National Organization for Women
Interfaith Voices for Reproductive Justice (IVRJ)
Ipas
Jacobs Institute of Women's Health
Jewish Women International
Medical Students for Choice
Men4Choice
Midwest Access Project
MomsRising
Mujeres Latinas en Acción
NARAL Pro-Choice Texas
National Birth Equity Collaborative
National Council of Jewish Women
National Health Law Program
National Institute for Reproductive Health
National Network for Immigrant & Refugee Rights

National Network of Abortion Funds
National Partnership for Women & Families
National Women's Health Network
New Voices for Reproductive Justice
Personal PAC
Physicians for Reproductive Health
Planned Parenthood Federation of America
Population Institute
Positive Women's Network-USA
Private Citizen
Progress Texas
Religious Coalition for Reproductive Choice
Religious Coalition for Reproductive Choice - IL affiliate
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
SisterLove, Inc.
SisterSong Women of Color Reproductive Justice Collective
SPARK Reproductive Justice NOW!, inc.
Texas Equal Access Fund
The Afiya Center
The Leadership Conference on Civil and Human Rights
Third Wave Fund
University of Pennsylvania Carey Law School
Voices for Progress
We Testify
WHARR, Womxn's Health and Reproductive Rights
Win Without War
Women's Foundation California
WV FREE



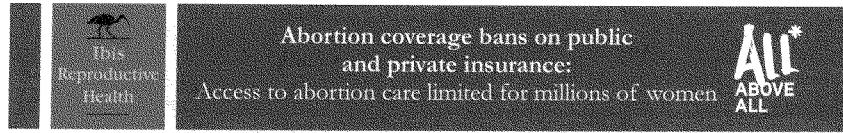
The National Abortion Federation (NAF) is the professional association of abortion providers. Our mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care. NAF's Hotline offers patients resources and assistance in accessing their abortion care, including medically-accurate information about pregnancy and abortion, referrals to quality abortion providers, and limited financial assistance for patients in difficult situations. Restrictions on insurance coverage of abortion care jeopardize both the health and economic security of patients, and fall hardest on low-income patients and patients of color. The NAF Hotline hears every day from patients whose access to safe abortion care is inhibited by the Hyde Amendment. Below are excerpts of a few these patients' stories.

Reese* spent almost three months attempting to raise enough money to cover the cost of her abortion care, struggling to keep up as the price increased with each passing week. Reese reached out to her family for help, only to be told by her mother that she would not support Reese in her decision. Reese eventually obtained funding assistance from not one, but two different funding organizations, which finally enabled her to access the abortion care she needed.

Peggy's* husband abandoned her and their two children. Subsisting on food stamps and relying on Medicaid for health care coverage, Peggy was in the process of applying for disability benefits but had no income coming into the home when she learned she was pregnant. Because of the Hyde Amendment, Peggy couldn't rely on her insurance to cover the cost of the abortion care she needed. She had significant difficulty even in borrowing gas money to travel to her nearest clinic; without the assistance of a private fund, there is no way Peggy would have been able to access her abortion care.

Barbara* relies on food stamps as her only current source of income. She borrowed as much as she could from family members to pay for her abortion care, but the process of collecting funds took so long that she was forced to get a different kind of care than she originally wanted. This doubled the cost of Barbara's abortion care. Because of the Hyde Amendment, Barbara wasn't able to rely on her insurance to cover those costs. She was forced her to seek assistance from a private fund to cover the cost of her care and her travel needs.

*All names have been changed to protect patient privacy.



AUGUST 2017

INTRODUCTION ➤

Health insurance is intended to help people cover both preventive and unexpected health costs. Yet federal and state politicians have singled out abortion and placed numerous bans on coverage for this health service within government-sponsored and private health insurance plans. Restrictions on insurance for abortion can have negative impacts for millions of women, especially low-income women, including higher out-of-pocket costs, increased stress, delays in accessing abortion care, or the inability to access abortion care altogether.¹

**PUBLIC FUNDING AND INSURANCE COVERAGE ➤
RESTRICTIONS ON ABORTION**

The first restriction on US abortion coverage and funding after the *Roe v. Wade* decision was the Hyde Amendment, passed in 1976. This amendment prohibits coverage of abortion care through the federal Medicaid, Children's Health Insurance Program (CHIP), and Medicare programs, except in limited cases when a woman is pregnant as a result of rape or incest, or when a pregnancy endangers her life.² Congress has renewed the Hyde Amendment every year since 1976, and this restriction paved the way for similar provisions in other federally-managed health insurance programs.^{3,4}

Restrictions under the Hyde Amendment: Although under the Hyde Amendment states have the option to use state Medicaid or CHIP funds to cover abortion services, most have placed restrictions on this coverage of abortion care except for the limited circumstances laid out in the Hyde Amendment. Only 17 states have policies in place to cover abortion care for Medicaid enrollees; only 15 do so in practice.⁵

Thus, as a result of the Hyde Amendment, **about 7.4 million women ages 15-49 who have health insurance through Medicaid cannot use their insurance to cover abortion in most circumstances.**⁶

Restrictions on federally funded services and coverage: Politicians have also placed restrictions on federal coverage for women who are covered under federal programs like the Federal Employee Health plans, Indian Health Services, and TRICARE (including military personnel and their dependents). These types of restrictions also affect Peace Corps volunteers, veterans, and federal prisoners and detainees who all receive health care through federal programs, thereby increasing the number of women who are unable to use their insurance for abortion coverage.⁷

**RESTRICTIONS ON PRIVATE HEALTH INSURANCE ➤
COVERAGE FOR ABORTION FUNDING**

Individual states have the right to regulate the Health Insurance Marketplaces (referred to hereafter as Marketplaces) established under the Affordable Care Act (ACA) within their own borders. This means that states can restrict coverage for abortion under private insurance plans, including employer-based plans and plans offered through the Marketplaces.

To date, 25 states ban insurance coverage for abortion through plans offered on the Marketplaces. Using data from the Kaiser Family Foundation on Marketplace plan selections for 2017, we estimate that over 2.9 million women aged 19-64 are enrolled in Marketplace plans in states that banned abortion coverage (see appendix for detailed calculations).^{8,9} Ten of these 25 states impose even stricter limits on insurance coverage, banning insurance companies from offering any private plan that covers abortion services (including both employer-based plans and Marketplace plans), and thus further increasing the number of women who cannot use private insurance for abortion services.^{6,8,9}

State bans on comprehensive coverage of abortion care through insurance ¹⁰	# of states
Bans on all insurance plans	10
Bans on Marketplace and Medicaid plans	14
Bans on Medicaid only	10*
Bans on Marketplaces only	1
No bans on coverage	16

*Includes Washington, DC.

Finally, even in states where private insurance plans are not subject to state-level restrictions of abortion coverage, accessing abortion coverage through insurance is often impossible, or at best, confusing, as many private plans do not offer abortion coverage, or do not explicitly state that they do so in policy documents.⁴

NEW THREATS TO INSURANCE COVERAGE OF ABORTION

The current administration and Republican-led Congress have put forth various health care reform bills, some of which include measures to effectively repeal the ACA, phase out Medicaid expansion, expand restrictions on abortion coverage, and defund Planned Parenthood. It is estimated that these measures could put health insurance coverage financially out of reach for tens of millions of people and further reduce access to abortion and contraception.^{10,12} We estimate that approximately 2.3 million women aged 19–64 are enrolled in Marketplace plans in states that currently allow for coverage of abortion; under the changes proposed by the House and Senate, these women could be prevented from using their Marketplace insurance plan to cover their abortion care, or lose coverage for health care altogether.^{6,7,13} In addition, many women who gained insurance under the ACA and Medicaid expansion could lose health insurance coverage, including coverage for critical services such as contraceptive care, and other preventive reproductive health services.¹⁰

THE IMPACT OF BANS ON COVERAGE OF ABORTION

Changes to the ACA will vastly increase the number of women without insurance coverage for abortion care, adding to the millions who are currently impacted by the Hyde Amendment and other federal and state bans on abortion coverage. Insurance bans place a disproportionate burden on low-income women, women of color, and young women. Historical oppression coupled with structural and economic inequalities contribute to economic disparities, resulting in the reality that women of color, especially Black and Latina women, are more likely to struggle to make ends meet, get their health insurance through Medicaid, and receive subsidies to enroll in Marketplace insurance plans.^{14–17}

"I did a payday loan against my [pay]check. Some bills did not get paid... I didn't send my daughter to preschool... Whatever money I had to pay for other stuff, I was trying to save and hustle it. I actually pawned some of my jewelry as well."

-27-year-old abortion client in Florida

"I just know that every time I know somebody who has to go through that [an abortion], it's a struggle having to come up with the money because they're very rarely ever covered by health insurance. So, even my friends that have insurance still have to pay out-of-pocket for their abortions, and you know it's unexpected. I mean, women don't know that they're going to have to have one, we don't plan for that. We don't put away a fund for it or anything. So it's really an unexpected expense, and I know a lot of people that have been really burdened by it."

-24-year-old abortion client in Arizona

The Congressional Budget Office estimates that under the proposed repeal bills, low-income people will disproportionately lose their health insurance, further exacerbating financial stress and decreased access to reproductive health services for low-income Americans.^{11,12,16–20}

Abortion costs: Eighty-nine percent of abortions in the United States take place in the first trimester of pregnancy. The average cost of a first-trimester abortion is approximately \$500.²¹ Five-hundred dollars can be an extraordinarily burdensome cost for many women; in a recent survey, 47% of Americans did not have \$400 on hand to pay for an emergency expense and would have to sell something or borrow the money to cover the amount.²² Poor and low-income women, women of color, and young adults disproportionately experience unintended pregnancy, and thus have a disproportionate need for abortion services.^{1,3,14,23} An unexpected cost, such as an abortion, forces many women to choose between paying for the abortion and paying for basic expenses such as rent, food, or school. In addition, when women are forced to pay for abortion care out-of-pocket, trying to find financial resources to cover costs often causes delays in obtaining care. Additionally, lack of sufficient financial resources to cover the cost of an abortion can compel women to continue unwanted pregnancies. Studies also show that a woman who seeks an abortion but is unable to access one is more likely to fall into poverty than one who is able to get an abortion.^{24–26}

Everyone has the human right to health, which includes a right to reproductive and sexual health, and being able to access the care they need, where and when they need it. Insurance bans and funding restrictions for abortion inflict harm on women, especially poor and low-income women, women of color, and young women, and interfere with their ability to make the decisions they feel are best for themselves and their families. Protecting a woman's ability to access abortion will not only safeguard her health and guarantee her rights, but will also help bolster financial and social outcomes for her and her family.

APPENDIX: REFERENCES AND DATA NOTES

Data notes: Calculations for the number of women enrolled in Marketplace plans who are or could be subject to bans on insurance coverage for abortion through the Health Insurance Marketplaces were calculated using the Kaiser Family Foundation's publicly available dataset: 2017 Marketplace Plan Selections by Gender: Nov 1, 2016-January 31, 2017.⁶ Previous literature indicates that approximately 80-90% of those who select a plan remain enrolled during the course of the year.⁷ We estimated that 80% of all women who selected plans would continue to be enrolled throughout the year and therefore are either affected by the current ban (for those women living in states where Marketplace bans are in place) or would be affected should the ACA be repealed (for those women living in states where Marketplace plans can currently cover abortion).

Data limitations: In this fact sheet, we use a variety of data sources in order to estimate the number of women impacted by bans on abortion coverage. Where possible, we have used data for women of reproductive age (defined as aged 15-49); however, in cases where data sources only provide data for nonelderly women between ages 19 and 64 we have chosen to use that data, as all would lose this coverage opportunity. Finally, there are some groups of women (such as federal prisoners and detainees and dependents of those with insurance through a federal employee) for whom data are not available and could not be included in this publication; thus, we operate under the assumption that these calculations likely underestimate the true number of women affected by insurance bans and funding restrictions.

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Policy matters

Abortion as a Catastrophic Health Expenditure in the United States

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Article history: Received 24 October 2019; Received in revised form 16 June 2020; Accepted 10 July 2020

ABSTRACT

Purpose: Abortion is a critical reproductive health service that is difficult for many in the United States to afford owing to policies aimed at restricting insurance coverage of this basic health service. This article assesses whether the resulting high out-of-pocket cost for abortion could be considered a catastrophic health expenditure, and explores potential policies that could prevent households from experiencing financial hardship or impoverishment.

Methods: We assessed if the average costs of a first and second trimester abortion procedure in 2016 were catastrophic health expenditures by applying a 40% threshold to the monthly nonsubsistence income of households earning their state's median income in all 50 states and Washington, DC.

Results: The out-of-pocket cost for a first trimester abortion procedure would have been catastrophic for households earning their state's median monthly income in 39 states. In nine of these states, the average cost was between 100% and 199% of a household's nonsubsistence income, and in another nine states, this cost was at least double a household's nonsubsistence income. The out-of-pocket cost of a second trimester abortion would have been catastrophic for households earning their state's median monthly income in all 50 states and Washington, DC.

Conclusions: In a majority of states, the out-of-pocket cost of an abortion is financially catastrophic for households earning no more than their state's median monthly income. The United States should implement policies to create or improve health care safety nets to guarantee abortion care for all individuals, regardless of their income or insurance status.

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To address the fact that millions around the globe are unable to access essential health care or are impoverished from paying for health care out-of-pocket (World Health Organization & The World Bank, 2017), all member states of the United Nations have agreed to work to "ensure healthy lives and promote well-being for all at all ages" and made this one of the 17 global sustainable development goals to achieve by 2030 (Transforming Our World: The 2030 Agenda for Sustainable Development, 2015). To accomplish this overarching health objective, countries identified nine specific health-related goals, one of which is to ensure universal health coverage, so that all individuals and

communities can obtain health care without experiencing financial hardship (World Health Organization, 2018). A second goal is to ensure access to sexual and reproductive health care in particular (World Health Organization, 2020b), as services are of low quality and inaccessible in many low- and middle-income countries (Germain, Sen, García-Moreno, & Shankar, 2015), or are restricted in some high-income settings (Connolly, 2019; Eddy, 2019; International Campaign for Women's Right to Safe Abortion, 2018; Jerman, Frohwirth, Kavanaugh, & Blades, 2017). The United States, as a member of the United Nations, has agreed to achieve both goals, yet one particular reproductive health service—abortion—remains difficult for many women in the United States to access without financial hardship.

In the United States, policies at the federal and state levels prevent many individuals, particularly those with limited financial resources, from accessing their legal right to abortion. One such policy is the Hyde Amendment, which prohibits federal funds contributed to the joint federal-state Medicaid health insurance program (and other programs like Indian Health Service

This analysis was made possible by generous general support funding from the David and Lucile Packard Foundation the William and Flora Hewlett Foundation.

The authors report no conflict of interests.

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and Tricare, a health program for current and previous members of the U.S. armed forces and their families) from being used for abortion care unless the pregnancy "place[s] the woman in danger of death" or is a result of rape or incest (H.R.2740, *Health, Energy and Water Development Appropriations Act, 116th Congress, 2019–2020*, 2019; Salganicoff, Sobel, & Ramaswamy, 2020). Although states can use their own Medicaid funds to cover abortion in other circumstances, only 16 states have such a policy in place as of February 2020 (Guttmacher Institute, 2020f). In 2016, Medicaid covered approximately 13.2 million low-income women of reproductive age, and more than one-half of these women lived in states that restrict public funding of abortion (Guttmacher Institute, 2020c). Because 75% of abortion patients in the United States have low incomes and almost 50% earn incomes below the federal poverty level (Jerman, Jones, & Ondra, 2016), this policy severely restricts abortion access to individuals most in need of public insurance coverage for this reproductive health service. However, restrictions on public insurance are not the only impediment to abortion access, because 11 states place restrictions on abortion coverage for all private insurance plans and 26 states place restrictions on abortion coverage for plans offered in health insurance exchanges (Guttmacher Institute, 2020e). Furthermore, residing in a state that allows insurance plans to cover abortions does not guarantee coverage, as plans may choose not to offer abortion coverage or may choose to offer coverage only in certain parts of the state (Salganicoff, 2016). Only six states require private insurance plans to cover abortion (Guttmacher Institute, 2020d). Without coverage through a private or public insurance plan, abortion seekers must find the money to pay for the procedure out-of-pocket, or carry an unwanted pregnancy to term (Roberts, Johns, Williams, Wingo, & Upadhyay, 2019).

Data gathered in 2011, the year for which data from a geographically diverse sample are most recently available, reveal that, among women paying out-of-pocket, the average costs for an abortion procedure range from \$397 for a first trimester abortion to \$854 for a second trimester abortion (Jones, Upadhyay, & Weitz, 2013). Accounting for inflation, average patient costs for abortion in 2018 would equal approximately \$447 and \$961, respectively (Bureau of Labor Statistics, 2020). Given that 39% of U.S. adults in 2018 were unable to cover a \$400 emergency expense with cash, savings, or a credit card they could pay off in the next statement (Reserve Board, 2019), the out-of-pocket cost of an abortion could consume a significant—and possibly catastrophic—proportion of monthly income for many individuals and their families.

The term "catastrophic health expenditure" (CHE) is used globally to describe out-of-pocket spending for a health service that is above a certain threshold of one's income or expenditure. The proportion of households experiencing a CHE within a given timeframe is a commonly used metric for measuring how well a nation's health system protects households against financial hardship (Raban, Dandona, & Dandona, 2013), and has been used to assess changes from proposed or implemented health care reforms (Scott et al., 2018; Xu, Zhou, & Gao, 2017). Two variations of this metric are used as indicators for monitoring a nation's progress toward its sustainable development goal of achieving universal health coverage (World Health Organization, 2020a). In the United States, the occurrence of catastrophic health costs has been documented among uninsured patients seeking care for heart attack and stroke (Khera et al., 2018), as well as for traumatic injuries (Scott et al., 2018). However, we are not aware of

any studies measuring the occurrence or extent of CHEs with regard to sexual and reproductive health care costs in the United States, despite the fact that out-of-pocket abortion costs present a significant barrier to abortion seekers with limited financial resources or no insurance coverage (Finer, Frohwirth, Dauphine, Singh, & Moore, 2006; Jerman et al., 2017; Kiley, Yee, Niemi, Feinglass, & Simon, 2010). To better understand the extent to which out-of-pocket abortion costs impact the financial well-being of U.S. households, this article assesses whether abortion costs could be considered a CHE for households earning their state's median income, and explores potential policies that could prevent households from experiencing financial hardship or impoverishment to access this essential reproductive health service.

Methods

We assessed whether estimated 2016 out-of-pocket abortion costs are considered catastrophic expenses based on whether they exceeded a certain percentage, or threshold, of monthly household income. We used data on the median household income for each state and Washington, DC, in 2016 inflation-adjusted U.S. dollars, gathered by the U.S. Census Bureau through the American Community Survey (Guzman, 2017). Although data on state median income were reported as annual income, we calculated and analyzed monthly income because abortion is an emergency expenditure for a nonchronic condition that would most strongly impact one's income during the month the procedure occurred.

A 40% threshold was chosen for calculating a CHE because it is used by the World Health Organization and has been applied to nonsubsistence income for sexual and reproductive health services in various countries with different health care systems (Barennes, Fritchittavong, Grinenberg, & Koffi, 2015; Beauliere et al., 2010; Bonu, Bhushan, Rani, & Anderson, 2009; Dyer, 2012; Honda, Randaoharison, & Matsui, 2011; Prinji et al., 2015; Quayum, Nadir, Ensor, & Sucalaya, 2010; Tran et al., 2013). The 40% threshold has also been applied to unanticipated, time-sensitive, reproductive health services similar to abortion, such as emergency caesarean sections (Honda et al., 2011). As noted elsewhere in this article, we did not find any U.S.-based literature on CHEs for a sexual and reproductive health service, but studies on CHEs for urgent, unplanned health needs in the United States have also used a 40% threshold (Khera et al., 2018; Scott et al., 2018).

Monthly nonsubsistence income

$$\begin{aligned} &= (\text{state median monthly household income} \\ &\quad - \text{monthly state living wage}) \end{aligned}$$

$$\text{CHE threshold} = (0.40) \times (\text{monthly nonsubsistence income})$$

We theorize that a household's ability to pay out-of-pocket for an unpredictable expense like abortion depends on income remaining after basic needs have been met. Therefore, the threshold chosen was applied to nonsubsistence income. We defined nonsubsistence household income for each state as the median monthly income minus the monthly minimum wage needed to buy basic necessities. Estimates on this minimum wage, also referred to as a living wage, took into account expenses for food, childcare, health, housing, transportation, taxes, and other necessities (such as clothing and personal care items)

(Glasmeier, 2018). Based on data showing that more than one-half of abortion patients have had at least one previous birth (59%) and are not living with a partner the month they become pregnant (54%) (Jerman et al., 2016), we decided to use living wage data for households with one full-time working adult and one child. Because only hourly wage data for these households were available, we multiplied these wages by 168 hours (in 2016, there were 251 work days [Calender-12.com, 2020], which averages to 21 work days, or 168 hours, per month) to estimate the minimum income an adult working full-time needs to earn each month to buy basic necessities for themselves and a child in 2016 in each state. Living wage data are in 2016 inflation-adjusted U.S. dollars.

Abortion cost data were taken from a study that surveyed 639 women obtaining abortions at six geographically diverse facilities in 2011 (Jones et al., 2013). This was the most recent study reporting out-of-pocket costs for an abortion procedure paid by first trimester and second trimester abortion patients in various regions throughout the United States. The study found that women paid an average of \$397 out-of-pocket for a first trimester abortion and \$854 for a second trimester abortion (Jones et al., 2013). These costs, in 2016 inflation-adjusted U.S. dollars, are \$427 and \$919, respectively (Bureau of Labor Statistics, 2020).

Results

Applying the CHE threshold to the monthly nonsubsistence income calculated for each state and Washington, DC, the 2016 average out-of-pocket cost of a first trimester abortion procedure would have been catastrophic for households earning their state's median monthly income in 39 states. In nine of these states, the average cost of a first trimester abortion was between 100% and 199% of a household's nonsubsistence income, and in

another nine states, this cost was at least double a household's monthly nonsubsistence income. In four states, households earning their state's median income did not have enough to cover the cost of basic necessities. Of the 11 states where the average out-of-pocket cost of a first trimester abortion procedure would not have been catastrophic for households earning their state's median monthly income, households in four states and Washington, DC, were on the brink of (less than \$100 away from) experiencing abortion as a CHE. The out-of-pocket average cost of a second trimester abortion would have been catastrophic for households earning their state's median monthly income in all 50 states and Washington, DC. Figure 1 illustrates the amount that would have been catastrophic for median-income households in each state and Washington, DC, to pay in 2016, and how this amount compares with the 2016 average out-of-pocket cost of a first and second trimester abortion.

Impact of State Policies on Abortion Coverage for People Seeking First Trimester Abortions

Taking into account state policies on insurance coverage for abortion, we find that of the 39 states where the cost of a first trimester abortion is catastrophic, 31 place Hyde-like restrictions on public insurance coverage of abortion (Guttmacher Institute, 2020), 24 place Hyde-like restrictions on individual plans offered in insurance marketplaces (Guttmacher Institute, 2020e), and 9 place Hyde-like restrictions on all private insurance plans, revealing that abortion coverage is severely limited in states where women would benefit from it the most. Owing to abortion coverage restrictions, most first trimester abortion seekers living in a household earning the state's median income or less would experience the cost of a first trimester abortion as a CHE in these states, even if they have health insurance.

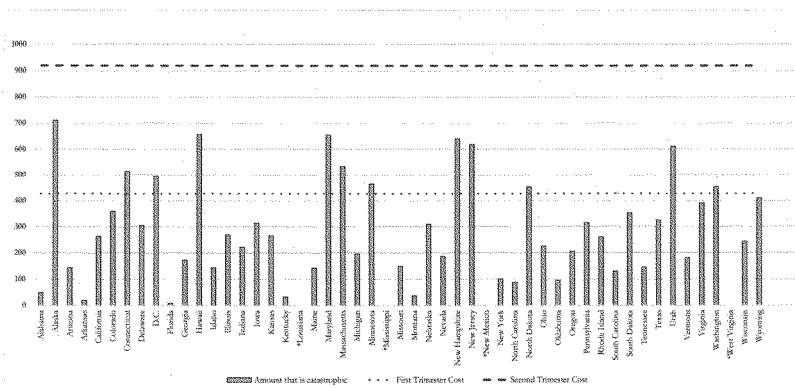


Figure 1. Amount catastrophic to households, compared to abortion costs. This figure displays the amount that would have been catastrophic for households making their state's median monthly income in 2016, and compares this cost to the average 2016 costs of a first and second trimester abortion. Catastrophic amounts are obtained by applying a 40% threshold to nonsubsistence income for a household earning their state's median income. States marked with an asterisk are states where households earning the median income could not afford basic necessities and therefore had a nonsubsistence income of \$0.

Eight of the 39 states where the cost of a first trimester abortion is catastrophic use state Medicaid funds to cover all or most medically necessary abortions, which are determined to be necessary to protect a patient's health by a physician after considering "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient" (*Doe v. Bolton*, 410 US 179, 1973; Guttmacher Institute, 2020f). This ensures that some low-income individuals who qualify for Medicaid are unlikely to incur catastrophic costs for obtaining a first trimester abortion. Five of these eight states (California, Illinois, Maine, New York, Oregon) also require private insurance plans to cover abortions (Guttmacher Institute, 2020d), providing a safety net for individuals who qualify for coverage through a marketplace plan or are on an employer-based plan.

Impact of State Policies on Abortion Coverage for People Seeking Second Trimester Abortions

As mentioned, the out-of-pocket average cost of a second trimester abortion would have been catastrophic for households earning their state's median monthly income in all 50 states and Washington, DC. However, considering state policies on insurance coverage for abortion (Guttmacher Institute, 2020d, 2020f), people with either private insurance coverage or who qualify for Medicaid in six states would not experience the cost of a second trimester abortion as a CHE. In 10 states, Medicaid recipients would not have to pay out-of-pocket, but those who do not qualify for public insurance coverage and live in households earning their state's median income would find the average cost of a second trimester abortion a CHE. In the remaining 34 states and Washington, DC, Hyde-like restrictions on public funding of abortion prevent Medicaid recipients from using their insurance to cover the cost of an abortion except in very few circumstances (Guttmacher Institute, 2020f). Many Medicaid recipients in these states would therefore find the cost of a second trimester abortion catastrophic. In addition, 26 of these states place Hyde-like restrictions on plans offered in health exchanges (Guttmacher Institute, 2020e), and 11 place Hyde-like restrictions on all private insurance plans (Guttmacher Institute, 2020d), so even individuals with private insurance and who live in median-income households would find the cost of a second trimester abortion a CHE in these states.

Tables 1 and 2 list the states where abortion is a CHE and are organized by state policy on Medicaid abortion coverage. These tables highlight the amount remaining or still needed after all of a household's monthly nonsubsistence income goes toward the average cost of a first trimester abortion (Table 1) and second trimester abortion (Table 2).

Abortion as a CHE for Low- and Middle-Income Households

To better understand the impact of out-of-pocket abortion costs on households that receive less than the median income, we focused on households defined as low-income. There are various methods used to determine if households are low-income, with one method considering low-income to mean households earning no more than 80% of the median family income for a given area (Office of Policy Development and Research, U.S. Department of Housing and Urban Development, 2016). Applying the 80% threshold to state median income, low-income households in only two states (Alabama and Utah) would have had sufficient nonsubsistence income to pay the

average out-of-pocket cost of a first trimester abortion in 2016. Low-income households with one adult and one child make less than median-income households of similar compositions, and would likely face CHEs for both first and second trimester abortions in states that restrict public insurance coverage of abortion.

Our analyses also suggest that some households considered middle-income would face CHEs if forced to pay out-of-pocket for an abortion. Although there is no consensus on the definition of middle-income, one definition states these households earn between two-thirds and double the median income (Pew Research Center, 2018). Using this definition, middle-income households earning between 67% and 99% of their state's median income would also experience the cost of an abortion as a CHE.

Discussion

For households with one adult and one child earning the median monthly income in a majority of states, the out-of-pocket cost for a first and second trimester abortion is financially catastrophic. A lack of insurance coverage and the fact that 40% of Americans have insufficient funds saved to cover the cost of an abortion (Reserve Board, 2019) may force many abortion seekers with limited finances to sacrifice basic necessities and/or take on considerable financial risks to pay for an abortion. Research has shown that women are forced to forgo food or other basic necessities (Center for Reproductive Rights, 2010; Dennis, Manski, & Blanchard, 2014; Jones et al., 2013); take out payday or other loans (Dennis et al., 2014); delay or miss paying bills or rent (Dennis et al., 2014; Dennis & Blanchard, 2013; Jones et al., 2013; Nickerson, Manski, & Dennis, 2014); rely heavily on credit cards (Dennis et al., 2014; Dennis & Blanchard, 2013; Nickerson et al., 2014); and pawn personal belongings (Center for Reproductive Rights, 2010; Dennis et al., 2014) to afford an abortion. Gathering enough money to pay for an abortion can result in delays to receiving care (Finer et al., 2006; Jerman et al., 2017; Kiley et al., 2010), resulting in some individuals facing a more expensive second trimester abortion (Kiley et al., 2010) or a denial of abortion care altogether (Upadhyay, Weitz, Jones, Baran, & Foster, 2014). For those living far distances from an abortion clinic, travel expenses may increase the costs of accessing care, placing abortion even further out of reach. One study found that "travel and procedure costs" was the most frequently reported reason for delays among women denied an abortion owing to gestational limits (Upadhyay et al., 2014). The authors of this study noted that public financing and insurance coverage would have made abortion possible for many of these women, because it would have allowed them to pay for a first trimester abortion and obviated the need for a more expensive second trimester procedure (Upadhyay et al., 2014).

Although this study focuses on how obtaining abortion care could be a CHE, it is important to note that individuals unable to afford an abortion would also be the ones most impacted by childcare costs, which could place long-term financial strain on households. Previous research has shown how financial hardship resulting from the inability to obtain wanted abortion care negatively impacts the entire household, and can have long-term economic consequences (Foster, Raifman, Gipson, Rocca, & Biggs, 2018; Foster et al., 2019) and developmental impacts on existing children (Foster et al., 2019). One study examining the impacts of carrying an unwanted pregnancy to term found that from 6 months to 4.5 years after their mothers were denied a wanted

Table 1
States Where First Trimester Abortion Cost Is Catastrophic for Median-Income Households

State	State Median Monthly Income	State Monthly Living Wage (1 Adult, 1 Child)	Monthly Non-Subsistence Income	First Trimester Abortion Cost as a Percent of Monthly Non-Subsistence Income	Amount Remaining if 100% of Non-Subsistence Income is Used for Abortion	Amount Still Needed if 100% of Non-Subsistence Income Goes Toward the Cost of an Abortion
States with the same or similar restrictions as the Hyde amendment for public insurance^a						
Alabama	\$3,854.75	\$3,734.64	\$120.11	355.5%	—	\$306.89
Arizona	\$4,463.17	\$4,104.24	\$359.93	119.0%	—	\$88.07
Arkansas	\$3,694.50	\$3,647.28	\$47.22	904.3%	—	\$379.78
Colorado	\$5,473.75	\$4,574.64	\$89.11	47.5%	\$472.11	—
Delaware	\$5,146.42	\$4,386.48	\$759.94	56.2%	\$332.94	—
D.C.	\$6,252.17	\$5,058.48	\$1,233.69	74.5%	\$314.69	—
Florida	\$4,238.33	\$4,218.48	\$19.85	2150.8%	—	\$407.15
Georgia	\$4,463.25	\$4,032.00	\$431.25	99.0%	\$4.25	—
Idaho	\$4,317.25	\$3,995.76	\$357.49	119.4%	—	\$69.51
Indiana	\$4,359.50	\$3,806.88	\$552.62	77.3%	\$125.62	—
Iowa	\$4,687.25	\$3,902.64	\$784.61	54.4%	\$357.61	—
Kansas	\$4,577.92	\$3,912.72	\$665.20	64.2%	\$238.20	—
Kentucky	\$3,888.25	\$3,806.88	\$81.37	524.8%	—	\$345.63
Louisiana	\$3,762.17	\$3,936.24	\$174.07	—	—	\$427.00
Michigan	\$4,374.33	\$3,884.16	\$490.17	87.1%	\$63.17	—
Mississippi	\$3,479.50	\$3,576.72	-\$97.22	—	—	\$427.00
Missouri ^b	\$4,312.17	\$3,939.60	\$372.57	114.6%	—	\$54.43
Nebraska	\$4,743.92	\$3,971.52	\$772.40	55.3%	\$345.40	—
Nevada	\$4,598.33	\$4,131.12	\$467.21	91.4%	\$40.21	—
North Carolina	\$4,215.33	\$3,998.40	\$216.93	196.8%	—	\$210.07
Ohio	\$4,361.17	\$3,798.48	\$562.69	75.9%	\$135.69	—
Oklahoma ^c	\$4,098.00	\$3,860.64	\$237.36	179.9%	—	\$189.64
Pennsylvania	\$4,742.25	\$3,956.40	\$789.85	54.3%	\$358.85	—
Rhode Island	\$5,049.67	\$4,398.24	\$651.43	65.5%	\$224.43	—
South Carolina	\$4,125.08	\$3,801.84	\$323.24	132.1%	—	\$103.76
South Dakota	\$4,538.92	\$3,657.36	\$881.56	48.4%	\$454.56	—
Tennessee ^d	\$4,045.58	\$3,682.56	\$363.02	117.6%	—	\$63.98
Texas	\$4,713.75	\$3,902.64	\$811.11	51.6%	\$384.11	—
Virginia	\$5,676.17	\$4,700.64	\$975.53	43.8%	\$548.53	—
West Virginia	\$3,615.42	\$3,706.08	-\$90.66	—	—	\$427.00
Wisconsin	\$4,734.25	\$4,127.76	\$606.49	70.4%	\$179.49	—
Wyoming	\$4,990.17	\$3,969.84	\$1,020.33	41.8%	\$593.33	—
States that publicly fund all or most medically necessary abortions^e						
California	\$5,644.92	\$4,986.24	\$658.68	64.8%	\$231.68	—
Illinois	\$5,080.00	\$4,404.96	\$675.04	63.3%	\$248.04	—
Maine ^f	\$4,423.25	\$4,067.28	\$355.97	120.0%	—	\$71.03
Montana	\$4,168.92	\$4,079.04	\$89.88	475.1%	—	\$337.12
New Mexico	\$3,895.67	\$4,137.84	\$242.17	—	—	\$427.00
New York ^g	\$5,242.42	\$4,991.28	\$251.14	170.0%	—	\$175.86
Oregon	\$4,794.33	\$4,282.32	\$512.01	83.4%	\$85.01	—
Vermont	\$4,806.42	\$4,334.56	\$451.86	94.5%	\$24.86	—

For states that place restrictions on public insurance, bolded states denote that similar restrictions exist for private insurance plans, plans on the marketplace, or insurance policies for public employees. For states that publicly fund abortions, bolded states also require private insurance plans to cover abortions.

^aGuttmacher Institute. State Funding of Abortion Under Medicaid. July 01, 2019. Accessed July 9, 2019. Available at: <https://www.guttmacher.org/print/state-policy/explore/state-funding-abortion-under-medicaid>; and Guttmacher Institute. Restricting Insurance Coverage of Abortion. Oct 01, 2019. Accessed Oct 3, 2019. Available at: <https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion>.

^b Abortion cost is between 100%–199% of monthly non-subsistence income.

^c Abortion cost is double or more than double (>200%) monthly non-subsistence income.

abortion, existing young children had lower mean child development scores and were more likely to live in poverty than existing children of women who had received a wanted abortion (Foster et al., 2019).

Limitations

Our study has several limitations. The first is that our results likely underestimate the total amount individuals pay for an abortion because we did not take into account associated travel costs, lost wages, and childcare expenses. These expenses place an additional financial strain on households already struggling to pay for the procedure itself. Although travel expenses vary by

state, one study of more than 600 abortion patients across six states found that more than two-thirds of patients incurred transportation expenses averaging \$44, one-quarter reported almost \$200 in lost wages, and a small proportion spent an average of \$57 for childcare and \$140 on hotel and related travel costs in 2011 (Jones et al., 2013).

A second limitation is that the cost of an abortion procedure varies by state and even by facilities within the same state. The cost data used in this analysis are limited to the average out-of-pocket amounts paid by patients who visited one of six abortion providers in different states in 2011 and, although we have attempted to adjust for inflation, these adjustments may not accurately reflect the actual 2016 cost of a first and second

Table 2
States Where Second Trimester Abortion Cost Is Catastrophic for Median Income Households

State	State Median Monthly Income	State Monthly Living Wage	Monthly Non-Subsistence Income	Second Trimester Abortion as a Percent of Monthly Non-Subsistence Income	Amount Remaining if 100% of Non-Subsistence Income is Used for Abortion	Amount Still Needed if 100% of Non-Subsistence Income Goes Toward the Cost of an Abortion
States with the same or similar restrictions as the Hyde amendment for public insurance*						
Alabama*	\$3,854.75	\$3,734.64	\$120.11	765.1%	-	\$798.89
Arizona*	\$4,463.17	\$4,104.24	\$358.93	255.0%	-	\$560.07
Arkansas*	\$3,694.50	\$3,647.28	\$47.22	1946.2%	-	\$871.78
Colorado*	\$5,473.75	\$4,574.64	\$899.11	102.2%	-	\$19.89
Delaware*	\$3,146.42	\$3,086.48	\$759.94	120.9%	-	\$159.06
D.C.	\$6,292.17	\$5,058.48	\$1,233.69	74.5%	\$314.69	-
Florida*	\$4,238.33	\$4,218.48	\$19.85	4628.9%	-	\$899.15
Georgia*	\$4,463.25	\$4,032.00	\$431.25	213.1%	-	\$487.75
Idaho*	\$4,317.25	\$3,959.76	\$357.49	257.1%	-	\$561.51
Indiana*	\$4,359.50	\$3,806.88	\$552.62	166.3%	-	\$366.38
Iowa*	\$4,687.25	\$3,902.64	\$784.61	117.1%	-	\$134.39
Kansas*	\$4,577.92	\$3,912.72	\$665.20	138.2%	-	\$253.80
Kentucky*	\$3,888.25	\$3,806.88	\$81.37	1129.4%	-	\$837.63
Louisiana*	\$3,762.17	\$3,936.24	\$174.07	-	-	\$919.00
Michigan*	\$4,374.33	\$3,884.16	\$490.17	187.5%	-	\$428.83
Mississippi*	\$3,479.50	\$3,576.72	\$97.22	-	-	\$919.00
Missouri*	\$4,312.17	\$3,939.60	\$372.57	246.7%	-	\$546.43
Nebraska*	\$4,743.92	\$3,971.52	\$772.40	119.0%	-	\$146.60
Nevada*	\$4,588.33	\$4,131.12	\$467.21	196.7%	-	\$451.79
New Hampshire	\$5,911.33	\$4,312.56	\$1,598.77	57.5%	\$679.77	-
North Carolina	\$4,215.33	\$3,998.40	\$216.93	423.6%	-	\$702.07
North Dakota	\$5,054.67	\$3,919.44	\$1,135.23	81.0%	\$216.23	-
Ohio*	\$4,361.17	\$3,798.48	\$562.89	163.3%	-	\$356.31
Oklahoma*	\$4,098.00	\$3,860.64	\$237.36	387.2%	-	\$681.64
Pennsylvania*	\$4,742.25	\$3,956.40	\$785.85	116.9%	-	\$133.15
Rhode Island	\$5,049.67	\$4,398.24	\$651.43	141.1%	-	\$267.57
South Carolina	\$4,125.08	\$3,801.84	\$232.24	284.3%	-	\$595.76
South Dakota*	\$4,538.92	\$3,657.36	\$881.56	104.2%	-	\$37.44
Tennessee*	\$4,045.58	\$3,682.56	\$363.02	253.2%	-	\$555.98
Texas*	\$4,713.75	\$3,902.64	\$811.11	113.3%	-	\$107.89
Utah*	\$5,498.08	\$3,969.84	\$1,528.24	60.1%	\$609.24	-
Virginia*	\$5,676.17	\$4,700.64	\$975.53	94.2%	\$56.53	-
West Virginia	\$3,615.42	\$3,706.08	-\$90.66	-	-	\$919.00
Wisconsin*	\$4,734.25	\$4,127.76	\$606.49	151.5%	-	\$312.51
Wyoming	\$4,990.17	\$3,969.84	\$1,020.33	90.1%	\$101.33	-
States that publicly fund all or most medically necessary abortions*						
Alaska	\$6,370.00	\$4,593.12	\$1,776.88	51.7%	\$857.88	-
California*	\$5,644.92	\$4,986.24	\$658.68	139.5%	-	\$260.32
Connecticut	\$6,119.42	\$4,835.04	\$1,284.38	71.6%	\$365.38	-
Hawaii	\$6,209.25	\$4,566.24	\$1,043.01	55.9%	\$724.01	-
Illinois*	\$5,080.00	\$4,404.96	\$675.04	136.1%	-	\$243.96
Maine*	\$4,423.25	\$4,067.28	\$355.97	258.2%	-	\$563.03
Maryland	\$6,578.75	\$4,940.88	\$1,637.87	56.1%	\$718.87	-
Massachusetts	\$6,274.75	\$4,935.84	\$1,338.91	68.6%	\$419.91	-
Minnesota	\$5,465.58	\$4,304.16	\$1,162.42	79.1%	\$243.42	-
Montana*	\$4,168.92	\$4,079.04	\$89.88	1022.5%	-	\$829.12
New Jersey	\$6,343.83	\$4,798.08	\$1,545.75	59.5%	\$626.75	-
New Mexico*	\$3,895.67	\$4,137.84	-\$242.17	-	-	\$919.00
New York	\$5,242.42	\$4,991.28	\$251.14	365.9%	-	\$667.86
Oregon*	\$4,794.33	\$4,282.32	\$512.01	179.5%	-	\$406.99
Vermont	\$4,806.42	\$4,354.56	\$451.86	203.4%	-	\$467.14
Washington	\$5,592.17	\$4,457.04	\$1,135.13	81.0%	\$216.13	-

For states that place restrictions on public insurance, bolded states denote that similar restrictions exist for private insurance plans, plans on the marketplace, or insurance policies for public employees. For states that publicly fund abortions, bolded states also require private insurance plans to cover abortions.

*Guttmacher Institute, State Funding of Abortion Under Medicaid, July 01, 2019. Accessed July 9, 2019. Available at <https://www.guttmacher.org/print/state-policy/explore/state-funding-abortion-under-medicaid>; and Guttmacher Institute, Restricting Insurance Coverage of Abortion, Oct 01, 2019. Accessed Oct 3, 2019. Available at <https://www.guttmacher.org/state-policy/explore-restricting-insurance-coverage-abortion>.

† Abortion cost is between 100%-199% of monthly non-subsistence income.

‡ Abortion cost is double or more than double (>200%) monthly non-subsistence income.

trimester abortion procedure. In addition, although these six providers are geographically diverse, our analysis would be more accurate if state-specific data on out-of-pocket abortion costs were available. If the average out-of-pocket cost in most states is

below or above the average costs used in our calculations, we would have overestimated or underestimated the number of states where households would find the cost of an abortion a CHE.

A third limitation is that data on living wages are best reflected at the county level, but we chose to use state-level data because our calculations for nonsubsistence income were based on the median household income for each state. Living wage data also incorporated estimated costs for medical services derived from the Bureau of Labor Statistics Consumer Expenditure Survey, which asks participants if any members of their household made out-of-pocket payments or co-pays for physician services (Bureau of Labor Statistics, 2016). It is possible that some participants disclosed abortion costs in this survey, which could have resulted in an overestimation of monthly living wage costs. However, because our calculations assumed 168 work hours per month, whereas the source of the hourly living wage rate is based on the assumption that full-time employees work 173 hours per month, it is more likely that we may have underestimated monthly living wage costs.

A fourth limitation is that our analysis does not consider households of various compositions or households with members of different employment statuses. Our analysis is based on the income of households with one full-time working adult and one child, because previous data have revealed that the majority of abortion patients have had at least one previous birth and are not living with a partner the month they become pregnant (Jerman et al., 2016). Future studies could evaluate the financial burden of a first and second trimester abortion for households with more than one full-time or part-time working adults and with no or multiple dependents.

Although not a limitation per se, this study did not take into account assistance individuals may have received from abortion funds. These funds exist owing to private donations and although they help to fill the gaps left by a lack of insurance coverage, they are not systematic in their eligibility criteria or available to everyone in need of financial assistance. Very little research exists on the impact these funds have on abortion access. Although research has been conducted on the characteristics of some abortion fund clients and the amount of support they received, these results are specific to a certain fund (Ely, Hales, Jackson, Maguin, & Hamilton, 2017). We are unaware of any recent, nation-wide data on the percentage of women using abortion funds to help pay for first and second trimester abortions, the length of time it takes women seeking financial support from abortion funds to obtain assistance, or the number of women who are and are not able to obtain abortions after requesting or receiving pledges from abortion funds. Future research on the extent to which abortion funds are sought after and utilized by abortion seekers is essential if policymakers are to fully understand the unmet need for abortion and address the financial gaps currently filled by abortion funds.

Implications for Practice and/or Policy

Universal health coverage means that all individuals and communities are able to access health services without financial distress (World Health Organization, 2018), and as a member state of the United Nations, the United States has assented to the sustainable development goal of achieving universal health coverage by 2030 (Sustainable Development Goals, 2015). As a step toward achieving this goal, as well as the goal of ensuring access to sexual and reproductive health care, the United States should ensure that the cost of an abortion is not a CHC to any resident by implementing policies to create or improve health care safety nets that guarantee abortion care for individuals, regardless of their insurance plan or status. The United States is

also a state party to the International Covenant on Civil and Political Rights, and a recent comprehensive interpretation by the committee that monitors implementation of this treaty clarified that "State parties should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion" (Human Rights Committee, 2018). Based on this guidance, as well as the WHO's recommendation that health systems make safe abortion services "readily available and affordable to all women," the United States should remove restrictions that limit private and public insurance plans from covering abortion services so that insured individuals will not experience financial hardship owing to obtaining an abortion (World Health Organization, 2012). Because our results also show that low-income households in a vast majority of states would not have had sufficient non-subsistence income to pay the average out-of-pocket cost of a first trimester abortion, states should also ensure Medicaid covers abortion costs and expand Medicaid eligibility requirements to cover as many individuals with low incomes as possible. Similar to the contraceptive mandate under the Affordable Care Act that requires most private insurance plans to cover contraceptive methods and related services such as counseling (Guttmacher Institute, 2020b), an abortion mandate requiring insurance plans to cover the costs of abortion procedures and evidenced-based abortion counseling would help expand access to these basic health services. Only six states currently require both Medicaid and private insurance plans to provide abortion coverage (Guttmacher Institute, 2020d, 2020f). However, even if private and public insurance plans covered abortion, our results indicate that many individuals without any insurance living in households earning their state's median income or less would still experience the cost of an abortion as a CHC. It is therefore also important to consider individuals without public or private health insurance, including those who cannot afford private insurance but do not qualify for Medicaid; individuals who feel they do not need health insurance; qualified noncitizens (such as lawful permanent residents or green card holders) waiting to become eligible for Medicaid (U.S. Centers for Medicare & Medicaid Services, n.d.); and those not eligible for Medicaid regardless of income, such as undocumented immigrants. To provide a safety net for all U.S. residents, legislation has been introduced in Congress proposing a "Medicare for all" plan, which would make the U.S. government, rather than private insurance plans or employers, the sole payer of health care costs (S.1129. To Establish a Medicare-for-All National Health Insurance Program. 116th Congress, 2019), and similar efforts have been proposed at the state level in at least 20 states (Liu & Brook, 2017). Policymakers at the federal and state levels should ensure that Medicare-for-all plans cover abortion so that abortion care is financially accessible to all residents. In addition, policymakers at the state and municipal levels can put safety nets in place to ensure that people without health insurance have access to abortion care in particular. For example, California's "Pregnancy-related Medi-Cal program" guarantees that all uninsured pregnant people who do not qualify for California's full-scope Medicaid program have abortion coverage, regardless of citizenship status (Covered California, 2020). In regard to policies at the municipal level, New York City offers a health care access program that allows individuals without insurance, and regardless of immigration status, to pay fees on a sliding scale based on income for health services (NYC Care, 2020). However, at the time of writing, this does not include coverage for abortion services unless the abortion is for a "medically necessary" reason.

(Personal communication with NYC Care staff, February 14, 2020). As cities and states consider programs and policies to ensure all residents have access to essential health care, it is important for policy makers at the federal, state, and municipal levels to explicitly recognize abortion as a critical reproductive health service that should be available to all regardless of income or insurance status.

In tandem with expanding abortion coverage through insurance plans and programs, states must ensure adequate and timely reimbursement for abortion services. Research has shown an association between provider reimbursement levels and patient access, with providers being dis-incentivized from accepting patients with certain payment plans because of low reimbursement rates (Cunningham & May, 2006) or owing to difficulty securing reimbursement at all (Dennis & Blanchard, 2013). One study that conducted in-depth interviews from 2007 to 2010 with representatives from 70 abortion-providing facilities in 15 states found that only 58% of abortions that qualified for coverage were actually reimbursed by Medicaid, and that reimbursement rates were sometimes inadequate because they were not based on gestation (Dennis & Blanchard, 2013). Participants in 13 of the 15 states reported difficulties obtaining reimbursement, including claims being rejected for unclear or arbitrary reasons and time-consuming billing processes (Dennis & Blanchard, 2013). Instituting universal coverage without attention to the reimbursement process and rates may result in fewer abortion providers accepting health insurance plans, forcing some insured patients to either pay out-of-pocket and experience a CHE or to not receive the abortion care they need.

Median-income households in some states were on the brink of experiencing the cost of a first trimester abortion as a CHE, so any logistical support costs incurred as a result of restrictive abortion policies may make the cost of actually obtaining an abortion a CHE for households barely able to afford the cost of the procedure itself. To help ensure that abortion-related costs do not place additional financial burdens or prevent individuals from obtaining an abortion laws that force abortion seekers to incur unnecessary indirect abortion costs, such as expenses associated with traveling to an abortion clinic, should be eliminated. For instance, 14 states requiring a waiting period between receiving abortion counseling and obtaining abortion care force abortion seekers to travel to a health clinic twice (Guttmacher Institute, 2020a). Another example is targeted regulations on abortion provider laws, which place unnecessary restrictions on providers and clinics in an attempt to reduce the availability of abortion services (Guttmacher Institute, 2020a). Clinic closures resulting from these laws force some to travel long distances to access a clinic (Gerdts et al., 2016). Individuals traveling owing to required waiting periods or a lack of a nearby abortion facility may also incur lost wages from time taken off work (Gerdts et al., 2016; Jones et al., 2013; Lindo & Pineda-Torres, 2019; Sanders, Conway, Jacobson, Torres, & Turok, 2016), as well as travel-related costs, such as gas (White, DeMartelly, Grossman, & Turan, 2016), childcare or eldercare (Gerdts et al., 2016; Jones et al., 2013; Lindo & Pineda-Torres, 2019), and lodging expenses (Gerdts et al., 2016; Jones et al., 2013) to simply visit an abortion facility. For individuals with limited access to safe and reliable transportation or for those who have to use various means of transportation, travel itself regardless of distance may be a barrier (Jerman et al., 2017). Households that barely have the financial means to pay for a first trimester procedure (and that would otherwise not experience the cost of a first trimester

procedure as a CHE) may actually experience a CHE from obtaining an abortion if forced to incur additional costs required to physically access an abortion clinic.

Conclusions

This study is the first to apply a CHE analysis on a reproductive health service in the United States, and highlights policies that can be implemented at the federal, state, and municipal levels that would allow the United States to make progress on several goals it has agreed to achieve by 2030. Easily accessible and affordable insurance coverage will prevent individuals from having to sacrifice basic necessities or incur debt to pay out-of-pocket for an abortion. Access to all aspects of reproductive health care, including abortion care, is critical for exercising one's right to decide if and when to have children, and to be able to make other crucial decisions impacting one's course of life. Universal health coverage that includes abortion will allow individuals to avoid carrying unwanted pregnancies to term, and thereby reduce the likelihood of negative economic and child-development consequences for their households. Abortion care is an essential reproductive health service and, as such, laws and policies should aim to make abortion care and abortion-related services financially accessible to all individuals.

Acknowledgments

The authors thank Moria Mahanaimy and Basile Moreau for their assistance reviewing the literature.

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Original Research Article

Contextualizing Medicaid reimbursement rates for abortion procedures[☆]Yves-Yvette Young ^{a,b*}, Terri-Ann Thompson ^b, David S. Cohen ^c, Kelly Blanchard ^b^a Ibis Reproductive Health, 1736 Franklin Street, Suite 600, Oakland, CA 94612, USA^b Ibis Reproductive Health, 2067 Massachusetts Avenue, Suite 320, Cambridge, MA 02140, USA^c Drexel University – Thomas R Kline School of Law, 3320 Market Street, Philadelphia, PA 19104, USA

ARTICLE INFO

Article history:

Received 25 September 2019

Received in revised form 9 March 2020

Accepted 11 March 2020

Keywords:
Medicaid reimbursement
Abortion
Insurance
Advocacy

ABSTRACT

Objective: Low Medicaid reimbursement rates have been cited as a key threat to abortion clinic sustainability in the United States. This study examines differences between Medicaid and Medicare reimbursements for abortion and miscarriage management procedures under a fee-for-service (FFS) model.

Study design: Using 2017 Medicaid and Medicare Physician fee schedules, we extracted reimbursement data for the two most commonly-billed abortion procedures and two miscarriage management procedures for 45 states and the District of Columbia (DC). We compared Medicaid and Medicare reimbursement rates for each procedure by state.

Results: Medicaid reimbursement rates for both procedures varied widely across the states. Medicaid rates for second-trimester abortion procedures had the widest range: \$79–\$626. Median Medicaid reimbursement rates were lower than median Medicare rates for first- and second-trimester abortion procedures. Median reimbursement rates for first-trimester induced abortion were lower than median reimbursement rates for miscarriage management for both Medicaid and Medicare.

Conclusion: Our findings indicate that Medicaid reimbursement rates for abortion are low; the median patient cost for a first- and second-trimester abortion have been reported as \$490 and \$750, respectively. Median Medicaid reimbursement rates for a first- and second-trimester abortion covers approximately 37% and 41% of patient costs for a first- and second-trimester abortion. Further, while induced abortion procedures are similar to miscarriage management procedures, Medicaid and Medicare reimbursement rates are lower for first- and second-trimester abortion procedures.

Implication statement: Ensuring reimbursement rates are closely aligned with procedural costs bolsters provider willingness to accept Medicaid. Data that highlights the potential impact of fee-for-service reimbursement rates on healthcare provision and ultimately patient access can help inform healthcare policies. This is especially important as more states consider expanding Medicaid coverage of abortion.

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1. Introduction

Access to safe, high-quality abortion care is a critical part of comprehensive reproductive health care and is associated with positive health and financial outcomes for women and their children [1]. One in four women living in the United States (US) will have an abortion by age 45 [2]. However, access to abortion care

is limited; clinics are few in number and legally restricted. In 2017, approximately 7.3 million women aged 15–44 on Medicaid¹ lived in a state that does not provide abortion coverage outside of the Hyde Amendment² exceptions (in cases of life endangerment, rape, and incest) [3]. An additional one million women aged 15–44 on Medicare³ were impacted by the Hyde Amendment [3].

* Declaration of Interest: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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¹ https://doi.org/10.1016/j.contraception.2020.03.094
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² A joint federal-state health insurance program for eligible low-income individuals.

³ The Hyde Amendment bars the federal Medicaid health insurance program from covering abortion care except in the limited cases of rape, incest, and life endangerment.

⁴ A federal health insurance program for individuals 65 or over and also covers women of childbearing age with disabilities or end-stage renal disease.

Table 1Medicaid and Medicare, fee-for-service, reimbursement amount for induced abortion and miscarriage management procedure only in US dollars, 2017.¹

State ²	Current Procedural Terminology (CPT) codes							
	Medicaid		Medicare					
	59820 ³	59821 ⁴	59840 ⁵	59841 ⁶	59820	59821	59840	59841
Alabama	\$258	\$270	\$167	\$277	\$352	\$356	\$202	\$357
Alaska	\$609	\$618	\$353	\$626	\$485	\$492	\$280	\$498
Arizona	\$355	\$358	\$203	\$359	\$383	\$386	\$219	\$387
Arkansas	\$412	\$523	\$298	\$365	\$349	\$353	\$200	\$355
California	\$169	\$169	\$251	\$354	\$393	\$395	\$223	\$393
Colorado	\$136	\$136	\$186	\$204	\$397	\$400	\$227	\$402
Connecticut	\$224	\$228	\$128	\$224	\$427	\$430	\$243	\$430
District of Columbia	\$358	\$360	\$100	\$359	\$447	\$450	\$230	\$407
Florida	\$241	\$243	\$117	\$213	\$429	\$433	\$246	\$439
Georgia	\$270	\$274	\$231	\$337	\$383	\$387	\$220	\$389
Hawaii	\$216	\$214	\$173	\$264	\$402	\$403	\$228	\$398
Idaho	\$315	\$318	\$182	\$321	\$353	\$356	\$202	\$357
Illinois	\$200	\$289	\$200	\$200	\$423	\$428	\$243	\$434
Indiana	\$361	\$364	\$206	\$365	\$355	\$359	\$203	\$359
Iowa	\$291	\$298	\$247	\$363	\$351	\$354	\$201	\$354
Kentucky	\$229	\$213	\$189	\$214	\$361	\$365	\$208	\$369
Louisiana	\$238	\$244	\$141	\$247	\$391	\$395	\$225	\$400
Maine	\$209	\$213	\$132	\$230	\$370	\$373	\$211	\$373
Maryland	\$368	\$375	\$213	\$371	\$412	\$415	\$235	\$416
Massachusetts	\$379	\$382	\$361	\$398	\$409	\$411	\$233	\$409
Michigan	\$216	\$216	\$124	\$219	\$395	\$399	\$227	\$403
Minnesota	\$284	\$286	\$161	\$282	\$365	\$367	\$208	\$364
Mississippi	\$311	\$315	\$179	\$316	\$346	\$349	\$198	\$351
Missouri	\$180	\$184	\$105	\$183	\$386	\$389	\$221	\$392
Montana	\$423	\$428	\$243	\$430	\$410	\$414	\$235	\$419
Nebraska	\$234	\$472	\$233	\$233	\$347	\$350	\$198	\$349
Nevada	\$387	\$391	\$220	\$391	\$396	\$399	\$226	\$399
New Hampshire	\$135	\$133	\$154	\$180	\$399	\$402	\$228	\$402
New Jersey	\$105	\$105	\$79	\$79	\$424	\$427	\$241	\$425
New Mexico	\$339	\$355	\$205	\$350	\$387	\$391	\$222	\$396
New York	\$221	\$226	\$230	\$350	\$461	\$465	\$264	\$467
North Carolina	\$277	\$282	\$158	\$268	\$368	\$371	\$211	\$373
North Dakota	\$371	\$374	\$212	\$373	\$372	\$374	\$212	\$373
Ohio	\$222	\$221	\$184	\$228	\$377	\$381	\$217	\$385
Oklahoma	\$317	\$321	\$182	\$324	\$367	\$371	\$211	\$374
Oregon	\$267	\$269	\$153	\$254	\$383	\$386	\$218	\$385
Pennsylvania	\$194	\$231	\$82	\$306	\$402	\$406	\$230	\$408
Rhode Island	\$101	\$126	\$126	\$126	\$400	\$402	\$228	\$402
South Carolina	\$260	\$264	\$157	\$273	\$360	\$363	\$205	\$365
Texas	\$252	\$254	\$148	\$258	\$385	\$388	\$220	\$388
Vermont	\$303	\$305	\$173	\$304	\$377	\$380	\$215	\$379
Virginia	\$342	\$345	\$196	\$346	\$383	\$386	\$224	\$397
Washington	\$225	\$226	\$128	\$225	\$395	\$397	\$225	\$395
West Virginia	\$275	\$278	\$228	\$407	\$378	\$382	\$218	\$390
Wisconsin	\$325	\$327	\$345	\$345	\$360	\$363	\$205	\$362
Wyoming	\$358	\$365	\$213	\$369	\$394	\$397	\$225	\$399

¹ Dollar amounts within the table reflect the amount reimbursed for the procedure only.² Excluded states: Delaware, Kansas, South Dakota, Tennessee, Utah.³ CPT code: 59820 – Treatment of missed abortion, completed surgically; first trimester.⁴ CPT code: 59821 – Treatment of missed abortion, completed surgically; second trimester.⁵ CPT code: 59840 – Induced abortion, by dilation and curettage.⁶ CPT code: 59841 – Induced abortion, by dilation and evacuation.

In cases where abortion is covered—when the woman qualifies under the Hyde exceptions or because the state covers abortion using its own funds—access is limited by reimbursement for the services provided. A 2010 study of twenty-five abortion providers in six states found that more than half of Medicaid-eligible abortion cases were not reimbursed over the course of a year, and significant administrative and systematic barriers caused many providers to stop contracting with Medicaid [4]. Clinics that remain enrolled in Medicaid and receive reimbursement often report that the rate at which they are reimbursed for services is too low [5]. Low reimbursement rates for abortion services has been linked to greater out-of-pocket costs for women [6], which can lead to delays in obtaining abortion care or continuation of an unwanted pregnancy [7,8]; fewer providers and/or clinics that accept federal

insurance coverage [5]; and significant financial losses for unreimbursed services, which can threaten the sustainability of clinics [5,7,9].

States offer Medicaid benefits on a fee-for-service (FFS) basis and/or through managed care (MCO) plans.⁷ In a FFS Medicaid reimbursement model, states pay providers directly for each individual covered service provided to a Medicaid beneficiary. Reimbursement rates are set by the state based on one of three criteria: the healthcare costs associated with providing services, a review of commercial payer rates, or a percentage of what Medicare reimburses for

⁷ A model where states pay an overall fee to managed care plans for every person enrolled. In return, managed care plans reimburse medical providers for all Medicaid services a beneficiary may require that are included in the state contract.

equivalent services. In a recent Medicaid and CHIP⁵ Payment and Access Commission report, thirty-eight out of the 51 US Medicaid programs set their FFS rates based on the charge for the service or the maximum amount a plan will pay for a covered health care service, whichever is lesser [10]. In contrast, Medicare reimbursement rates are set by The Centers for Medicare and Medicaid Services (CMS) based on relative time and work related to the provision of the service, expense to the practice (e.g. buying supplies, rental costs, etc.), and the cost of malpractice insurance, and are adjusted annually and for geographic cost variation.

Fee-for-service rates for abortion care are particularly important for patients who either qualify for a Hyde Amendment exemption or live in one of the 16⁶ states that uses its own funds to pay for abortion services. Approximately, 17 states have a Medicaid FFS population of 25% or more [11].

In this study, we examine Medicaid and Medicare FFS reimbursement rates for first- and second-trimester abortion care across the United States. Further, we compare Medicaid and Medicare reimbursement rates for abortion care with an almost identical medical procedure: miscarriage management (spontaneous abortion) in the first- and second-trimester. We assess FFS rates because they are the only publicly available rates.

2. Materials and methods

2.1. Sample

Medicaid and Medicare FFS data for 45 states and the District of Columbia (DC) ($n = 46$) were analyzed. Data for four procedures,⁷—the two most commonly billed abortion procedures, dilation and curettage (D&C) and dilation and evacuation (D&E); and two miscarriage management procedures, first-trimester miscarriage management and second-trimester miscarriage management—were extracted from publicly available 2017 Medicaid and Medicare Physician fee schedules. Medicaid fee schedules were accessed via state websites. The Medicare fee schedule was accessed via the Center for Medicare and Medicaid services website [12]. We searched all fee schedules for the reimbursement rate associated with the CPT codes of interest. States where publicly available data for Medicaid were missing for the selected reproductive health services or where there wasn't a Medicaid FFS program in place were excluded from analyses.⁸

2.2. Types of rates

All available rates for Medicaid and Medicare were extracted. This includes facility, non-facility, general, and Ambulatory Surgical Center (ASC) rates. Facility procedures take place in a hospital-like setting. Non-Facility procedures happen in an office or independent clinic setting [13]. ASCs specialize in same-day outpatient surgical care. All rates that were unlabeled within their fee schedule were classified as "general" rates. Since a very small percentage of abortions are performed in hospitals [14,15], non-facility rates were used for our analyses. In cases where only one

value was reported for the state, that value was extracted. In cases where multiple reimbursement rates were reported (due to rates that varied by regions within the state), a state average was computed.

2.3. Analytic approach

A database containing Medicaid and Medicare reimbursement rates for each selected code for the 45 states and DC was constructed. Reimbursement rates for Medicaid and Medicare, as well as reimbursement rates for induced abortion and miscarriage management were compared. See Table 1.

3. Results

Medicaid and Medicare reimbursement rates for the selected services differed substantially from each other and across the 45 states and DC. Differences were observed when comparing the lowest and highest reimbursement rates for each service, and when comparing Medicaid-to-Medicare rates. Medicaid reimbursement rates for induced abortion procedures varied widely by state, ranging from \$79 to \$626. Wide ranges were also observed among Medicaid reimbursement rates for miscarriage management procedures, from \$101 to \$618. Medicare reimbursement rates for induced abortion and miscarriage management tended to start at a higher reimbursement rate and had a narrower range than reimbursement rates for Medicaid. Induced abortion procedures ranged from \$198 to \$498 and miscarriage management procedures ranged from \$346 to \$492. See Table 2. In 35 of the 46 states reviewed (76%), Medicaid reimbursement rates were lower than the median Medicare reimbursement rate in the first-trimester. In the second trimester, 91% ($n = 42$) of states had Medicaid reimbursement rates lower than the median Medicare rates.

To compare reimbursement rates, researchers have used a Medicaid-to-Medicare fee index [16] which measures the ratio of each state's average Medicaid fee to the Medicare fee for the same service. In Fig. 1 we show the Medicaid-to-Medicare reimbursement ratios for first- and second-trimester induced abortion by state. In both the first- and second-trimester, the majority of Medicaid rates were reimbursed at 0.67–0.99 of the Medicare rate.

In twelve states⁹ Medicaid rates were equal to or higher than Medicare rates for a first-trimester induced abortion. In seven states¹⁰ Medicaid rates were equal to or higher than Medicare for a second-trimester procedure.

In Fig. 2 we show the reimbursement ratios for induced abortion and miscarriage management in the first- and second-trimester in each state. In 61% ($n = 28$) of states, first-trimester induced abortion procedures are reimbursed between 0.50 and 0.74 of first-trimester miscarriage management rates; in seven states first-trimester induced abortion procedures are reimbursed at higher rates than miscarriage management. In the second-trimester 65% ($n = 30$) of states reimburse abortion at an amount equal to or higher than the miscarriage management rate.

4. Discussion

Medicaid reimbursement rates vary widely across states, with more than \$500 separating the lowest and highest rates among Medicaid reimbursement rates for a D&E, and miscarriage manage-

⁵ A sister program to Medicaid, CHIP extends coverage to children and adolescents up to age 19 of families with incomes too high to qualify for Medicaid but too low to afford private insurance.

⁶ In 2017, 17 states used their own funds to cover abortion: Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia.

⁷ CPT code: 59840 - Induced abortion, by dilation and curettage; CPT code: 59841 - Induced abortion, by dilation and evacuation; CPT code: 59820 - Treatment of missed abortion, completed surgically; first trimester; CPT code: 59821 - Treatment of missed abortion, completed surgically; second trimester.

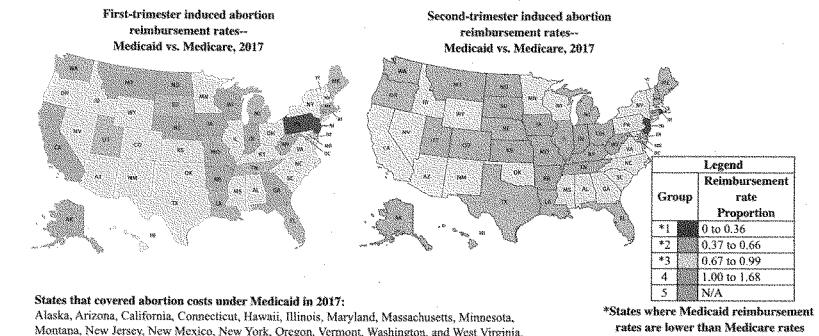
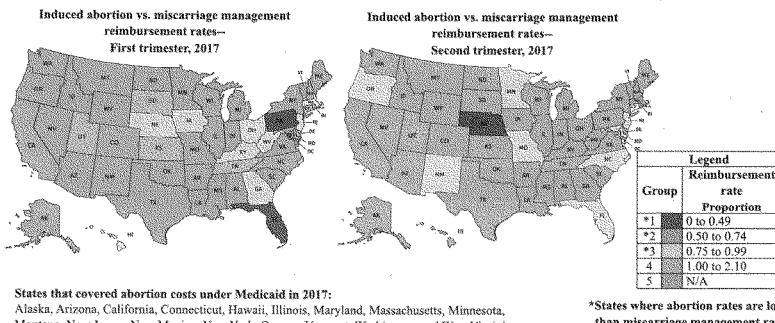
⁸ Excluded states: Delaware, Kansas, South Dakota, Tennessee, Utah.

⁹ States where Medicaid is equal to or higher than Medicare for a first-trimester induced abortion: Alaska, Arkansas, California, Georgia, Indiana, Iowa, Massachusetts, Montana, Nebraska, North Dakota, West Virginia, Wisconsin.

¹⁰ States where Medicaid is equal to or higher than Medicare for a second-trimester induced abortion: Alaska, Arkansas, Indiana, Iowa, Montana, North Dakota, West Virginia.

Table 2Medicaid and Medicare physician fee schedule definitions, median values, and range,¹ 2017.²

Procedure type	Medicaid (n = 46)		Medicare (n = 46)	
	median value	(range)	median value	(range)
Induced abortion, (D&C)	\$183	(\$79–\$361)	\$221.5	(\$198–\$280)
Induced abortion, (D&E)	\$305	(\$79–\$626)	\$392.5	(\$349–\$498)
Missed abortion, surgical, 1 _{st} trimester	\$269	(\$101–\$609)	\$385.5	(\$346–\$485)
Missed abortion, surgical, 2 _{nd} trimester	\$280	(\$105–\$618)	\$388.5	(\$349–\$492)

¹ Excluded states: Delaware, Kansas, South Dakota, Tennessee, Utah.² Dollar amounts within the table reflect the amount reimbursed for the procedure only.**Fig. 1.** Medicaid vs. Medicare, first- and second-trimester, induced abortion reimbursement rates, 2017.**Fig. 2.** Medicaid, first- and second-trimester, induced abortion vs. miscarriage management reimbursement rates, 2017.

ment procedures in the first- and second-trimester. In contrast, Medicare reimbursement rates were more consistent across states; with the majority of states receiving the median or close to the median reimbursement rate for first- and second-trimester induced abortion care. On average, Medicaid reimbursement rates for induced abortion and miscarriage management were lower than Medicare rates for the same procedures. Only a few ($n = 8$) states had similar or higher Medicaid reimbursement rates in the

first-trimester for induced abortion versus miscarriage management. However, significantly more states ($n = 34$) states reimbursed at equal or higher Medicaid rates in the second-trimester. It is important to note that while more states reimbursed similarly for second-trimester induced abortion and miscarriage management procedures, the median reimbursement rates for these states was only \$323, despite these procedures being more complex, labor intensive, and costly to provide at higher gestational ages.

In a study of abortion-providing facilities in select states that had ever sought reimbursement for abortion cases which qualified for federal funding, some patients enrolled in Medicaid had to pay out of pocket or seek financial assistance for abortion care that was legally covered under the federal Medicaid program because many providers did not accept Medicaid [9]. Inconsistent reimbursement, low reimbursement rates, and complicated billing processes were cited among the reasons providers did not accept Medicaid [5]. Abortion providers in 15 states reported receiving Medicaid reimbursement in only 58% of the cases eligible under the Hyde Amendment. Further, providers reported receiving an average reimbursement of \$235 (range \$60–\$498)—an amount described as lower than the cost of providing the service—from Medicaid irrespective of the gestation of the abortion [5].

While there is no published data on the actual cost to provide an abortion, the median patient price for a first- and second-trimester abortion is \$490 and \$750 respectively [6]. Based on the FFS rates presented in our study, the median Medicaid reimbursement rates for a first- and second-trimester abortion would cover 37% and 41% of the cost to a patient, respectively. Median Medicaid reimbursement rates for abortion leave a significant gap for providers to cover and could explain why some providers decide against seeking Medicaid reimbursement for abortion care.

Research from the Kaiser Family Foundation shows Medicaid FFS rates tend to be lower than Medicare reimbursement rates for similar services. Medicaid physician fees were 72% of Medicare physician fees for all services, 66% of Medicare physician fees for primary care, and 81% of Medicare physician fees for obstetric care across all states [16]. Analysis of our data shows that Medicaid physician fees for abortion procedures were also lower than Medicaid fees for abortion procedures; Medicaid physician fees were 88% of Medicare physician fees for first-trimester abortion and 76% for second-trimester abortion across all states included in our analysis. This is important because Medicaid reimbursement rates have been shown to impact a patient's ability to access care. For select health services, higher Medicaid reimbursement rates have been shown to be associated with improved access to care [17], while low Medicaid payments have been shown to reduce provider willingness to accept Medicaid [8]. Further, in the wake of the Affordable Care Act, CMS intentionally increased Medicaid reimbursement rates for primary care to parity with Medicare rates to promote primary care access for current and newly eligible Medicaid beneficiaries [18].

Findings from our comparative study highlight the disparity between Medicaid and Medicare reimbursement rates for abortion care and support qualitative findings that the rates are inadequate for the service being provided. In states where abortion care is covered, reimbursement rates should align with those of similar reproductive health care services and reflect the significant difference in provision costs for abortions at different gestational ages, especially in the second-trimester.

This study has several limitations. First, extracted data only includes the amount that is reimbursed for the abortion procedure and does not include other associated fees that may be reimbursed. Second, we are not able to present data on the number of procedures that were reimbursed at these rates. Finally, while 31% of non-hospital abortions and 45% of abortions before nine weeks are medication abortions, reimbursement data for this service was only available for eight states and therefore not included in our analyses.

5. Conclusion

With more than a third of abortion patients nationwide currently enrolled in Medicaid [19] as well as an increase in laws

expanding state Medicaid coverage of abortion [20], attention to Medicaid reimbursement is critical to ensure access to abortion care. Findings from this study support qualitative reports of low Medicaid reimbursement rates for abortion services and highlight both an inconsistency in reimbursement rates across states and a difference in rates between induced abortion and miscarriage management: two nearly identical reproductive health care services. Given that FFS rates are set by the state, state coalitions will be a necessary part of advocacy to increase reimbursement rates. Future studies in this area should aim to compare reimbursement rates to actual abortion costs, compare how reimbursement for abortion has changed over time in relation to the cost of providing care, and assess reimbursement by MCO plans and private insurance.

Acknowledgements

We acknowledge Samantha Ruggerio, Moria Mahanaimy, Alex Male, and Constance Chang for their assistance with data extraction. This work was funded by an anonymous donor. The funding source was not involved in the development of the study idea, collection of data, analysis, writing of the report, or the decision to submit the article for publication.

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Taxpayer Funding of Abortion and Abortion Businesses

by Connor Semelsberger, MPP

Key Points

The Hyde Amendment, which restricts taxpayer funding of abortion, has had bi-partisan support for over forty years. Democrats now want to repeal it.

The Hyde Amendment has saved an estimated 2,409,311 lives since 1976.

The decades-long consensus against public funding for abortion should not only be maintained but further strengthened to ensure that no taxpayer funding is used to promote or provide abortion as legitimate health care.

Summary

Ever since the Supreme Court handed down its infamous *Roe v. Wade* decision in 1973, legalizing abortion nationwide, a national debate has raged over whether the government should subsidize abortion, the legal practice of terminating the lives of unborn children in the womb.¹ In 1976, Congress took its first definitive action in prohibiting taxpayer funding for elective abortions in Medicaid by passing the Hyde Amendment. Several states have followed suit, passing their own restrictions on abortion funding. However, because government funding is a complex system of joint federal and state programs, completely banning taxpayer funding for abortions and abortion businesses like Planned Parenthood is challenging. There is still much work to be done to free the American taxpayer from subsidizing the horrific practice of abortion.

Federal Funding for Abortions

The Hyde Amendment

In the years following *Roe v. Wade*, the government paid for an estimated 300,000 abortions annually through Medicaid, a joint federal-state program that provides health care coverage for low-income individuals.² The national debate over public funding for abortions rose to the forefront in 1976, when Rep. Henry Hyde (R-Ill.) proposed an amendment to the fiscal year (FY) 1977 *Department of Labor, Health, Education and Welfare Appropriation Act* (H.R. 14232) prohibiting federal Medicaid funds from paying for abortions.³ The amendment was adopted into the base bill and sent to then-President Gerald Ford for signature. However, President Ford vetoed the legislation because it exceeded the proposed budget. In response, both the House (312-93) and the Senate (67-15) voted to override the presidential veto, passing the first federal funding bill that restricted taxpayer funding for abortion into law on September 30, 1976.⁴ It was a major victory to pass an annual spending bill with abortion funding restrictions. However, due to the nature of the federal appropriations process, this amendment must be included in each year's funding bill in order for it to take effect. The federal policy prohibiting the use of taxpayer funds to pay for or subsidize elective abortions has since been known as the Hyde Amendment. A version of the Hyde Amendment has been passed every year since 1976.

However, shortly after the Hyde Amendment's passage, implementation was blocked by a federal court in New York after a Medicaid recipient challenged the constitutionality of the law. In 1977, this case made its way to the Supreme Court in *Califano v. McRae*.⁵ It was ultimately sent back to the district court for further review, which allowed the Hyde Amendment to go into effect temporarily. After further review at the district court, the case made its way back to the Supreme Court. On June 30, 1980, in a 5-4 decision, the Supreme Court ruled in *Harris v. McRae* that the Hyde Amendment did not violate the U.S. Constitution.⁶ Since 1980, the Hyde Amendment has been fully enforced every year, creating a long precedent of prohibiting taxpayer funding for elective abortions.

The passage of the Hyde Amendment would not have been possible without the broad support of Democrat members, as 247 House Democrats and 48 Senate Democrats voted for the final spending package with the Hyde Amendment included.⁷ Notably, Shirley Chisholm, the first African American woman in Congress and a public supporter of legal abortion, voted alongside 16 of her African American colleagues in favor of the 1977 spending package with the first Hyde Amendment. Throughout its history, the Hyde Amendment has received widespread bipartisan support both from Congress and the White House. Every president since Jimmy Carter has signed an appropriations bill with the Hyde Amendment into law.

The historic bipartisan support ended in 2016, when the Democratic National Committee (DNC) decided to include the Hyde Amendment's repeal as a policy priority in its party platform—the first time either party had made such a declaration.⁸ Since then, several Democrat members of Congress have called for repealing the Hyde Amendment, culminating in an effort by Rep. Ayana Pressley (D-Mass.) to offer an amendment to the FY 2021 Labor, Health and Human Services, and Education appropriations bill that would have done just that. The amendment was never voted on, but it has renewed the national debate over whether public funds should pay for elective abortions.

Hyde Adaptations

The Hyde Amendment has taken various forms since its inception. The original version passed in 1976 included exceptions for abortions when the pregnancy threatened the life of the mother. After the original version was upheld in court, Congress passed a new iteration in 1977 that added exceptions for rape and incest victims. After the Supreme Court upheld the original language in 1980, Congress returned to the more limited exceptions (*i.e.*, the life of the mother) in fiscal years 1981 through 1993. Then, with President Bill Clinton in the White House, the exceptions for rape and incest abortions were added back into the annual Hyde Amendment. These exceptions have been included in every version since FY 1994, meaning that the federal government currently pays for abortions when the pregnancy threatens the life of the mother or resulted from rape or incest. The number of abortions and the dollar amount paid out for these abortions is not publicly known. The programs covered by the Hyde Amendment were expanded to apply to health benefits coverage premiums for Medicaid managed care programs in 1998 and the Medicare trust fund in 1999.

Ever since Congress' successful passage of the Hyde Amendment in 1976, the principle of restricting taxpayer funding for abortion has spread to other federal programs. Because the Hyde Amendment is attached to the appropriations bill covering the Department of Health and Human Services (HHS), it restricts funding for all HHS health programs, including Medicare, the Indian Health Service, and the Children's Health Insurance Program. Various other amendments have also been added to the annual appropriations bills, including the Smith Amendment (banning abortion coverage in the Federal Employees Health Benefits Program), the Dornan Amendment (restricting funding of abortions in Washington, D.C.), and other various amendments covering the Department of Defense's TRICARE program, federal prisons, and the Peace Corp.

Tax Subsidies for Abortion

Outside of the annual appropriations bills, which include many good protections against funding for abortions, the IRS code allows abortions to be deducted as a medical expense. Medical care deductions were first enacted in 1942 when abortion was illegal in almost every state. Then in 1973, following *Roe v. Wade*, the IRS adopted Rev. Rul. 73-201, which allows expenses paid for abortion to be deducted as a “medical expense” defined in §213(d)(1)(A).⁹ Because the IRS defines a medical expense to include abortion, this medical deduction essentially acts as a tax subsidy for abortions. The same is true of health flexible spending accounts (FSAs), health savings accounts (HSAs), health reimbursement arrangements, and any other tax-preferred account that uses the definition for medical care in §213(d).

Although some argue that tax-preferred accounts like FSAs and HSAs merely let the user set aside more of their earnings tax-free to be used for specific medical expenses, these arrangements still amount to a taxpayer subsidy inasmuch as the government does not collect taxes on the amounts put aside in these accounts. Furthermore, the money in these accounts can only be used for medical expenses as determined by the government, not any personal expense the user chooses. Because the IRS has defined eligible “medical care” for tax deductions to include abortion alongside services like X-rays or chemotherapy treatments, it is a government endorsement of abortion as legitimate health care.

Pro-life members of Congress have identified this issue in the tax code and have introduced legislation to correct it. The *Abortion is Not Health Care Act* sponsored by Rep. Andy Biggs (R-Ariz.) and Sen. Mike Lee (R-Utah) would clarify §213(d) to make clear that money paid for abortions shall not be treated as a tax-deductible expense.¹⁰ Additionally, in 2020 Rep. Warren Davidson (R-Ohio) and Sen. Mike Braun (R-Ind.) led a letter to the Treasury secretary signed by 103 members of Congress, requesting new regulations that would stop the IRS from defining abortion as medical care for tax deductions.

The Affordable Care Act (ACA) Breaks from the Hyde Amendment Principle

The passage of the ACA (also known as Obamacare) in 2010 directly appropriated federal funds to subsidize health plans that cover elective abortion. It is the largest deviation from the principle behind the Hyde Amendment since 1976.

Senators Ben Nelson (D-Nebr.) and Harry Reid (D-Nev.) offered an amendment to the ACA that included section 1303. This section explicitly allowed elective abortion coverage in these federally subsidized health plans. The ACA directly appropriates taxpayer funds for various health programs and through tax credits that subsidize health plans. Since the Hyde Amendment only covers funds that are

appropriated under the Labor and Health and Human Services (HHS) Appropriations Act, these funds bypass restrictions on abortion funding.

On the surface, section 1303 appeared to be a pro-life solution because it allowed each state to opt-out of abortion coverage in state exchanges. However, the status quo is that all state exchanges allow plans that cover elective abortion unless a state takes executive or legislative action to exclude these plans. As of 2020, 26 states have opted out of covering abortion on their state exchange. Of the 24 states which permit elective abortion coverage in exchange plans, nine exclusively offer health plans that subsidize abortion. Section 1303 also added a “secrecy clause” that prohibits insurers from informing individuals whether a specific plan covers abortion or not. The only way an enrollee can discover if the plan covers abortion is from the summary of benefits they are given. For this reason, Family Research Council and the Charlotte Lozier Institute collaborated to create Obamcareabortion.com, a website that tracks which ACA plans cover abortion.¹¹

- Twenty-six states have opted out of elective abortion coverage in the state-based insurance exchanges: Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin. Individuals living in these states can purchase any plan on the exchange, knowing that none will cover elective abortions.
- Twenty-two states prohibit elective abortion coverage in insurance policies for public employees: Arizona, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Virginia.
- Eleven states have the most pro-life policies, prohibiting elective abortion coverage in private insurance plans in the state as well as on the Obamacare state exchanges: Idaho, Indiana, Kansas, Kentucky, Michigan, Missouri, Nebraska, North Dakota, Oklahoma, Rhode Island, and Utah.

State efforts to ban coverage for elective abortion on their state exchanges is a worthwhile effort. However, the federal taxes collected from residents in those states are still used to subsidize health plans that cover abortion in the remaining states. The ACA directly spends money in the form of advanceable, refundable tax credits to assist low-income individuals in purchasing health care plans on state exchanges, including plans that cover elective abortion. The government may either pay out this “premium tax credit” to a federally approved insurance company to lower out-of-pocket monthly

premiums for qualifying individuals, or individuals can get the tax credit directly when filing taxes.¹² In 2019 alone, the government paid out \$11.8 billion in advanceable premium tax credits for plans that cover abortion on demand.¹³

Section 1303 also set up a separate abortion surcharge payment for any health plan with elective abortion coverage. Everyone enrolled in an ACA plan with elective abortion coverage must pay an abortion surcharge of no less than \$1 to subsidize the abortion coverage, whether they use it or not. This accounting gimmick set up under the Obama administration never followed Section 1303's requirement that abortion surcharge funds must be collected separately and segregated from all other health care premium funds. Fortunately, in December 2019, the Trump administration issued new regulations ensuring that consumers know their health care plan covers abortion and that abortion funding is kept separate from all other covered services.¹⁴ Even with these efforts, a permanent congressional remedy is still needed to ensure that ACA funds do not subsidize elective abortion.

State Funding for Abortions

The Hyde Amendment bans federal funding for abortions in Medicaid and other HHS health programs. However, because Medicaid is a joint federal-state program that provides health care coverage for millions of low-income Americans, states can use state taxpayer funds to cover abortions for Medicaid eligible patients.¹⁵ As with the Hyde Amendment, a legal challenge was brought against state efforts to restrict funding for abortions. However, in 1980, the Supreme Court decided in *Williams v. Zbaraz* that state action to restrict funding for elective abortions is also constitutional.¹⁶ Since then, most states have put in place regulations to restrict state funding for elective abortions. Nevertheless, 16 states currently use taxpayer money to directly fund abortions in their state Medicaid programs.¹⁷ It is important to note that nine of these states do so because of a state court ruling requiring them to fund abortions, but seven of these states have taken voluntary executive or legislative actions to fund abortions with state funds.

Impact of the Hyde Amendment

Restricting taxpayer funding for abortion has had broad support from Americans for many years. The annual Knights of Columbus/Marist polling on attitudes concerning abortion has shown that since 2015, a majority of Americans oppose using tax dollars to pay for abortion. The latest poll from January 2020 shows that 60 percent of Americans, including 35 percent of Democrats, oppose funding abortions.¹⁸ This support has been reinforced by almost every national poll on abortion funding. A 2018

PRRI poll on health care coverage found that 51 percent of Americans believe Medicaid should not pay for abortions, and a 2016 Harvard poll found that 58 percent of likely voters believe the same.¹⁹

The Hyde Amendment is one of the most impactful successes of the pro-life movement. Several peer-reviewed studies have substantiated its impact on directly saving unborn children from the horrors of abortion. A 2009 Guttmacher literature review found that out of 22 peer-reviewed studies, 19 had statistically significant evidence showing that restricting Medicaid funding for abortions reduced the rate of abortion.²⁰ The reviewed studies demonstrated that restrictions on Medicaid funding for abortion, like the Hyde Amendment, lowered abortion rates. However, the studies did not provide details on the number or percentage at which abortions decreased.

Dr. Michael New, a researcher at the Charlotte Lozier Institute, analyzed available data to find the best estimate for lives saved by the Hyde Amendment. The exact language of the Hyde Amendment and state laws on Medicaid coverage for abortion have varied since the Hyde Amendment first passed in 1976, making concrete numbers difficult to calculate. Despite the changing federal and state laws on abortion funding, Dr. New's research estimates that the Hyde Amendment has saved a total of 2,409,311 lives.²¹ It is challenging to capture the real impact of pro-life efforts. Still, nothing has more directly impacted saving unborn children from abortion than the annual passage of the Hyde Amendment.

Taxpayer Funding for Abortion Businesses

Even though the Hyde Amendment and other similar provisions prevent the federal government from funding most abortions, these provisions do not stop federal funds from going to abortion businesses like Planned Parenthood, the nation's largest abortion business. Planned Parenthood reported 345,672 abortions in FY 2019, and is also a massive beneficiary of taxpayer funding. The best data on how much federal funding Planned Parenthood receives comes from a report published by the Government Accountability Office (GAO) every three years. The most recent report, covering 2013-2015, reveals that Planned Parenthood received nearly \$500 million in taxpayer funds in 2015.²² It also reveals that Planned Parenthood's two largest sources of federal funding are Medicaid and Title X.

2015 Federal Funding of Planned Parenthood by Program:

- \$414.37 million – Medicaid
- \$57.28 million – Title X Family Planning Program
- \$5.83 million – Maternal and Child Services Block Grant

- \$5.44 million – Teen Pregnancy Prevention Program
- \$3 million – Obamacare Education Program
- \$2.29 million – Social Services Block Grant
- \$840,000 – Medicare
- \$180,000 – Children’s Health Insurance Program (CHIP)
- \$9.5 million – Miscellaneous grants and contracts

Medicaid

Medicaid is the single largest federal funding stream for Planned Parenthood, and the majority of federal Medicaid funds are paid out to individual Planned Parenthood affiliates, not the Planned Parenthood Federation of America headquarters. Individual Planned Parenthood affiliates will perform health care services like cancer screenings, clinical breast exams, or prenatal services for Medicaid recipients and are reimbursed for those services via the state’s Medical Assistance program. The federal government then reimburses states for a percentage of their total Medicaid Expenditures, called the Federal Medical Assistance Percentage (FMAP), which averages 57 percent of all state paid Medicaid costs. Although the funds abortion businesses receive cannot be used to pay for abortions directly, due to the Hyde Amendment, these funds subsidize the abortion industry by allowing abortion businesses to be reimbursed for the actual health services they perform, which then frees up other money to hire abortionists, pay for abortions, or build abortion facilities. There are several pass-throughs before the federal funds end up in the hands of Planned Parenthood affiliates. However, this still equates to over \$400 million annually in federal funding from Medicaid alone.

In the wake of the 2015 Center for Medical Progress undercover videos, which revealed countless questionable actions by Planned Parenthood affiliates (including the illegal sale of aborted baby body parts), several states took action to exclude them from the Medicaid program. These actions took the form of directives from governors notifying the individual Planned Parenthood affiliates of their exclusion from the program or legislative action prohibiting entities that supply abortions from participating in Medicaid. Nearly all these efforts, however, have been blocked in federal courts because of the Medicaid Statute. 42 U.S.C. 1396a, the code governing the state plans for Medicaid assistance, says that “any individual eligible for medical assistance may obtain such assistance from any institution, agency, community pharmacy or person qualified to perform the service or services required.”²³ In 2016, the Obama administration had sent a letter to state Medicaid Directors that went beyond the current interpretation of the Medicaid statute to direct states that they cannot take action against a provider without evidence of fraud, criminal conduct, substantive noncompliance with state requirements, or some other material issues affecting the providers’ “fitness to perform covered services.”²⁴ Fortunately,

in January 2018, President Trump's administration rescinded this letter because it limited states' ability to establish Medicaid provider standards. However, states have still not had any success in excluding Planned Parenthood from the Medicaid program because of 42 U.S.C. 1396a and 42 C.F.R. § 431.51, which requires that Medicaid recipients may obtain services from any qualified provider that will provide services to them.²⁵ Until the Medicaid statute or current regulations governing the program are amended, it will be challenging for individual states to cut all Planned Parenthood facilities from receiving Medicaid funds.

Title X

The second-largest government funding source for Planned Parenthood is the Title X Family Planning Program. This program was created in 1970 under the Nixon administration to provide funding for voluntary family planning services, including contraception, wellness exams, natural family planning education, breast cancer screenings, and HIV/AIDS testing. The program is administered through grants awarded to both public and private health agencies. In many instances, grants will be awarded to state health agencies and then subgranted to individual health clinics to perform the family planning services. Fortunately, the statute is clear that "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."²⁶ However, at various times over the years, the regulations implementing this program have changed whether abortion businesses are eligible for these family planning grants or not.

In 1993, President Bill Clinton issued regulations that allowed abortion and family planning activities to be co-located at the same facilities and share the same finances. Under these regulations, Planned Parenthood affiliates have received millions of dollars in federal grants, both as a direct grantee and as a subgrantee, by getting Title X funding via state health agencies. States caught on to this direct connection between Title X and abortion facilities and began taking action to cut out abortion businesses from being eligible for their Title X grants. However, in the midnight hour of his administration, President Barack Obama instituted a new regulation that prohibited states from excluding abortion businesses from the program on the basis of them supplying abortions.²⁷ Some states, like Texas and Ohio, had passed legislation with a tiered system for granting Title X funds, with abortion businesses being the last in line to get the money. Still, even these types of laws were called into question under the Obama regulation.

Then in 2017, the new pro-life majority in Congress and the White House began a strong effort to restore the Title X program's original intent of not subsidizing abortions. Congress acted quickly to pass a disapproval resolution of the Obama administration regulation that prevented states from redirecting Title X grants away from abortion businesses. President Trump signed this into law and

then followed with an even stronger action to create a new regulation governing the program. The 1993 Clinton regulations were in place until 2019 when the Trump administration instituted the *Protect Life Rule*, which mandates that abortion must be physically and financially separate from any Title X family planning services. It also removed the requirement that clinics must refer patients for abortions. As a result of these new regulations, Planned Parenthood and other abortion businesses withdrew from the Title X program. They chose abortion over providing women's health services, thereby sacrificing millions of dollars in federal funding.

Looking Ahead: Legislative Efforts

Federal Legislation

In response to the public's overwhelming support of restricting taxpayer funding for abortion, Congress has introduced legislation to make permanent laws against federal taxpayer funding for abortion and abortion businesses. The most comprehensive bill is the *No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act* sponsored by Rep. Chris Smith (R-N.J.) and Sen. Roger Wicker (R-Miss.).²⁸ First, this bill would make the Hyde Amendment (which covers annual LHHS appropriated funds and other annually renewed federal laws that restrict funding for abortion) permanent. If this bill were signed into law, the funding restrictions for abortion and health plans covering abortion would be codified and not be subject to an annual fight throughout the appropriations process. Second, it would apply the principles of the Hyde Amendment to Obamacare, preventing these tax-subsidized health plans from covering abortion.

Representative Vicky Hartzler (R-Mo.) has introduced two bills in the House that would protect taxpayers from funding abortion businesses. *The Protecting Life and Taxpayers Act* would put a sweeping ban on funding abortion businesses by prohibiting tax dollars from being provided (either directly or indirectly through a contract or subcontract) to any entity unless they certify that they will not supply abortions.²⁹ *The Defund Planned Parenthood Act* would place a one-year moratorium on federal funds for Planned Parenthood and any of its affiliates unless they certify that they will not supply abortions.³⁰

Additionally, the *Women's Health and Safety Act* sponsored by Rep. Michael Cloud (R-Texas) and Sen. James Lankford (R-Okla.) would amend the Medicaid statute to give states the ability to exclude abortion businesses from participating in Medicaid.³¹ This bill would provide the necessary legislative fix to allow states to fully cut Planned Parenthood out of the Medicaid program, its largest source of government funding. So far, congressional legislative efforts to defund Planned Parenthood have not

been successful. However, the opportunity remains for Congress to act in fully severing the abortion industry from federal taxpayer funds.

State Efforts

In the absence of strong congressional action to restrict taxpayer funding for abortions, states have stepped in.

- Thirty-four states have passed state Hyde Amendments or have taken administrative action to stop state funds from paying for abortion in Medicaid: Alabama, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

With increased discussions by pro-abortion politicians on Capitol Hill to remove the federal Hyde Amendment, it is critical for states to enact laws or strengthen their existing statutes that prohibit Medicaid funds from paying for elective abortion. Some states have gone even beyond what Congress has done in passing the Hyde Amendment to untangle taxpayer funds from subsidizing the abortion industry.

- Sixteen states have passed laws to exclude abortion businesses from federal Title X family planning grants: Arizona, Arkansas, Florida, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, Ohio, Oklahoma, South Carolina, Tennessee, Texas, and Wisconsin.
- Sixteen states have gone even further to defund abortion businesses from state appropriations or state family planning funds: Arizona, Arkansas, Florida, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, South Carolina, Texas, and Wisconsin.
- Fourteen states have taken legislative or administrative action to exclude abortion businesses like Planned Parenthood from Medicaid: Alabama, Arizona, Arkansas, Florida, Idaho, Indiana, Kansas, Louisiana, Mississippi, Missouri, South Carolina, Tennessee, Texas, and Utah. However, because of the federal Medicaid statute that allows the free choice of provider for Medicaid eligible patients, no state has successfully defunded abortion businesses completely in Medicaid.

Because of the complex system set up under Medicaid, there are several legal hurdles for states attempting to divert federal Medicaid funds away from abortion businesses. However, section 1115 of the *Social Security Act* gives HHS the authority to approve experimental state projects that promote the objectives of Medicaid.³² These section 1115 waivers give states flexibility to design their own state-specific approaches, and some pro-life states have used these waivers as a way to redesign Medicaid family planning programs to not include abortion businesses. In January 2020, Texas was the first state to have its section 1115 family planning waiver program (which diverts federal Medicaid funds away from abortion businesses) approved.³³ Idaho, South Carolina, and Tennessee have also applied for approval of similar programs and are waiting for a determination from the Centers for Medicare and Medicaid Services.

Conclusion

Abortion is an act that ends the life of an innocent human being and can cause lasting physical and mental harm to the mother. Though legal, abortion is morally wrong and should not be endorsed by the government nor subsidized by taxpayers. Public officials from both sides of the aisle have taken steps to prohibit or restrict taxpayer funding for abortions and abortion businesses. This consensus against public funding for abortion, which has existed for decades, should not only be maintained but further strengthened to ensure that no taxpayer funding is used to promote or provide abortion as legitimate health care.

Connor Semelsberger, MPP is Legislative Assistant at Family Research Council.

¹ *Roe v. Wade*, 410 U.S. 113 (1973), <https://www.law.cornell.edu/supremecourt/text/410/113>.

² Julie Rovner, "Abortion Funding Ban Has Evolved Over The Years," NPR, December 14, 2009, accessed September 14, 2020, <https://www.npr.org/templates/story/story.php?storyId=121402281>.

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**March for Life Statement on the Hyde Amendment for House Appropriations Labor,
Health and Human Services (HHS) Subcommittee Hearing
December 8th, 2020**

If the Hyde Amendment were to be eliminated, tragically every state will be required to fund abortion with state tax-dollars since Medicaid is federal matching grant program, and under law requires state subsidization. This includes the up to 35 states that currently exercise their freedom to not fund abortion with residents' taxes.

Joe Biden previously supported the Hyde Amendment banning this practice, but changed his mind last summer after extremists in the party threatened to withhold their support.

In every poll, a plurality of Americans opposes public funding of abortions. In every poll but one, that plurality is a majority. The questions vary, but the results are the same. Respondents support “banning federal funding for abortion” except in rape cases or to save the woman’s life (Politico/Morning Consult, 2019). They believe that “government health insurance programs for low-income women, like Medicaid,” should not “cover abortion” (PRRI, 2018). They oppose “using tax dollars to pay for a woman’s abortion” (Marist, 2019). They oppose allowing “Medicaid funds to be used to pay for abortions” (Politico/Harvard, 2016). When Americans are told that “the Hyde Amendment prohibits federal funds from being used to fund abortions, except in the case of incest, rape or to save the life of the mother,” they endorse the amendment (YouGov, 2016). These polls are not close; the average gap between the pro-funding and anti-funding positions is 19 percentage points.

The Hyde Amendment saves lives - Since its enactment, an estimated 2.13 million lives have been saved due to the Hyde Amendment.

While we still have our work cut out for us to make abortion unthinkable in the United States, the Hyde Amendment has been a policy – perhaps the single most impactful pro-life policy --that has aided in building a culture of life, through education and literally saving over 2 million lives since 1976.

Jeanne Mancini
President
March for Life Education and Defense Fund



December 8, 2020

Submitted Electronically

United States House of Representatives
 House Committee on Appropriations
 Subcommittee on Labor, Health and Human Services, Education, and Related
 Agencies
 2358-B Rayburn House Office Building
 Washington, DC 20515

Re: Hearing on “The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay”

Chairwoman DeLauro, Ranking Member Cole, and Members of the Committee:

On behalf of Americans United for Life, I write in strong support of the Hyde Amendment and its continuing protections for low-income families and their unborn children.

Americans United for Life (AUL) is the first and most active pro-life nonprofit legal advocacy organization in the country. Founded in 1971, before the Supreme Court’s decision in *Roe v. Wade*,¹ AUL has dedicated nearly 50 years to advocating for comprehensive legal protections for human life from conception to natural death and for conscience rights of healthcare professionals and all Americans. To this end, AUL has created model bills protecting rights of conscience in healthcare and prohibiting taxpayer funding for abortion through government programs.² In 1980, AUL attorneys successfully defended the Hyde Amendment—which ensures that federal and state governments do not have to fund elective abortion—before the U.S. Supreme Court in *Harris v. McRae*.³

The Hyde Amendment, named for Illinois Congressman Henry Hyde, is a recurring budget amendment that prohibits federal funds from paying for abortion, including through Medicaid, in most circumstances. It was originally adopted in 1976

¹ 410 U.S. 113 (1973).

² AUL’s model legislation is available on its website here: <https://aul.org/what-we-do/legislation/>.

³ 448 U.S. 297 (1980).

as part of the Department of Health, Education, and Welfare⁴ appropriations bill and has been included in federal law in various forms every single year since.

In 1980, the year *Harris* was decided, it stated:

"[N]one of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service."⁵

It was then—and continues to be now—a necessary protection for the conscience rights of the millions of Americans who oppose taxpayer money being spent on abortions.

After its passage in 1976, the Hyde Amendment was immediately challenged in the courts, testing the scope of the *Roe* decision. In 1980, Americans United for Life attorneys won a momentous victory when the Supreme Court upheld the Hyde Amendment in *Harris v. McCrae*. It also reaffirmed the government's legitimate interest in protecting life (and potential life), even in a post-*Roe* world.

Until recently, the Hyde Amendment was popular; in fact, 107 Democrats voted in favor of the original Hyde Amendment in the U.S. House of Representatives.⁶ After the *Harris* decision, it was seen as prudent public policy and found support among many politicians who also supported a right to abortion. For nearly four decades, the Hyde Amendment was considered a noncontroversial, bipartisan addition to appropriations bills. As a U.S. Senator, Joe Biden voted in support of the Hyde Amendment every year from 1976–2008.⁷ Despite shifting political winds, the Hyde Amendment remains popular with the public. A recent Marist poll found that 54% of Americans oppose taxpayer funding of any kind for abortion.⁸

The Hyde Amendment secures federal funding for life-affirming assistance. Government programs that provide prenatal, birth, and infant care resources are critically important to prevent economic circumstances at the time of

⁴ Since then, these Departments have split into separate agencies. The Hyde Amendment currently is applied to appropriations for the Department of Health and Human Services (HHS).

⁵ *Harris v. McCrae*, 448 U.S. 297, 302 (1980) (quoting Pub. L. 96-123, § 109, 93 Stat. 926).

⁶ *On a Separate Vote in the House, to Agree to the Hyde Amendment to H.R. 14232, Which Prohibits the Use of Funds in the Bill to Pay For or To Promote Abortions*, GovTrack.us (last visited Dec. 8, 2020), <https://www.govtrack.us/congress/votes/94-1976/h952>.

⁷ Zachary B. Wolf, *What Is the Hyde Amendment and Why Did Joe Biden Once Support It?*, CNN (June 6, 2019), <https://www.cnn.com/2019/06/05/politics/what-is-hyde-amendment-joe-biden/index.html>.

⁸ *Marist Poll Finds 5 in 4 Americans Support Substantial Abortion Restrictions*, Knights of Columbus (Jan. 15, 2019), <https://www.kofc.org/en/news/polls/abortion-restrictions-supported.html>.

birth from determining whether a child gets a chance at life. Researchers estimate that it has saved 2.4 million lives over the past four decades.⁹

One such story was told by former-AUL attorney Deanna Wallace, whose single mother received prenatal and postnatal care through Medicaid:

“Policy is not made in a vacuum, and the policy choices we make as a nation deliver a very important message about our values. *The Hyde Amendment sends the positive message that one’s economic status does not determine one’s worth and dignity as a human being.* If we were to abolish the Hyde Amendment, what message would we be sending to poor women — that their unborn children are a problem and abortion is a solution? That the government takes a utilitarian stance on whether the lives of their unborn children have value?”

Our nation has sent a strong message through the Hyde Amendment over the past 41 years and has enabled more than two million Americans to pursue our inalienable rights to life, liberty, and the pursuit of happiness.”¹⁰

Maintaining the Hyde Amendment in federal law is crucial to protecting the conscience rights of millions of Americans, and ensuring that government resources are spent enriching families, not harming women and babies through abortion.

Respectfully,

Katie Glenn
Government Affairs Counsel
Americans United for Life

⁹ Michael J. New, *The Hyde Amendment is Life-Saving and Worth Saving*, National Review (July, 27, 2020), <https://www.nationalreview.com/corner/the-hyde-amendment-is-life-saving-and-worth-saving/>.

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CONCERNED
WOMEN *for* AMERICA
 LEGISLATIVE ACTION COMMITTEE

December 8, 2020

The Honorable Rosa DeLauro
 Chairman
 House Appropriations Subcommittee on
 Labor, HHS, Education and Related
 Agencies
 United States House of Representatives
 Washington, DC 20515

The Honorable Tom Cole
 Ranking Member
 House Appropriations Subcommittee on
 Labor, HHS, Education and Related
 Agencies
 United States House of Representatives
 Washington, DC 20515

Dear Chairman DeLauro and Ranking Member Cole,

Today I write on behalf of the hundreds of thousands of members and supporters of Concerned Women for America Legislative Action Committee (CWALAC) to appeal to this committee and the Congress for a renewed bipartisan commitment to the fundamental principle embodied by the Hyde Amendment: abortion is not health care, and it is not the answer to truly caring for women.

The title of today's hearing, "The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay," is a sad reflection of the brazen attitude toward innocent human life being advanced by the majority party of the 116th Congress. At every turn, the Democrat-controlled U.S. House of Representatives has denied the fundamental impact to, and the care and protection of, vulnerable pre-born children. An innocent child, full of potential, is always part of the abortion equation. The impact to these lives cannot be ignored.

This hearing seeks to legitimize a narrative that abortion is the answer to empowering a pregnant woman facing economic burden or hardship. It asserts that the inability to pay for abortion is the biggest obstacle and detriment to her life. What about the life of her child? What about the physical scarring and emotional wounding that may follow her all the days of her life?

This hearing seeks to dismantle the long-standing (previously) bipartisan Hyde amendment that protects taxpayers from being forced to finance the killing of innocent human life, a value that any humane society should preserve.

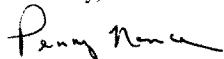
Since 1976, the Hyde Amendment, enacted annually through an appropriations provision, protects federal taxpayer dollars from being used to pay for abortion, except in the case of rape, incest, or to save the life of the mother. The Charlotte Lozier Institute has found that some 2.4 million lives have been saved because of the Hyde amendment, and one in nine children born to mother on Medicaid owes his or her life to Hyde.¹ We must codify and protect this life-saving provision.

¹ Addendum to Hyde @ 40: Analyzing the Impact of the Hyde Amendment, Michael J. New, PhD, July 21, 2020, available at <https://lozierinstitute.org/addendum-to-hyde-40-analyzing-the-impact-of-the-hyde-amendment/>

Regardless of what the Democrat party thinks, women are not a monolithic, single-minded block of people who hold the same views. In fact, annual polls show a strong majority of Americans, men and women alike, oppose taxpayer-funding of abortion.² Six in 10 Americans (60%) oppose tax dollars paying for abortion domestically, which is what the Hyde Amendment assures at the federal level. This includes 89% of those who identify as pro-life, and 37% of those who identify as pro-choice. This is not a partisan issue for the American people.

As you hold this hearing today and debate these issues in the upcoming Congress, CWALAC is committed to representing the voices of millions of women who proudly stand for the sanctity of life and the intrinsic value of every human being created in the image of God, inside and outside the womb. We will not be ignored.

Sincerely,



Penny Nance
CEO & President
Concerned Women for America LAC

² Marist Poll, Americans' Opinions on Abortion, January 2020, available at <https://www.kofc.org/en/resources/news-room/polls/americans-opinions-abortion.pdf>



ADVANCING FAITH, FAMILY AND FREEDOM

December 8, 2020

The Honorable Rosa DeLauro
 Chairwoman
 Committee on Appropriations
 Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies
 2362-A Rayburn HOB
 Washington, DC 20515

The Honorable Tom Cole
 Ranking Member
 Committee on Appropriations
 Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies
 2358-B Rayburn HOB
 Washington, DC 20515

Dear Chairwoman DeLauro and Ranking Member Cole:

On behalf of Family Research Council (FRC) and the thousands of families we represent, I write to express our strong support for the Hyde Amendment, which was the subject of the Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies hearing, *The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay*. Since 1976, the Hyde Amendment has prevented federal funding for abortion—except in cases of rape, incest, and the life of the mother—under Medicaid and other Health and Human Services (HHS) programs. Hyde's removal would substantially increase the number of abortions performed each year and require taxpayers to fund elective abortions for women receiving Medicaid. For these reasons, we strongly support the Hyde Amendment.

Each year, the Hyde Amendment saves thousands of unborn babies' lives. Between 1973 and 1977, the years between the *Roe v. Wade* decision and Hyde's passage, the federal government funded 300,000 abortions per year under Medicaid.¹ In stark contrast to that, in 2015, the federal government funded 153 abortions, all of which fell under the Hyde Amendment's rape, incest, and life of the mother exceptions.² A 2007 Guttmacher report indicated Hyde's ban on federal funding for elective abortion has prevented between 18–35 percent of women from having an abortion.³ In other words, unrestricted federal funding for abortion would have increased the number of abortions by 25 percent. The Hyde Amendment saves lives. Its removal will not increase health care; it will increase the number of unborn babies killed.

Furthermore, Hyde's removal would require taxpayers to fund the killing of an unborn child. Although the country is divided on whether abortion should be legal, the majority of Americans

¹ See Statement of the Department of Health, Education and Welfare, "Effects of Sec. 209, Labor-HEW Appropriations Bill, H.R. 14232," June 25, 1976; John Thomas Noonan, *A Private Choice: Abortion in America in the Seventies* (Toronto: Life Cycle Books, 1979); ch. 12, fn. 6.

² FY 2017 Moyer Report, Addendum: Abortion-Related Reporting, submitted by the Office of the Assistant Secretary for Financial Resources, U.S. Department of Health and Human Services, February 22, 2016, p. 10.

³ Heather D. Boonstra, "The Heart of the Matter: Public Funding Of Abortion for Poor Women in the United States," *Guttmacher Policy Review* 10, no. 1 (2007): 12–16.

oppose taxpayer funding for abortion. From its inception in 1976, the Hyde Amendment has received bipartisan support.⁴ The majority of the American people are still in favor of this amendment. A 2020 Marist poll found that 60 percent of Americans, including 37 percent of people who identify themselves as pro-choice, oppose taxpayer funding of abortion.⁵ Notably, the Hyde Amendment does not attempt to restrict abortion; it simply states that American taxpayers should not be required to fund a practice that takes the life of an innocent unborn child.

Since its bipartisan passage in 1976, the Hyde Amendment has saved the lives of over two million unborn children.⁶ This amendment defends the unborn and protects taxpayers from paying for abortions against their will. As noted in our recent publication, *Taxpayer Funding of Abortion and Abortion Businesses*,⁷ FRC strongly supports the Hyde Amendment, and we urge you to do the same.

Thank you for your time and consideration. We implore you to see the implications of this issue for the protection of all human life. Should you need any more information, please do not hesitate to contact us.

Sincerely,

Travis Weber
Vice President for Policy and Government Affairs

⁴ Connor Semelsberger, "Taxpayer Funding of Abortion and Abortion Businesses." Family Research Council, December 2020, downloads.frc.org/EF/EF20L09.pdf.

⁵ "Americans' Opinions on Abortion," Knights of Columbus, January 22, 2020, accessed December 8, 2020, <http://www.kofc.org/en/news-room/polls/americans-opinions-abortion.html>.

⁶ Michael J. New, "Hyde @ 40 – Analyzing the Impact of the Hyde Amendment," Charlotte Lozier Institute, September 2016. https://lozierinstitute.org/wp-content/uploads/2016/09/OP_hyde_9.28.3.pdf

⁷ Connor Semelsberger, "Taxpayer Funding of Abortion and Abortion Businesses," Family Research Council, December 2020, downloads.frc.org/EF/EF20L09.pdf.

House Committee on Appropriations, Subcommittee: Labor, Health and Human Services,
Education, and Related Agencies

"The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay"
December 8, 2020, 10 a.m.

For Submission to the Record

Melanie Israel, Research Associate, The Heritage Foundation

This appeared in The Daily Signal on December 8, 2020

Pro-abortion Democrats, led by Rep. Rosa DeLauro, D-Conn., are renewing their attempts force taxpayers to fund elective abortions by attacking the Hyde Amendment.

The attack came on Tuesday during a subcommittee hearing of the powerful Appropriations Committee for the House of Representatives, entitled "The Impact on Women Seeking an Abortion but Are Denied Because of an Inability to Pay," in which DeLauro, the incoming committee chair, expressed her intent to no longer incorporate the Hyde Amendment into annual appropriation bills.

What is the Hyde Amendment, and why does it matter? And importantly, what does the absence of the Hyde Amendment mean for taxpayers if congressional Democrats and the abortion lobby get their way?

One of the pro-life movement's first victories following the *Roe v. Wade* and *Doe v. Bolton* decisions in 1973, which effectively legalized abortion on-demand across the country, came about thanks to Rep. Henry Hyde, R-Ill., in 1976. He championed an amendment to the annual Labor, Health and Human Services, Education, and Related Agencies funding bill, which prohibited the department from expending taxpayer dollars for most abortions.

Since then, similar language has been included in annual appropriation bills for the U.S. Department of Health and Human Services and other departments, and was held constitutional by the Supreme Court in 1980.

This important guardrail has, for 44 years, ensured that taxpayer dollars do not pay for most abortions (the language includes an exception for rare instances of rape or incest, for example). Under its first iteration, the amendment applied to the Medicaid health program. Since then, the similar language has been incorporated to apply funding restrictions in other services and programs including Medicare, TRICARE, the Federal Employees Health Benefits Program, and the Children's Health Insurance Program.

The Hyde Amendment has saved an estimated 2.4 million lives since 1976. These lives aren't abstractions—they're real people that we live and work alongside each day. They have gone on to have families and children of their own, faced trials and challenges, achieved victories small and large in their homes and their communities.

These lives are more than a statistic. Each and every one of these 2.4 million individuals has immeasurable worth and dignity. The Hyde Amendment saved roughly 60,000 lives in 2019 alone, and about 30,000 through the first half of 2020.

If congressional Democrats have their way and the Hyde Amendment is no longer incorporated in annual appropriations bills—which DeLauro and House Speaker Nancy Pelosi have said will be the case—thousands of unborn boys and girls will pay the price.

The only thing standing between the Hyde Amendment and pro-abortion members of Congress might be the Senate. However, the exact makeup of the Senate remains an open question. If pro-life policymakers hold the majority in the upper chamber, they will have an opportunity to reject calls to do away with the Hyde Amendment during spending negotiations, and they should do so unequivocally.

The Hyde Amendment is good policy as a matter of principle. It is also a popular policy, too. After all, six in 10 Americans oppose taxpayer funding for abortion, including 42% of independents and one-third of Democrats.

So why the calls to do away with a popular, consensus policy? Three words: the abortion lobby.

Radical and well-funded actors like Planned Parenthood, NARAL Pro-Choice America, and others have exerted increasing influence on the left in recent years. As a presidential candidate, Joe Biden even reversed his decades-long history of supporting the Hyde Amendment and abandoned his long-held position in light of the left’s new abortion orthodoxy.

Congressional policymakers must stand firm in the upcoming 117th Congress and reject all attempts to force American taxpayers to pay for elective abortions. And the pro-life movement should continue its good work supporting women facing unplanned pregnancies and difficult circumstances.

According to a recent Charlotte Lozier Institute report, last year roughly 2,700 pro-life pregnancy resource centers served 2 million people, provided 486,000 free ultrasounds, offered 291,000 clients parenting and prenatal education programs, and provided millions of supplies, such as diapers and clothing for babies.

The Hyde Amendment is a life-saving policy. Rather than repeal it, Congress should make it permanent law by enacting the No Taxpayer Funding for Abortion Act. Millions of fellow Americans are with us today thanks to the amendment’s continued presence in federal funding bills.

Congress must reject attempts to change course, and the pro-life movement must continue its efforts to provide women, children, and families with the tools and resources—not abortion—that they need to flourish and thrive.

Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality

| Isabelle L. Horon, DrPH

The magnitude of the problem of maternal mortality is underestimated when mortality rates are based only on maternal deaths reported on death certificates. Studies have shown that physicians completing death certificates after a maternal death fail to report that the woman was pregnant or had a recent pregnancy in 50% or more of these cases.¹⁻³ Because a history of pregnancy must be recorded on a death certificate for a death to be coded as resulting from a maternal cause, these deaths are not included in the calculation of maternal mortality rates. This leads to an underestimation of the problem of maternal mortality on both the state and national levels because death certificate data collected by states are used to compute maternal mortality rates for the nation.

Previous research has shown that the completeness of reporting of deaths related to pregnancy can be improved by linking death records of women of reproductive ages with birth and fetal death records⁴⁻⁶ and through the use of a check box on the death certificate to indicate that a decedent was pregnant at the time of death or had recently been pregnant.⁷ Other studies have shown that review of medical examiner records is successful in identifying deaths that were not ascertained through other sources, particularly those among women who were pregnant at the time of death.^{8,9} Studies that have used medical examiner records to study pregnancy-associated mortality have focused on pregnancy-associated deaths, defined as deaths from any cause during pregnancy or within 1 calendar year of delivery or pregnancy termination.¹⁰ Because maternal deaths, as defined below, are a subset of pregnancy-associated deaths, review of medical examiner records to identify maternal deaths should also improve the completeness of maternal death reporting.

The purpose of this study was to determine the extent to which maternal deaths are underreported on death certificates by using both linkage of records and review of medical

Objectives. I studied the extent to which maternal deaths are underreported on death certificates.

Methods. We collected data on maternal deaths from death certificates, linkage of death certificates with birth and fetal death records, and review of medical examiner records.

Results. Thirty-eight percent of maternal deaths were unreported on death certificates. Half or more deaths were unreported for women who were undelivered at the time of death, experienced a fetal death or therapeutic abortion, died more than a week after delivery, or died as a result of a cardiovascular disorder.

Conclusions. The number of maternal deaths is substantially underestimated when death certificates alone are used to identify deaths, and it is unlikely that the *Healthy People 2010* objective of reducing the maternal mortality rate to no more than 3.3 deaths per 100 000 live births by 2010 can be achieved. Increasing numbers of births to older women and multiple-gestation pregnancies are likely to complicate efforts to reduce maternal mortality. (*Am J Public Health*. 2005;95:478-482. doi:10.2105/AJPH.2004.040063)

examiner records to identify unreported maternal deaths. The overall undercount of maternal deaths was estimated, sources of identification of deaths were reported, and the degree of underreporting among subgroups of the population was described.

METHODS

The World Health Organization (WHO) definition of a maternal death was used to identify deaths for inclusion in this study because this is the definition used by the National Center for Health Statistics (NCHS) to compile national maternal mortality statistics. WHO defines a maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."¹¹ This definition includes deaths assigned to the cause "complication of pregnancy, childbirth and the puerperium" (*International Classification of Diseases, Ninth Revision [ICD-9]* codes 630-676¹¹ and *Tenth Revision [ICD-10]* codes O00-O95, O98-O99, and A34).¹²

Data were collected from 3 sources: (1) review of death certificates to identify those records on which a complication of pregnancy, childbirth, or the puerperium was listed as an underlying or contributing cause of death; (2) linkage of death certificates of reproductive-age women with live birth and fetal death records to identify a delivery within 42 days of death; and (3) review of medical examiner records for evidence that a woman was pregnant at the time of death or experienced a recent pregnancy. Data were collected for all maternal deaths occurring during the years 1993 through 2000.

Vital records data were obtained from the Vital Statistics Administration of the Maryland Department of Health and Mental Hygiene. Death records were identified by searching for records on which a complication of pregnancy, childbirth, or the puerperium was listed as an underlying or contributing cause of death. For the years 1993 through 1998, this included all deaths with *ICD-9* codes 630 through 676. Because Maryland and the remainder of states began using *ICD-10* codes beginning with 1999 mortality data,¹³ all deaths with *ICD-10* codes O00 to O95, O98 to O99, or A34 were included for the years 1999 and 2000.

Changes were made in the classification of maternal deaths between *ICD-9* and *ICD-10*. *ICD-9* classified a death as having a maternal cause only if pregnancy was reported as part of the sequence of events leading to death. These deaths are classified as maternal in *ICD-10* as well. However, the coding rules for *ICD-10*, unlike the rules for *ICD-9*, classify deaths aggravated by pregnancy as maternal deaths. This includes deaths from previously existing diseases and deaths from nonobstetric conditions that developed during pregnancy and were aggravated by physiological effects of pregnancy.¹³ To account for this discontinuity in the rules for classifying deaths as having a maternal cause, records for all deaths occurring before 1999 were recoded using *ICD-10* rules. The study group therefore includes 16 deaths occurring between 1993 and 1998 that would not have been classified as maternal deaths using *ICD-9* rules. Late maternal deaths (deaths occurring 43 days through 1 year after termination of pregnancy) were not included in the study group.

Identification of maternal deaths through linkage of vital records was performed by matching death certificates for all women of reproductive age against live birth and fetal death records to identify pregnancies occurring within 42 days of death. Records were linked by matching either the mother's social security number or the mother's name and date of birth on the death record with corresponding information on live birth and fetal death records. All linked records were manually reviewed to ensure accurate matching.

Medical examiner records were reviewed for all women aged 10 through 50 years who died between 1993 and 2000. Death certificates were obtained for all women for whom medical examiner records identified an undelivered or recent pregnancy.

All death certificates that were identified through linkage of records or review of medical examiner records were reviewed by a team of 3 board-certified obstetrician-gynecologists and 2 trained nosologists to determine the underlying cause of death that would have been assigned if a history of pregnancy had been reported on the death certificate. All records meeting the WHO definition of a maternal death were included in the study population.

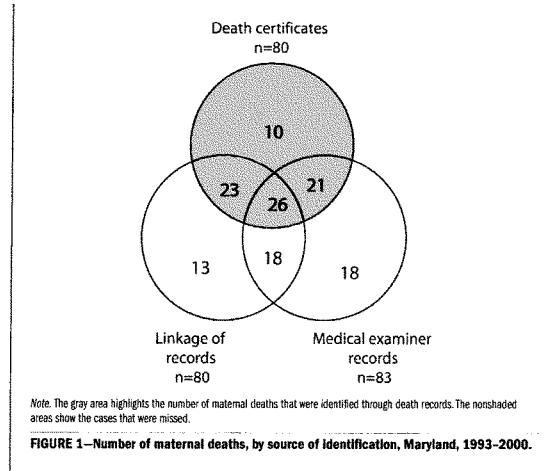


FIGURE 1—Number of maternal deaths, by source of identification, Maryland, 1993–2000.

The distribution of maternal deaths identified through death records alone, and deaths identified from all sources, were compared by outcome of pregnancy, time of death, cause of death, maternal race, age, education and marital status, parity, and plurality.

RESULTS

A total of 129 maternal deaths occurring between 1993 and 2000 were identified from the 3 data sources. Only 80 of these deaths (62.0%) were identified through cause-of-death information obtained from death records (Figure 1). Inclusion of all 129 identified maternal deaths resulted in a maternal mortality rate of 22.2 per 100 000 live births for the years 1993 through 2000, substantially higher than the rate of 13.8 per 100 000 live births based on information reported on death records alone.

A similar number of maternal deaths were identified from each of the 3 data sources (Figure 1). Eighty deaths (62.0%) were identified through death records, 80 (62.0%) through linkage of records, and 83 (64.3%) through review of medical examiner records (Figure 1). Although most deaths were identi-

fied through more than 1 source, 41 deaths (31.8%) were identified through only a single data source. These included 10 deaths (7.8%) identified through death records, 13 deaths (10.1%) identified through linkage of records, and 18 deaths (14.0%) identified through review of medical examiner records.

The number of maternal deaths following a live birth increased from 50 to 80 and the number of deaths following a fetal death increased from 4 to 8 when multiple data sources were used to identify maternal deaths. Death records identified all 8 deaths that occurred as a result of an ectopic pregnancy and the single death that occurred as a result of a molar pregnancy but neither of the 2 deaths that followed a therapeutic abortion. Death records identified only 10 of the remaining 23 deaths among women who were pregnant at the time of death (Table 1).

Among women who were no longer pregnant at the time of death, the percentage of unreported deaths increased with the length of time between delivery or pregnancy termination and death. Six of 28 deaths (21.4%) occurring within 1 day of delivery or pregnancy termination and 6 of 24 deaths (25.0%) occurring 2 through 7 days after delivery were

TABLE 1—Number of Maternal Deaths, by Source of Identification, Outcome of Pregnancy, Time of Death, and Cause of Death: Maryland, 1993–2000

	Source of Identification		Maternal Deaths Unreported on Death Records (%)
	Death Records	All Sources*	
Total deaths	80	129	38.0
Outcome of pregnancy			
Live birth	50	80	37.5
Fetal death	4	8	50.0
Therapeutic abortion	0	2	100.0
Ectopic pregnancy	8	8	0.0
Molar pregnancy	1	1	0.0
All other undelivered	10	23	56.5
Unknown	7	7	0.0
Days from delivery to death			
Undelivered	16	28 ^b	42.9
0–1 day	22	28	21.4
2–7 days	18	24	25.0
8–14 days	8	16	50.0
15–21 days	3	8	62.5
22–30 days	3	7	57.1
31–42 days	2	8	75.0
Unknown	9	10	10.0
Cause of death			
Cardiovascular disorders ^c	17	39	56.4
Embolism	15	24	37.5
Hemorrhage	15	17	11.8
Hypertensive disorders	15	19	21.1
Infection	5	8	37.5
Other	13	22	40.9

*Includes death records, linkage of records, and medical examiner records.

^bIncludes 5 deaths resulting from ectopic pregnancies, 1 death resulting from a molar pregnancy, and 22 deaths among other women who were undelivered at the time of death.

^cIncludes cardiomyopathy, congenital heart disease, pulmonary hypertension, endocarditis, valvular dysfunction, and other cardiac conditions related to or aggravated by pregnancy.

not reported on death records. The percentage of unreported maternal deaths rose to 75.0% for deaths occurring 31 to 42 days after delivery or termination. Twelve of the 28 deaths (42.8%) that occurred among women who were pregnant at the time of death were not reported on death records. This figure included 5 deaths resulting from ectopic pregnancies, 1 death resulting from a molar pregnancy, and 22 deaths among other women who were undelivered at the time of death.

Deaths were underreported on death records for all leading causes of maternal death. The percentage of unreported deaths was highest for cardiovascular disorders (56.4%),

followed by embolism and infection (37.5% each), hypertensive disorders of pregnancy (21.1%), and hemorrhage (11.8%).

On the basis of information reported on death certificates, it appeared that cardiovascular disorders, embolism, hemorrhage, and hypertensive disorders of pregnancy were each responsible for a similar proportion of maternal deaths. However, when previously unreported deaths were included, cardiovascular disorders were clearly the leading cause of maternal death, responsible for 39 of 129 deaths (30.2%). Embolism, the second leading cause of death, was responsible for 18.6% of deaths, whereas hypertensive disorders of

pregnancy, the third leading cause, were responsible for 14.7% of deaths.

Maternal deaths were underreported for all categories of maternal race, age, education, marital status, parity, and plurality (Table 2). The percentage of unreported deaths was particularly high for women at the extremes of the maternal age distribution; half of all maternal deaths among teenagers and more than half of all maternal deaths among women aged 40 and above were unreported.

DISCUSSION

Today, maternal deaths are relatively rare events in developed countries. Nevertheless, maternal deaths still occur, frequently among young, apparently healthy women, and they have a devastating impact on the families left behind. Furthermore, for each woman who dies, many more experience life-threatening and often long-lasting complications.¹⁴

This study supports the findings of earlier studies that have shown that the number of maternal deaths is substantially underestimated when death certificates alone are used to identify deaths. In Maryland, collection of maternal death data from multiple sources showed that the maternal mortality rate in Maryland for the years 1993 through 2000 was 22.2 per 100 000 live births, 60.9% higher than the rate of 13.8 per 100 000 based only on information reported on death records. If maternal deaths are assumed to be underreported at the same level nationally as they are in Maryland, the maternal mortality rate for the United States for the year 2001 would have been 15.9 per 100 000 live births, substantially higher than the reported figure of 9.9 per 100 000.¹⁵ Because it is possible that not all maternal deaths were identified in this study even by using additional data sources, the adjusted rates of 15.9 per 100 000 for the nation and 22.2 per 100 000 for Maryland may also be underestimates of the true figures.

It is unlikely that the *Healthy People 2010* objective of reducing the maternal mortality rate to no more than 3.3 deaths per 100 000 live births by 2010¹⁶ can be achieved, especially because the number of women in 2 groups at increased risk of maternal death—women of advanced maternal age and women with multiple-gestation pregnancies—

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TABLE 2—Number of Maternal Deaths, by Source of Identification and Selected Maternal and Pregnancy Characteristics: Maryland, 1993–2000

Maternal and Pregnancy Characteristics	Source of Identification		Maternal Deaths Unreported on Death Records (%)
	Death Records	All Sources*	
Maternal race			
White	37	60	38.3
African American	42	67	37.3
All other races	1	2	50.0
Maternal age, y			
<20	5	10	50.0
20–24	12	19	36.8
25–29	16	28	42.9
30–34	23	37	37.8
35–39	19	23	17.4
>39	5	12	58.3
Maternal education (aged ≥ 20 y)^b			
<12 y	10	15	33.3
12 y	29	52	44.2
Some college	13	21	38.1
College graduate/graduate school	16	23	30.4
Marital status			
Married	37	58	36.2
Unmarried	43	70	38.6
Not stated	0	1	...
Live birth order			
1st child	20	30	33.3
2nd child	15	25	40.0
3rd child	8	15	46.7
4th child and over	8	14	42.9
Not stated	29	45	...
Plurality^c			
Singleton	53	87	39.1
Twin or multiple	4	7	42.9
Unknown	23	35	...

*Includes deaths identified from death records, record linkage, and review of medical examiner records.

^bFigures include data for women aged 20 years and older because younger women may not have completed their education at the time of death.

^cNumber of fetuses in a pregnancy.

has been increasing. Between 1990 and 2001, the US birth rate increased by 47% for women aged 40 to 44 and tripled for women aged 45 to 49, whereas the twin birth rate increased by 33% and the rate of triplet and higher order births rose by nearly 300%.¹⁷ Both the increase in births among older women and the increase in multiple-gestation pregnancies are attributable in large part to the increased use of fertility-enhancing therapies. Data compiled in the current study showed that the maternal mortality rate for

women aged 40 years and older was 84.5 per 100 000 live births, more than 4 times higher than the rate of 20.7 per 100 000 for all younger women. The maternal mortality rate for women experiencing multiple-gestation pregnancies was 38.5 per 100 000, more than double the rate of 15.5 per 100 000 for women with known singleton pregnancies. However, the true gap between maternal mortality rates for women with singleton and multiple-gestation pregnancies is not as large as these figures would suggest because most

of the 35 pregnancies of unknown plurality were likely to have been singleton pregnancies. Nevertheless, even if all pregnancies of unknown plurality are assumed to have been singleton pregnancies, the recalculated maternal mortality rate of 21.4 per 100 000 for women with singleton pregnancies would remain substantially lower than the rate for women with multiple-gestation pregnancies. Although several studies based on international data have also shown that multiple gestation increases maternal mortality,^{18–20} this association has not previously been shown using US data. Additional study using US data is needed to further explore the association between multiple gestation and maternal mortality because the increasing number of multiple births is likely to complicate efforts to reduce maternal mortality.

The findings of this report show that cardiovascular disorders, which include conditions such as cardiomyopathy, congenital heart disease, pulmonary hypertension, endocarditis, valvular dysfunction, and other cardiac conditions related to or aggravated by pregnancy, are the leading cause of maternal death in Maryland. This is in contrast to national death data compiled by the NCHS, which show the leading causes of maternal death to be hypertensive disorders of pregnancy, hemorrhage, and embolism.¹⁵ The Centers for Disease Control and Prevention's Pregnancy-Related Mortality Surveillance System (PMSS), which compiles national data on pregnancy-related deaths, has historically identified the same 3 leading causes of death.^{21–23} The PMSS data on pregnancy-related deaths, which are defined as all deaths causally related to pregnancy, are based largely on death certificate data provided by state vital records offices. It is likely that cardiovascular disorders have not been identified as a leading cause of maternal death in either NCHS or PMSS data because death records of women dying as a result of this cause frequently do not indicate that they were pregnant or had recently been pregnant. Fewer than half of all deaths resulting from cardiovascular disorders were identified from death records in the present study.

It is critical that physicians who care for pregnant women are aware that a pregnant patient or a patient who has recently given

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birth is more likely to die as a result of a cardiovascular disorder than from any other cause. Cardiovascular disorders may be of particular concern for adolescents; this cause was responsible for 6 of the 10 deaths among 14- to 19-year-olds in this study.

This study has also shown that a larger proportion of maternal deaths occur among undelivered women than previously reported. Although deaths resulting from an ectopic or molar pregnancy were well-reported on Maryland death certificates, more than half of the deaths that occurred among other undelivered women were unreported. Deaths among this subgroup of undelivered women represented 19.3% of all maternal deaths for which the time of death was known, compared with a figure of 11.7% in a recent PMSS report.²⁴

The lack of complete reporting of maternal deaths has led to misconceptions regarding the magnitude of the problem of maternal deaths, the leading cause of death, and the timing of maternal deaths. Death records are an important source of data on pregnancy mortality, but death records alone identify only a fraction of all maternal deaths. New York City and 17 states have attempted to improve ascertainment of pregnancy on death records by including a pregnancy check box or asking about pregnancy status on their death records. In Maryland, questions about pregnancy status in the 12 months preceding death, the outcome of pregnancy, and the date of delivery were added to the Certificate of Death in 2001. The NCHS has recommended use of a single pregnancy question by all states on the revised US Standard Certificate of Death, but it is likely to be a number of years before all states begin using the revised certificate. Currently, comprehensive identification of maternal deaths can be accomplished only by collecting information from multiple data sources. Both data linkage and review of medical examiner records contributed substantially to identification of maternal deaths in Maryland. Linkage of records identified 13 deaths that were not identified through death records or review of medical examiner records. Review of medical examiner records identified 18 deaths that could not be identified through death records or linkage of records, including 56% of all deaths among women who were undelivered

at the time of death, 21% of embolism deaths, 18% of cardiovascular deaths, and both deaths that followed therapeutic abortions. Review of paper copies of medical examiner records to identify maternal deaths can be a labor-intensive process. Fortunately, medical examiner records are increasingly becoming computerized, which will make the identification of women who were pregnant at the time of death or were recently pregnant a far less time-consuming process. We hope that this will encourage the use of medical examiner records for routine surveillance of deaths related to pregnancy. ■

Comprehensive identification of maternal deaths is necessary to determine the magnitude of maternal mortality, identify the major causes of death, and identify groups at increased risk of death. Without a clear understanding of these factors, it is not possible to develop comprehensive strategies to prevent this devastating pregnancy outcome. ■

About the Author

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This article was accepted May 18, 2004.

Acknowledgments

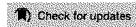
The author gratefully acknowledges Dr Diana Cheng for her guidance, support, and thoughtful review of this article, and Dr Robert Hayman for assistance with linkage of data.

Human Participant Protection

No protocol approval was needed for this study.

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Article



Induced Abortion and the Increased Risk of Maternal Mortality

The Linacre Quarterly
2020, Vol. 87(3) 302-310
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sagepub.com/journals-permissions
DOI: 10.1177/0024363920922687
journals.sagepub.com/home/lqr



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Abstract

After years of failure to obtain accurate statistics on maternal mortality, the United States noted a sharp increase in its maternal mortality rate with widening racial and ethnic disparities. The 2016 report shocked the nation by documenting a 26 percent increase in maternal mortality from 18.8/100,000 live births in 2000 to 23.8 in 2014. Suggested etiologies of this increase included artifact as a result of improved maternal death surveillance, incorrect use of *ICD-10* codes, healthcare disparities, lack of family support and other social barriers, substance abuse and violence, depression and suicide, inadequate preconception care, patient noncompliance, lack of standardized protocols for handling obstetric emergencies, failure to meet expected standards of care, aging of the pregnant patient cohort with associated increase in chronic diseases and cardiovascular complications, and lack of a comprehensive national plan. While some of the increase in maternal mortality may be a result of improved data collection, pregnancy-related deaths are occurring at a higher rate in the United States than in other developed countries. Some have suggested that the increased maternal mortality is due to limiting women's access to legal abortion. In order to discover effective strategies to improve pregnancy outcomes, maternal mortality must be investigated in an unbiased manner. This review explores the relationship between legal-induced abortion and maternal mortality.

Summary: In Finland, where epidemiologic record linkage has been validated, the risk of death from legal induced abortion is reported to be almost four times greater than the risk of death from childbirth. It is difficult to do this comparison in the United States not only because prior induced abortion history is often not recorded for a pregnancy-related death but also because less than one-quarter of the states require health care providers to report abortion deaths for investigation. These omissions are important because mortality risk in pregnancies subsequent to abortion is increased due to abortion-induced morbidities such as preterm birth and abnormal placentation. Legal induced abortion is a root cause of the racial and ethnic disparity noted in maternal mortality. In the United States, the death rate from legal induced abortion performed at 18 weeks gestation is more than double that observed for women experiencing vaginal delivery.

Keywords

Abortion, Abortion complications, Abortion-related mortality rate, Contextual-level social determinants of health, Incestuous citing, Maternal mortality, Maternal mortality ratio, Placenta accreta, Structural inequality, Women's reproductive issues

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In order to help identify pregnancy-related deaths, the Division of Vital Statistics at the National Center for Health Statistics modified the United States Standard Certificate of Death to include a question about pregnancy status in 2003. The states were so inconsistent applying it that an official maternal mortality report was not published from 2007 until 2016 (MacDorman et al. 2016). The 2016 report on 2014 data documented that maternal deaths had increased to 23.8/100,000 live births (Joseph et al. 2017), the highest of any developed country. The health departments of individual states now sponsor ongoing maternal mortality review committees. Identifying root causes will lead to the development of effective strategies to improve pregnancy outcomes.

The maternal mortality review committees report that 60 percent of these deaths may be preventable (Brantley et al. 2018). Even though they target the lack of standardized protocols for managing obstetrical emergencies as a root cause (*HRSA Maternal Mortality Summit 2019*), some healthcare professionals have suggested that the increase in maternal mortality is due to limiting women's access to abortion. Maternal mortality must be investigated in an unbiased manner to identify all contributing factors including the relationship between legal induced abortion and maternal mortality.

Classification of Maternal Deaths

The World Health Organization reports only deaths occurring during pregnancy or within forty-two days of the end of pregnancy in defining maternal mortality, while the Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC) reports all pregnancy-related deaths occurring within one year of the end of pregnancy.

Deaths are categorized based on their causation and proximity to the end of the pregnancy:

- "Maternal death" is the death of a woman while pregnant or within forty-two days of the end of her pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, excluding accidental or incidental causes.
- "Late maternal death" is the death of a woman from direct or indirect obstetric causes more than 42 days but within 365 days of the end of pregnancy.
- "Pregnancy-related death" is the death of a woman while pregnant or within 365 days

of the end of pregnancy, in which pregnancy may have contributed to the cause of the death.

- "Pregnancy-associated death" is the death of a woman while pregnant or within 365 days of the end of pregnancy from a cause that is either not related to pregnancy or pregnancy relatedness cannot be determined.

Maternal Mortality Estimates

Maternal deaths are investigated to identify root causes and develop effective preventive interventions. The maternal mortality rate that has been used is the number of maternal deaths per 100,000 women of reproductive age (Roser and Ritchie 2020). Because epidemiologists prefer to compare adverse outcomes to the number of at-risk individuals, an ideal mortality rate could be achieved by calculating the number of maternal deaths/100,000 pregnancies. Calculating this mortality rate is impossible because the numbers of spontaneous pregnancy losses are not known and induced abortion data are not available.

Maternal Mortality Ratio

Since the number of live births can be accurately measured due to mandated reporting on birth certificates, epidemiologists assume that the number of live births is a good representation of the number of pregnancies (Patel, Burnett, and Curtis 2003). This led to the development of the maternal mortality ratio, defining it as the number of deaths/100,000 live births. While two-thirds of maternal deaths occur in conjunction with a live birth (Jatlaoui et al. 2018), the rest may be separated from the end of pregnancy by days, weeks or even months and include spontaneous and induced pregnancy losses. Studies show as many as 50 percent of maternal deaths may be missed on death certificates in the United States (Horon 2005). It is not possible to accurately calculate the maternal mortality ratio without this information.

Racial and Ethnic Disparity

Maternal mortality in minority women, particularly non-Hispanic black women, has skyrocketed. Black women have a maternal mortality ratio 330 percent higher than white women (Petersen et al. 2019). Some argue that this is a result of implicit racism—the care provided to black or poor women is not as good as the care provided to non-Hispanic white women or affluent women.

Limiting the discussion to implicit racism does a disservice to women of color and women in poverty by ignoring other factors that contribute to maternal mortality.

Social Determinants

Poverty is a risk factor for failure to obtain appropriate medical care and may contribute to the racial disparity: 20 percent of black women live in poverty compared to 16 percent of Hispanic women and 8 percent of non-Hispanic white women. Only 5 percent of married couples live in poverty. In 2017, 67 percent of black women were unmarried when they gave birth compared with 39 percent of Hispanic women and 27 percent of white women ("Births to Unmarried Women" 2018). Prior to 1950, a black woman was more likely to be married than a white woman, with marriage rates nearing 80 percent, but marriage rates for black women have plummeted (Ricketts 1989). Giving birth and caring for a child without a partner places a woman at obvious disadvantage. If she should become ill, she may not seek emergency care due to lack of social support, childcare, or transportation. Violence is also more prevalent. Illinois reported that 13 percent of its maternal deaths were the result of homicide. While 14 percent of the population identifies as non-Hispanic black, these mothers accounted for 43 percent of the maternal homicide deaths (Koch, Rosenberg, and Geller 2016). Three of the main causes of maternal mortality in Texas were drug overdose, homicide, and suicide, accounting for almost 20 percent of the deaths (Baeva et al. 2018). Poverty and the lack of social and family support are causes of the disparity in maternal mortality ratios.

Diabetes, Hypertension, and Obesity

These social determinants of health are important. Poverty is linked to obesity, diabetes, and hypertension. Obesity is more prevalent in black (46.8 percent) and Hispanic (47 percent) populations than in the white population (37.9 percent; Hales et al. 2017). Diabetes is higher in blacks (12.7 percent) and Hispanics (12.1 percent) than in non-Hispanic whites (7.4 percent; CDC 2017). The rate of hypertension is higher among blacks (40.4 percent) compared to non-Hispanic whites (27.4 percent) or Hispanics (26.1 percent; CDC 2013). Preexisting hypertension increases the likelihood that a woman will develop preeclampsia or

eclampsia during her pregnancy. Obesity, diabetes, and hypertension predispose women to early obstetrical interventions and Cesarean sections, both of which are linked to increased maternal mortality.

Legal induced Abortion

Differences in pregnancy outcomes may affect maternal mortality risk. The rates of natural losses are similar (16 percent), but 34 percent of pregnancies in black women end in induced abortion compared to 11 percent for non-Hispanic white women. Black women more commonly have later abortions (13 percent) compared with non-Hispanic white women (9 percent; Jones and Finer 2012). The risk of death from legal abortion increases by 38 percent for every week after eight weeks of gestation (Bartlett, Berg, and Shulman 2004). Induced abortion, often in advanced pregnancy, is documented to lead to increased risk-taking behavior that results in death from drug overdose, suicide, or homicide. Legal induced abortion may be a factor in the racial disparity observed in pregnancy-related mortality.

Implicit Racism, Explicit Misogyny

A ten-year Harvard study completed in 2016 found that implicit bias based on race decreased by 17 percent, and explicit bias decreased by 37 percent (Charlesworth and Banaji 2019). If racial bias were a major cause, pregnancy-related mortality in the non-Hispanic black community should have decreased. It has not. To discuss social determinants of disparity without identifying antecedent enslavement and other factors unique to this demographic group is implicit bias, promoting the idea that black and nonblack women start on an equal playing field. It ignores the legacy of family disruption by enslavement's forced displacement as well as governmental programs that have undermined the intact family unit. The effects of legalized racism are still apparent in structural inequality and the resultant of high prevalence of poverty. It confirms the stereotype that black women, through their behavior, place themselves far behind the rest of the population.

Victim blaming diverts attention from racism, discrimination, segregation, and the powerlessness of the ghetto. Abortion advocacy organizations have a long history of targeting minority communities with inappropriate adventures such as placing abortion clinics in black neighborhoods. Abortionists are opportunists, nonresidents seeking gain by taking advantage of communities of color. Compounding

structural inequality, abortion advocates effectively perpetuate inveterate suppression. Induced abortion may be a root cause of pregnancy-related mortality disparity. Nowhere in America has the lack of respect for women been more prevalent and damaging than in the black community (WHO Working Group on Maternal Mortality and Morbidity Classification 2012). It is critical to address these contextual-level social determinants of health to eliminate this disparity.

Determining Pregnancy Deaths

The CDC relies on death certificates to determine maternal deaths, but death certificates have been proven unreliable in identifying all maternal deaths. Deaths due to live births are the most accurately recorded because most live births occur in a hospital setting or with the assistance of medical personnel. However, deaths from other pregnancy outcomes such as induced abortion are not accurately reported.

Information about abortion is often not recorded on death certificates for women of reproductive age. Inconsistent implementation of a pregnancy checkbox on death certificates and search engine failures to provide the *ICD-10* obstetric-specific codes for abortion-related deaths thwart this documentation (Owens 2018). The Texas Maternal Mortality Task Force discovered that more than 50 percent of the maternal deaths identified by *ICD-10* obstetric codes showed no evidence of pregnancy and another 10 percent had insufficient information to determine whether a pregnancy had occurred (Baeva et al. 2018).

Either these deaths were erroneously coded as pregnancy-related or the deaths were subsequent to spontaneous or induced losses early in pregnancy and could not be correlated with fetal birth or fetal death certificates. Independent providers perform almost all abortions in Texas, and their records are not available. In Finland, 73 percent of maternal deaths were not identified on death certificates, demonstrating the clear inadequacy of death certificate data alone (Gissler et al. 2004). The quality of US maternal mortality data is poor.

Determining Induced Abortion Deaths

Published abortion mortality rates are inaccurate because the total number of legal abortions performed in the United States is not known (Studnicki et al. 2017). Estimated numbers of abortions are voluntarily reported to the CDC by state health departments. California, the state with the largest

volume, does not report any data (Jatlaoui et al. 2018). The Guttmacher Institute also tracks abortions, consistently reporting higher numbers than the CDC. The Guttmacher Institute reported 926,000 abortions in 2014, while the CDC reported only 652,639 (Jatlaoui et al. 2017; DREWKE 2017). Twenty-seven states require abortion providers to report complications, but there are no enforcement penalties for noncompliance. Only twelve states require coroners, emergency rooms, and other healthcare providers to report abortion complications or deaths for investigation.

Deaths from Legal Induced Abortion May Not Be Recorded

If an abortion initiates a cascade of events that results in a woman's death, the doctor may not list it on the death certificate. Because most abortion providers lack hospital-admitting privileges, other healthcare providers must provide the hospital care. The physician certifying the death may be unaware of the abortion or mistakenly believe that a miscarriage led to the complications. Furthermore, ideological commitments may lead a certifier to omit this information. Correlating public documentation of malpractice cases with autopsy reports, an investigative reporter was able to document 30 percent more abortion deaths nationwide than the CDC (Reardon et al. 2004). The reported death rate from abortion represents only the tip of the iceberg; it is a problem much larger than it appears.

Legal Induced Abortion: Is It Safe?

There has been widespread misinformation about legal abortion. It seems that deaths rarely occur, and abortion is perceived to be a very safe procedure. When discussing pregnancy-related mortality, one must recognize that physiologic changes begin as soon as a pregnancy commences. Induced abortion interrupts this normal physiology, and there are unique risks due to this intervention (Skop 2019).

Death and Medical Abortion

Animal models of mifeprisone-induced pregnancy termination (medical abortion) warn of the potential for long-term negative well-being indicative of depression and anxiety (Camilleri et al. 2019). While medical abortion accounts for 31 percent of US abortions, it has been associated with 40 percent of legal abortion deaths in the United States (Strauss et al. 2007). Medical abortion may disrupt innate

immunity and fatal cases of septic shock following medical abortion have occurred (Aronoff et al. 2008; Miech 2008).

Death and Surgical Abortion

Severe injuries occur from surgical abortion. Experienced abortionists not infrequently damage adjacent organs or major blood vessels as they insert suction curettes or grasping forceps into the soft, gravid uterus (Autry et al. 2002). The frequency of abortion complications increases as the pregnancy advances due to greater technical complexity related to the anatomical and physiologic changes that occur (Zane et al. 2015). After eight weeks of gestation, the risk of death from abortion increases exponentially: 38 percent increased risk for each additional week (CDC 2017). The American Board of Medical Specialties recognizes the inherent danger of late-term abortions. In 2018, it approved the new American Board of Obstetrics and Gynecology subspecialty "Complex Family Planning" to train abortionists to perform late-term abortions (Marmion 2020). Emergency surgery may be required to perform a hysterectomy, bowel resection, bladder repair, or other repair (Niinimaki et al. 2009). Death from surgical abortion can occur due to hemorrhage, sepsis, pulmonary embolism, and complications of anesthesia such as cardiac or cerebrovascular events.

Abortion and Death in Subsequent Pregnancy

In addition to the immediate physical risks, there are long-term complications that increase a woman's risk of death during a subsequent pregnancy. Forcibly opening a cervix that is designed to remain closed until natural childbirth may result in cervical trauma and cervical incompetence in future pregnancies. Obstetrical interventions for the management of preterm birth raise the risk of maternal mortality. Instrumental trauma to the endometrium may result in faulty adherence of the placenta in subsequent pregnancies. The placenta may invade into the cervix, uterine wall, or adjacent organs. The Placenta Accreta Spectrum (PAS) includes placenta accreta, placenta increta, and placenta percreta. In 1950, the incidence of PAS was 1:30,000 deliveries, but in 2016, the incidence was reported to be 1:272 deliveries (Mogos et al. 2016). This 110-fold increase in incidence raises the risk of pregnancy-related mortality. Occurring in women with a history of uterine surgery, including induced abortion (Baldwin et al. 2018), PAS can cause massive hemorrhage, and

deaths occur even in tertiary hospitals (Klemetti et al. 2012).

Risk of Death in Postabortal Women

Childbirth may have a protective emotional effect, whereas voluntary or spontaneous pregnancy loss may be deleterious (Coleman, Reardon, and Calhoun 2013). A Finnish comprehensive record linkage study reported that, compared with women who carried to term, postabortal women were two to three times as likely to die within a year, six times as likely to commit suicide, four times as likely to die from an accident and fourteen times as likely to be murdered (Karalis et al. 2017).

Legal Induced Abortion Mortality Rate Unknown

Due to restricted data access, poor record keeping, and lack of mandatory complication reporting, the actual induced abortion mortality rate for the United States cannot be determined. Legal or ideological motivation may obscure the initiating event that led to death. The failure of most abortion providers to maintain hospital privileges forces a different hospital-based healthcare provider to treat complications (Reardon and Thorp 2017). It is not possible to link deaths related to early pregnancy events to an infant's birth or death certificate. Even in Finland, a country with single payer healthcare and meticulous record keeping, 94 percent of abortion deaths are not identified on death certificates (Gissler et al. 2004).

Report of the National Academies of Science

In spite of these documented risks of abortion mortality, the National Academies of Science, Engineering and Medicine (NAS) published a report stating that legal induced abortion is extremely safe. They concluded that serious complications or long-term physical or mental health effects are virtually nonexistent; specifically, they denied that abortion increases the risk developing mental health disorders, and they also denied that abortion increases the risk of preterm delivery in subsequent pregnancies. Abortion is so safe, they wrote, that it does not need to be performed by a physician. Trained midlevel practitioners can perform abortions in an office-based setting via telemedicine without the need for hospital admitting privileges, special equipment, or protocols for emergency transport of women with

complications. They wrote that the only risks associated with abortion are the imposition of “barriers to safe and effective care” by some state legislatures (NAS 2018).

Selection Bias

Stringent selection criteria allowed the NAS to exclude the eleven studies that provided results allowing comparison between the death rates associated with all possible pregnancy outcomes. These studies showed that the risk of death within 180 days is over twice as high following abortion compared to delivery, and this risk remains elevated for at least ten years (Deneux-Tharaux et al. 2005). The risk of death in a given year for a woman who was not pregnant was 57/100,000 women, but after an abortion, the risk was 83/100,000, after miscarriage 52/100,000, and for those who carried a pregnancy to term 28/100,000 (Studnicki et al. 2017). Danish studies reported that the risk of death within 180 days after a first trimester abortion was 244 percent higher than the risk of death after childbirth; the risk of death after a late-term abortion was 615 percent higher than that after childbirth (Reardon and Coleman 2012).

“Incestuous Citing”

The NAS allowed abortionists to control the dialogue by only discussing reports authored by them or their aligned organizations. This is known as “incestuous citing,” allowing abortionists to cite each other to prove their points. Planned Parenthood’s 317,000 California abortions were reviewed, yet California refuses to report to the CDC (Upadhyay et al. 2015). The paucity of voluntary reporting nationwide yields the outcome that abortion advocates demand: most abortion complications are never identified. The NAS was aware of its selection bias and should have made a call for more studies, not a categorical dismissal that abortion complications are nonexistent.

Legal Induced Abortion versus Childbirth: Safety

Epidemiologists define the abortion mortality rate as the number of induced abortion procedure deaths/100,000 induced abortions. There are many pregnancy events excluded from the denominator of “100,00 induced abortions” that may result in mortality. If abortion procedure deaths were erroneously or intentionally classified as pregnancy-related

maternal deaths, this would inflate the maternal mortality ratio and decrease the abortion mortality rate. For example, a death from an induced abortion following intentional feticide could be coded as a death caused by a procedure to evacuate an intrauterine fetal demise. Deaths from abortion are underreported and the numbers of abortions are inflated.

Abortion advocates claim that abortion is fourteen times safer than childbirth (Raymond and Grimes 2012). They even argue that since childbirth is so dangerous, abortion should be readily available so women can “opt out” of being pregnant.

A False Equivalence

Is abortion really safer than childbirth? Deaths from abortion are compared to the number of legal abortions while pregnancy-related deaths are compared to the number of live births. Of the four variables used in the abortion mortality rate and the pregnancy-related mortality ratio, the number of live births is the only variable that can be accurately determined. One cannot use three impossible-to-quantify variables to compare two disparate outcomes: it is a false equivalence.

To make a valid comparison, the abortion mortality rate must be compared to a maternal mortality rate. Finland has excellent record linkage, and they are able to compare rates using the common denominator “ended pregnancy.” The risk of death from abortion (101 deaths per 100,000 ended pregnancies) was almost four times greater than the risk of death from childbirth (27 deaths per 100,000 ended pregnancies; Gissler et al. 1997).

A Valid Comparison

It is not possible to use “ended pregnancy” to compare mortality rates in the United States. An outcome-specific measure must be used as the denominator when comparing these rates. This is already done for abortion-related mortality, the number of deaths/100,000 abortions. For childbirth, it should be the number of deaths/100,000 vaginal deliveries. Cesarean sections are excluded for these reasons:

- abortion and most childbirth deliveries are done vaginally and
- abortion may increase the percent of women undergoing Cesarean section in subsequent pregnancies due to preterm birth and abnormal placentation.

Using outcome-specific rates, the mortality rate for vaginal delivery is 3.6 deaths/100,000 vaginal deliveries (Caughey et al. 2014), while the mortality rate for abortion performed at eighteen weeks is 7.4 deaths/100,000 abortions (Niinimaki et al. 2009). Put another way, the risk of death from these abortions is more than double that for women who deliver vaginally.

Conclusion

Biased academic physicians have led the discussion on maternal mortality. These elite abortion advocates publish articles that document "safety" for an industry that profits from widespread abortion access. To increase their credibility, each one quotes the others' poor data. Journal editors are frequently ethically challenged (Silverman 2019), but they must ensure that independent reviewers critically evaluate submissions by academic abortion advocates before publication. The public must not be deluded by the abortion industry as it protects its product by reassuring that abortion is safe, an assertion based on deliberately deceitful and inadequate data. The politics of pregnancy-related mortality and induced abortion must not be allowed to continue to obstruct root cause analyses of maternal mortality.

Authors' Note

Patrick J Marmion and Ingrid Skop contributed equally to the literature review and writing and editing this article. The authors state that the article contents have not been previously presented. The research and opinions presented in this article are solely those of the authors and do not reflect the opinions or policies of Washington State University Elson S. Floyd College of Medicine or Northeast Obstetrics and Gynecology Associates.

Acknowledgment

The authors acknowledge the assistance of Anne Camille Talley, MBA, in proofreading and editing this manuscript.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research and/or authorship of this article.

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December 8, 2020

Dear Committee Members:

We write in regards to the Appropriations LHHS Subcommittee hearing entitled “The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay,” focused on changes to the Hyde Amendment. The National Right to Life Committee, the nationwide federation of 50 state right-to-life affiliates and more than 3,000 local chapters, writes in strong support of the Hyde Amendment.

After *Roe v. Wade* was handed down in 1973, various federal health programs, including Medicaid, simply started paying for elective abortions. By 1976, the federal Medicaid program was paying for about 300,000 elective abortions annually,¹ and the number was escalating rapidly.² On September 30, 1976, an amendment by pro-life Congressman Henry Hyde (R-Ill.) was enacted that prevents federal Medicaid funds from paying for abortions.

The Hyde Amendment is widely recognized as having a significant impact on the number of abortions in the United States saving an estimated two million American lives.³

We believe that the Hyde Amendment has proven itself to be the greatest domestic abortion-reduction measure ever enacted by Congress. Additionally, 60% of Americans have consistently opposed taxpayer funding for abortion.⁴

That is why it was necessary for Congressman Hyde to offer, beginning in 1976, his limitation amendment to the annual Health and Human Services appropriations bill, to prohibit the use of funds that flow through that annual appropriations bill from being used for abortions. In a 1980 ruling (*Harris v. McRae*), the U.S. Supreme Court ruled, 5-4, that the Hyde Amendment did not

¹ Statement of the Department of Health, Education and Welfare, “Effects of Sec. 209, Labor-HEW Appropriations Bill, H.R. 14232,” June 25, 1976.

² The 1980 CQ Almanac reported, “With the Supreme Court reaffirming its decision [in *Harris v. McRae*, June 30, 1980] in September, HHS ordered an end to all Medicaid abortions except those allowed by the Hyde Amendment. The department, which once paid for some 300,000 abortions a year and had estimated the number would grow to 470,000 in 1980 . . .” In 1993, the Congressional Budget Office, evaluating a proposed bill to remove limits on abortion coverage from Medicaid and all other then-existing federal health programs, estimated that the result would be that “the federal government would probably fund between 325,000 to 675,000 abortions each year.” Letter from Robert D. Reischauer, director, Congressional Budget Office, to the Honorable Vic Fazio, July 19, 1993.

³ Michael J. New, Ph.D., *Hyde @ 40 ANALYZING THE IMPACT OF THE HYDE AMENDMENT*

⁴ Marist/Knights of Columbus, survey of 1,237 adults conducted January 7th through January 12th, 2020

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contradict *Roe v. Wade*.

In the years after the Hyde Amendment was attached to LHHS appropriations, the remaining appropriations bills, as well as other government programs, were brought into line with this life-saving policy.

There is abundant empirical evidence that where government funding for abortion is not available under Medicaid or the state equivalent program, at least one-fourth of the Medicaid-eligible women carry their babies to term, who would otherwise procure federally-funded abortions. Some pro-abortion advocacy groups have claimed that the abortion-reduction effect is substantially greater –one-in-three, or even 50 percent.⁵

We strongly urge retention of the Hyde Amendment. Thank you for your consideration of National Right to Life's position on this critical issue.

Jennifer Popik, J.D.
Director of Federal Legislation

⁵ "Discriminatory Restrictions on Abortion Funding Threaten Women's Health," NARAL Pro-Choice America Foundation factsheet, January 1, 2010, citing Rachel K. Jones et al., *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, *Persp. on. Sexual & Reprod. Health* 34 (2002).



Commentary

Perceiving and Addressing the Pervasive Racial Disparity in Abortion

James Studnicki¹ , John W. Fisher¹, and James L. Sherley¹

Health Services Research and Managerial Epidemiology
Volume 7: 1-4
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DOI: 10.1177/2333392820949743
journals.sagepub.com/home/hme

**Abstract**

Black women have been experiencing induced abortions at a rate nearly 4 times that of White women for at least 3 decades, and likely much longer. The impact in years of potential life lost, given abortion's high incidence and racially skewed distribution, indicates that it is the most demographically consequential occurrence for the minority population. The science community has refused to engage on the subject and the popular media has essentially ignored it. In the current unfolding environment, there may be no better metric for the value of Black lives.

Keywords

abortion, racial disparity, Black abortion rate, premature death, YPLL

While induced abortion remains a contentious political issue, there is no credible scientific doubt that a unique human life begins at conception and, therefore, ends with an abortion. Even the Obama administration and the abortion-friendly Bill and Melinda Gates Foundation have acknowledged "the critical importance of a child's first 1,000 days after conception in determining a healthy and productive life trajectory... to ensure that all children... have an equal opportunity to survive and thrive."¹

Yet, the evidence is clear that for many decades Black children in the United States have not had, and do not have today, an equal opportunity to survive until birth. The most recent CDC report on abortion in the United States indicates that, in 2016, the Non-Hispanic Black abortion rate (25.1 abortions per 1,000 women age 15-44) was 3.8 times the Non-Hispanic White rate of 6.6.² One could reasonably hope, given the pattern of declining abortion rates for 3 decades, that the racial disparity in abortion also would be decreasing. However, between 2007-2016, the Black rate declined 29% and the White rate declined 33%-meaning that the racial disparity actually increased rather than decreased during that time period. It is also important to note that 5 states that did not report race-specific abortion data (or no data at all in the case of California) to the CDC (California, New York, Texas, Florida and Illinois) account for fully half of all U.S. abortions and a third of all Black women of child bearing age. Further, the CDC notes that non-reporting states have "populations of minority women so that the absence of their data reduces the representativeness of the CDC data." This means that the existing CDC reports possibly underestimate the size of the racial disparity in abortion nationwide.

The racial disparity in abortion rates in the U.S. is pervasive and persistent. Between 1990-2014, 43 states and the District of

Columbia reported race-specific abortion data to the CDC.³ Many states reported intermittently and only 22 states reported for all 25 years. The national average (aggregating all available states and years) Black/White abortion rate disparity for the entire period was 3.44. The 1990 disparity was 3.00 (B 25.87/W 8.63) and by 2014 it was 3.64 (B 12.68/W 3.48). In data collected directly from the individual states (not from CDC) for the more recent calendar year 2018, the 27 reporting states average a Black abortion rate of 21.78 and a White abortion rate of 6.38 for a racial disparity of 3.41. Some noteworthy states and their racial disparity in abortion include: Wisconsin (5.59), Michigan (5.41), Minnesota (4.78) and Pennsylvania (4.80).⁴ Therefore, despite incomplete reporting especially from high-volume abortion states with large populations of minority women, Black women have been experiencing abortions at a rate nearly 4 times that of White women for more than 30 years. It is very likely that the disparity existed even before there was any reporting.

One way to measure the impact of race-specific abortion rates on the size and demographic composition of the U.S. population is to calculate the years of potential life lost (YPLL) from abortion and to compare its impact to other causes of death. YPLL is the preferred public health metric for quantifying the social, economic and demographic loss resulting from premature death.

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Submitted July 13, 2020. Revised July 17, 2020. Accepted July 17, 2020.

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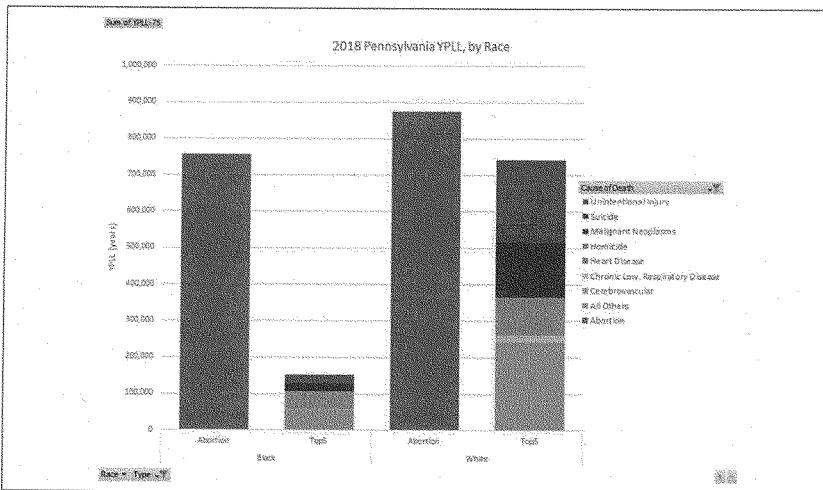


Figure 1. Pennsylvania 2018 YPLL by race and cause of death.

It allows the estimation of the burden of premature death for any cause and can assess socioeconomic inequalities by race (as in our application), education, gender or other available characteristics.⁵ YPLL 75 is calculated by accumulating all years from the age at death up to 75, for all deaths for each cause of death. We selected the state of Pennsylvania (2018) to illustrate the YPLL construct because of its relatively high abortion volume ($n = 30,364$), very high black abortion rate (37.16) and a high racial disparity in abortion rates (4.80).

In Pennsylvania in 2018, there were 61,011 White deaths (these are premature recorded deaths of all deceased persons up to age 75, plus abortions) from all causes and 20,976 Black deaths.⁶ Abortions were 23.9% of White deaths and 62.7% of Black deaths. To calculate YPLL we subtracted 23.8% of Black abortions and 20.9% of White abortions to reflect estimated natural fetal losses. Total White YPLL was 1,610,908 years and White abortions accumulated 866,916 YPLL or 53.8%. Total Black YPLL was 911,955 years and Black abortions accumulated 751,522 YPLL or 82.4% (Figure 1). In Pennsylvania in 2018, there were 472 Black homicide deaths that generated 20,964 YPLL. For comparison purposes, Black abortions represented 29 times more deaths and 36 times as many YPLL as Black homicides.

A vivid national-level illustration of the gap between the crucial demographic importance of abortion and its relative scientific and media obscurity can be found in its comparison with maternal mortality. The racial disparity in maternal mortality, that is, non-accidental death related to pregnancy, has received an abundance of attention both in the popular media and the professional

community. Stories expressing alarm over the high rate and racial disparity in maternal mortality have recently appeared in every major newspaper in the United States. Many states have formed expert committees to determine the causes of pregnancy-related maternal deaths and to implement preventive programs. The racial disparities in maternal mortality and induced abortion are of the same magnitude and in the same direction, a ratio of about 3-4 times. Yet, maternal mortality, in stark contrast to the high incidence of abortion, is an extraordinarily rare event. During the 5-year period 2011-2015, there was an average of 682 maternal deaths per year in the entire nation.⁷ That is an average annual age-adjusted YPLL of 29,996 years. In 2015, there were 900,135 abortions, derived from a linear interpolation of Guttmacher Institute 2014 and 2016 estimates. The fetal-loss-adjusted YPLL was over 52 million years. Therefore, there were 1,320 abortion deaths for every maternal death and 1,744 years of potential life lost to abortion for every year lost to a maternal death!

Abortion has been euphemistically described as a "choice" or a human "right." The undeniable objective reality, whatever one's political persuasion or ideological posture, is that each abortion is a death. Death by abortion, however, has proven to be an inconvenient reality for many of our politicians and scientists alike. Mortality and fertility are 2 of the 3 principal determinants, along with migration, of the size and demographic composition of the U.S. population.⁸ Given its high incidence and racially skewed distribution, abortion is unquestionably the most demographically consequential occurrence for the minority community. Its impact on the size and racial composition of the nation

- is undeniable. The exclusion of the major cause of death from the vital statistics system and the national psyche, one which disproportionately affects a racial minority, is a distressing denial of science. Cause-specific mortality rightly remains a major influence on public policy and resource allocation, and research suggests that notions about the relative importance of the mortality patterns of certain subpopulations often reflect subjective beliefs about the nature of the society.^{9,10} The silence of the popular media and the lack of a robust scientific dialogue on the longstanding racial disparity in induced abortion suggest that a disconnect exists between its overwhelming demographic importance and the willingness of thought leaders to engage on the subject. The current upheaval unfolding may portend at last, hopefully, a return to serious scientific inquiry, public transparency, and effective response.
- Declaration of Conflicting Interests**
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.
- Funding**
The author(s) received no financial support for the research, authorship, and/or publication of this article.
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- References**
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Author Biographies

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John W. Fisher is currently an Associate Scholar at the Charlotte Lozier Institute. Following a 22 year career as a nuclear submarine officer, he served as the Director of Life Support and Engineering at the Florida Aquarium, Chief Financial Officer of Technology Transfer Services, and 10 years as an Assistant Professor at the University of North Carolina at Charlotte College of Health and Human Services. Dr. Fisher holds a PhD in Information Systems and Decision Sciences from the University of South Florida, a JD from Massachusetts School of Law, and Master's degrees from the Massachusetts Institute of Technology (Ocean Engineering), University of Notre Dame (Administration), Indiana University (Business Administration), the United States Naval War College (National Security Policy), and the University of South Florida (Management Information Systems). He is a member of the bar in New Hampshire and Massachusetts.

James L. Sherley graduated from Harvard College in 1980 with a BA degree in biology; and he completed joint MD and PhD degrees at the Johns Hopkins University School of Medicine in 1988. After post-doctoral studies in cancer cell molecular biology at Princeton University, he joined the Fox Chase Cancer Center as a principal investigator in 1991. In 1998, he joined the faculty of the future Department of Biological Engineering at Massachusetts Institute of Technology, where he undertook research and teaching in the areas of cancer cell molecular biology, tissue stem cell bioengineering, toxicology, and environmental health science until moving to Boston Biomedical Research Institute (BBRI) in 2007. As a Senior Member of BBRI's research programs in Regenerative Biology and Cancer Biology, Dr. Sherley established an academic center for developing adult stem cell-based technologies for advancing cellular medicine. After leaving

BBRI, in October 2013 he founded stem cell biotechnology development company Asymmetrex, LLC, which he now directs. Asymmetrex has the mission of advancing technologies for stem cell medicine. The company recently developed the first method for determining the dosage of therapeutic stem cell treatments. Dr. Sherley's awards

include 1993 Pew Biomedical Research Scholar, 2003 Ellison Medical Foundation Senior Scholar in Aging Research, and 2006 NIH Director's Pioneer Award. Since 2016, he has served as an Associate Scholar of the Charlotte Lozier Institute, the education and research institute of the Susan B. Anthony List.

12/8/2020 USCCB PRO-LIFE SECRETARIAT EXPRESSES DEEP DISAPPOINTMENT AT SENATE FAILURE TO PASS NO TAXPAYER FUNDIN...

USCCB PRO-LIFE SECRETARIAT EXPRESSES DEEP DISAPPOINTMENT AT SENATE FAILURE TO PASS NO TAXPAYER FUNDING FOR ABORTION ACT

JANUARY 18, 2019 BY PUBLIC AFFAIRS OFFICE

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WASHINGTON— “Taxpayer dollars should not pay for abortion. The majority of Americans, including many who consider themselves pro-choice, agree on this,” said Kat Talalas, spokeswoman on abortion for the U.S. Conference of Catholic Bishops (USCCB), responding to the Senate’s vote today on the “No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2019” (S. 109).

The Senate voted (48-47) in favor of the bill, but Talalas expressed deep disappointment that it did not receive the 60 votes needed for passage in the Senate. The Senate held its vote on January 17, the day before the annual March for Life in Washington.

The bill would codify a permanent, government-wide policy against taxpayer subsidies for abortion and abortion coverage. It would also require health plans offered under the Affordable Care Act to disclose the extent of their coverage for abortion and the amount of any surcharge for that coverage to consumers. Archbishop Joseph Naumann, chair of the Secretariat of Pro-Life Activities at the USCCB, wrote to Congress prior to the vote, urging support for the legislation. Naumann said that “abortion is a false and violent response to an unplanned pregnancy that turns a woman in crisis and her unborn child against each other,” and that the federal government “should not force taxpayers to subsidize this violence.”

“The USCCB urges the House and Senate to work together to pass legislation that reflects the will of the American people, and prevents tax dollars from funding elective abortion,” Talalas said.

Keywords: USCCB, Catholic, U.S. bishops, U.S. Conference of Catholic Bishops, Roe v. Wade, abortion, anniversary, Pro-Life, Prolife, Archbishop Naumann, 9 Days for Life, People of Life, #9daysforlife, No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2019, H.R. 7, U.S. House of Representatives, U.S. Senate, Congress, March for Life, funding, Affordable Care Act

<https://www.usccb.org/news/2019/usccb-pro-life-secretariat-expresses-deep-disappointment-senate-failure-pass-no-taxpayer>

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