

SABOTAGE: THE TRUMP ADMINISTRATION'S ATTACK ON HEALTHCARE

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS

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SABOTAGE: THE TRUMP ADMINISTRATION'S ATTACK ON HEALTHCARE

WEDNESDAY, OCTOBER 23, 2019

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, Hon. Diana DeGette (chair of the subcommittee) presiding.

Members present: Representatives DeGette, Schakowsky, Kennedy, Ruiz, Kuster, Castor, Tonko, Clarke, Pallone (ex officio), Guthrie (subcommittee ranking member), Burgess, McKinley, Griffith, Brooks, Duncan, and Walden (ex officio).

Also present: Representatives Rush, Cárdenas, Blunt Rochester, Rodgers, Bucshon, Carter, and Gianforte.

Staff present: Kevin Barstow, Chief Oversight Counsel; Jesseca Boyer, Professional Staff Member; Jeffrey C. Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Saha Khaterzai, Professional Staff Member; Chris Knauer, Oversight Staff Director; Kevin McAloon, Professional Staff Member; Meghan Mullon, Staff Assistant; Joe Orlando, Executive Assistant; Alivia Roberts, Press Assistant; Tim Robinson, Chief Counsel; Benjamin Tabor, Policy Analyst; Sydney Terry, Policy Coordinator; Rick Van Buren, Health Counsel; C. J. Young, Press Secretary; Nolan Ahern, Minority Professional Staff Member, Health; Jen Barblan, Minority Chief Counsel, Oversight and Investigations; Margaret Tucker Fogarty, Minority Legislative Clerk/Press Assistant; Caleb Graff, Minority Professional Staff Member, Health; Brittany Havens, Minority Professional Staff Member, Oversight and Investigations; Peter Kielty, Minority General Counsel; J. P. Paluskiewicz, Minority Chief Counsel, Health; and Natalie Sohn, Minority Counsel, Oversight and Investigations.

Ms. DEGETTE. The Subcommittee on Oversight and Investigations hearing will now come to order. Today, the subcommittee is holding a hearing entitled "Sabotage: The Trump Administration's Attack on Healthcare." The purpose of the hearing is to examine the efforts of the Centers for Medicare & Medicaid Services to ensure quality and affordable healthcare for all Americans. The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. DIANA DeGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

It is no secret that the Trump administration has worked to sabotage healthcare in this country. On his very first day in office, President Trump issued an executive order directing all Federal agencies to dismantle the Affordable Care Act, “to the maximum extent by law.” And ever since then, the Trump administration has worked tirelessly to undermine the ACA and other critical health programs at every turn.

In her role as the Administrator of the Centers for Medicare & Medicaid Services, Seema Verma has been behind many of this administration’s efforts to undermine the Nation’s healthcare. Despite her role in this effort, today is the first time Administrator Verma has appeared to testify in an oversight hearing in the House, and we have many questions regarding the administration’s actions.

Since the Affordable Care Act was signed into law, more than 20 million people gained affordable, high-quality healthcare coverage. But now, under President Trump and Administrator Verma, this administration is determined to take us in the wrong direction. Last year, we saw the number of uninsured people in this country increase for the first time since the ACA was passed. About 1.9 million more people were uninsured last year compared to the year before, including nearly half a million more children. Further, the Kaiser Family Foundation estimates that health insurance premiums are 16 percent higher this year than they would have been if the Trump administration had not worked to undermine the ACA.

We know the Trump administration has taken numerous steps to sabotage the ACA. They are chipping away at critical protections guaranteed by the law. They are allowing States to increase consumers’ costs, reduce their coverage, and undermine protections for those with preexisting conditions. They are promoting junk insurance plans that do not provide essential health benefits and leave patients on the hook when they need coverage the most. They are making it more difficult and more expensive for individuals to find quality coverage on the health insurance marketplace, and, to top it all off, they are rooting for the ACA’s collapse by declining to defend the law in the *Texas v. United States* lawsuit.

We will likely hear today that Obamacare is the source of all our problems. But while the Nation’s healthcare law may not be perfect, it is important to understand what would happen if the Trump administration succeeded in dismantling the ACA entirely. Twenty-one million people could lose their health insurance.

Up to 133 million Americans with preexisting conditions could be denied coverage or charged higher premiums. Those lucky enough to keep their coverage if the ACA is dismantled could once again face lifetime caps on coverage and could lose coverage for things like prescription drugs and maternity care. Women could once again be charged more than men for their health coverage, and 60 million seniors and disabled Americans on Medicare will have to pay more for preventive care and prescription drugs.

Yesterday, CMS announced that ACA premiums will drop by about 4 percent this year. That is good news. However, let’s just

think about how many more people would be covered now and how much lower premiums could be if not for the repeated acts of sabotage at the hands of this administration.

The ACA is succeeding despite the Trump administration's efforts to tear it down. Time and time again, this administration's actions on healthcare have gone squarely against their duty to promote high-quality healthcare and the well-being of children and families in need. Under this administration, thousands of children and families have lost coverage of basic health services, and this administration's actions have disproportionately hurt those with disabilities, rural Americans, veterans, women, and young people of color.

The Trump administration and Administrator Verma, in particular, have tried to make philosophical arguments for why they are doing these things, but the numbers just don't lie. At a time when we as a nation are facing a series of critical health challenges like the opioid epidemic and unacceptably high rates of maternal and infant mortality, it is unconscionable that this administration is working to reverse the progress that we have made.

Today, the administration will have to answer for its unending sabotage of Americans' healthcare, and Administrator Verma will have to explain to the American public why she and this administration are actively trying to take their healthcare away.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

It's no secret that the Trump administration has worked to sabotage healthcare in this country.

On his very first day in office, President Trump issued an Executive Order directing all Federal agencies to dismantle the Affordable Care Act "to the maximum extent by law." And ever since then, the Trump administration has worked tirelessly to undermine the ACA and other critical health programs at every turn.

In her role as the Administrator of the Centers for Medicare & Medicaid Services, Seema Verma has been behind many of this administration's efforts to undermine the Nation's healthcare. Despite her starring role in this effort, today is the first time Administrator Verma has appeared to testify at an oversight hearing in the House, and she has many questions to answer regarding this administration's actions.

Since the Affordable Care Act was signed into law, more than 20 million people gained affordable, high-quality healthcare coverage. But now, under President Trump and Administrator Verma, this administration is determined to take us back in the wrong direction.

Last year, we saw the number of uninsured people in this country increase for the first time since the ACA was passed. About 1.9 million more people were uninsured last year compared to the year before—including nearly half a million more children. Further, the Kaiser Family Foundation estimates that health insurance premiums are 16 percent higher this year than they would have been if the Trump administration had not worked to undermine the ACA.

We know the Trump administration has taken numerous actions to sabotage the ACA.

They are chipping away at critical protections guaranteed by the law. They are allowing States to increase consumers' costs, reduce their coverage, and undermine protections for those with preexisting conditions.

They are promoting junk insurance plans that do not provide essential health benefits and leave patients on the hook when they need coverage the most.

They are making it more difficult and more expensive for individuals to find quality coverage on the health insurance marketplace.

And to top it all off, they are rooting for the ACA's collapse by declining to defend the law in the *Texas v. United States* lawsuit.

We will likely hear today that “Obamacare” is the source of all our problems. But while the Nation’s healthcare law may not be perfect, it’s important to understand what would happen if the Trump administration succeeds in dismantling it entirely:

- 21 million people could lose their health insurance.
- Up to 133 million Americans with preexisting conditions could be denied coverage or charged higher premiums.
- Those lucky enough to keep their coverage if the ACA is dismantled could once again face lifetime caps on coverage, and could lose coverage for things like prescription drugs and maternity care.
- Women could once again be charged more than men for their health coverage.
- And 60 million seniors and disabled Americans on Medicare will have to pay more for preventive care and prescription drugs.

Yesterday, CMS announced that ACA premiums will drop by about 4 percent next year. This is good news. However, just think about how many more people would be covered and how much lower premiums could be if not for the repeated acts of sabotage at the hands of this administration. The ACA is succeeding despite the Trump administration’s efforts to tear it down.

Time and time again, this administration’s actions on healthcare have gone squarely against their duty to promote high-quality healthcare and the well-being of children and families in need.

Under this administration, thousands of children and families have lost coverage of basic health services. And this administration’s actions have disproportionately hurt those with disabilities, rural Americans, Veterans, women, and young people of color.

The Trump administration, and Administrator Verma in particular, have tried to make philosophical arguments for why they are doing these things. But the numbers don’t lie.

At a time when we, as a nation, are facing a series of critical health challenges—such as the opioid epidemic and unacceptably high rates of maternal and infant mortality—it is unconscionable that this administration is working to reverse the progress we’ve made.

Today, the Trump administration will have to answer for its unending sabotage of Americans’ healthcare. And Administrator Verma will have to explain to the American people why she—and this administration—are actively trying to take their healthcare away.

Ms. DEGETTE. And with that, the Chair will recognize the ranking member of the subcommittee, Mr. Guthrie, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you, Chair DeGette, for holding this hearing with the Centers for Medicare & Medicaid Services today, and I would like to welcome Administrator Verma to her first appearance before the Energy and Commerce Committee.

CMS oversees the two largest Federal healthcare programs, Medicare and Medicaid, as well as numerous other Federal programs. CMS programs will impact over 145 million Americans in fiscal year 2020, and a CMS budget of over 1 trillion represents more than 25 percent of the entire Federal budget. I share this information about CMS not only to emphasize the critical role that the agency plays in the Nation’s healthcare system, but to illustrate how we cannot possibly cover all of CMS’s work in a single hearing.

And thank you, Administrator Verma, for your commitment to promoting competition and innovation for Americans’ healthcare and for that work you have accomplished in your role thus far. Just yesterday, I was pleased to see CMS announce that premiums for mid-level Silver plans will decrease 4 percent for 2020, a far cry

from the double-digit premium increases we have seen in past years.

I have also heard from my constituents on how CMS's Patients over Paperwork initiative will help providers spend more time focusing on the quality of care provided to patients rather than the overly burdensome administrative tasks. I am also glad that CMS is strengthening the agency's oversight of nursing homes in recent months. Last Congress' subcommittee examined CMS's oversight of the quality and safety of care in nursing homes after numerous reports described instances of abuse and neglect in standard care occurring in nursing homes across the country.

Another critical issue facing Americans that CMS has made a top priority is the opioid epidemic. This committee has long been at the forefront of the fight to combat the opioid crisis. Last Congress, our investigation and legislative work led to the SUPPORT for Patients and Communities Act, which was signed into law 1 year ago tomorrow. While there is much to be done both legislatively and through investigations, the SUPPORT Act included important provisions relating to CMS's role and responsibility in helping to address the opioid epidemic.

Many of the initiatives I have just described share bipartisan support, which is why the title for this hearing, "Sabotage: The Trump Administration's Attack on Healthcare," is over the top. I don't think anyone can reasonably categorize CMS's effort to protect vulnerable populations in nursing homes and assist States in fighting the opioid epidemic as sabotage. Moreover, the Democrats are likely going to spend a lot of time today criticizing CMS's recent actions relating to Medicaid demonstration projects and Section 1332 State Innovation Waivers. I find it disingenuous, however, to lay CMS's commitment to strengthen its partnership with States and promote innovation as sabotage.

I do, however, want to take some time to discuss areas where I hope CMS will take additional action in the future. We are at the beginning of flu season, and it will potentially be one of the worst flu seasons that we have experienced in recent years. This subcommittee held a hearing in 2018 examining HHS's efforts to respond to seasonal influenza, and while CMS was not a witness at the hearing, we did learn that FDA was working with CMS to use Medicare data to compare the effectiveness of different types of flu vaccines. I have some questions for CMS today about the status of this work, and I hope that we can hold another hearing on seasonal flu preparedness as soon as possible.

I also have questions for CMS about the agency's efforts to improve the interoperability of healthcare records while also taking into consideration the sensitive nature of healthcare data. We appreciate the work CMS has done to implement the 21st Century Cures Act, but as I said in my letter to CMS with Congressman Schrader this summer, I am concerned that a recent proposed rule issued by CMS does not adequately protect consumers' sensitive healthcare data.

Thank you again for being here today. I look forward to your testimony, and I would like to yield my time to the congresswoman from Indiana, Mrs. Brooks.

[The prepared statement of Mr. Guthrie follows:]

PREPARED STATEMENT OF HON. BRETT GUTHRIE

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Many of the initiatives I just described share bipartisan support, which is why the title for this hearing, "Sabotage: The Trump Administration's Attack on Healthcare," is so over the top. I don't think that anyone can reasonably categorize CMS' efforts to protect vulnerable populations in nursing homes and assist States in fighting the opioid epidemic as "sabotage." Moreover, the Democrats are likely going to spend a lot of time today criticizing CMS' recent actions relating to Medicaid demonstration projects and Section 1332 State Innovation Waivers. I find it disingenuous, however, to label CMS' commitment to strengthen its partnership with States and promote innovation as "sabotage."

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Thank you again for being here today, and I look forward to your testimony.

Mrs. BROOKS. Thank you, Ranking Member Guthrie. And welcome, Administrator Verma.

Seema and her family are constituents of mine back home in Indiana, and we actually have been friends for a couple of decades. We worked together in Mayor Stephen Goldsmith's office where she was focused on health policy in the late '90s. That innovation was

recognized also by former Indiana Governor Mitch Daniels, who asked Seema to work with him in ensuring that healthcare was working better for patients throughout Indiana.

She is the architect of the Healthy Indiana Plan, which was Indiana's popular bipartisan—again, I repeat, it was a bipartisan Medicaid program. Healthy Indiana Plan requires individual responsibility through small member contributions utilizing what are called POWER Accounts that function like traditional HSAs, and the Healthy Indiana Plan incentivizes preventive care to drive down costs and keep patients healthier.

We are very, very proud that Seema Verma stepped up at the invitation of the President to take the innovation and her incredible dedication to the health of Americans here in Washington, DC. We look forward to continuing working with you to continue to improve healthcare for all Americans.

Thank you, I yield back.

[The prepared statement of Mrs. Brooks follows:]

PREPARED STATEMENT OF HON. SUSAN W. BROOKS

Thank you, Ranking Member Guthrie. Welcome Administrator Verma. Seema has been a dear friend throughout the years and is a constituent of mine. Seema and I served together in Mayor Goldsmith's office in Indianapolis in the late '90s.

She was instrumental in our home State of Indiana in making healthcare work for patients. She is the architect of the Healthy Indiana Plan, Indiana's popular, bipartisan Medicaid program.

HIP requires individual responsibility through small member contributions utilizing POWER accounts that function like a traditional HSA. And HIP incentivizes preventative care to drive costs down and keep patients healthier.

We are proud to have a Hoosier working for the American people at CMS. We look forward to working with you to continue to improve healthcare for all Americans.

Thank you and I yield back.

Mr. GUTHRIE. Thank you. And I yield back.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes for purposes of an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I want to thank the chairwoman. Today's hearing continues this committee's ongoing work to bring oversight and accountability to the Trump administration's relentless attack on people's healthcare, whether it be attacks on the Affordable Care Act, Medicare, or Medicaid. Since day one, the Trump administration has engaged in a concerted effort to undermine, weaken, and outright eliminate health insurance coverage for tens of millions of Americans.

I heard what my colleague Ranking Member Guthrie said, that I guess he doesn't think that this administration is sabotaging anything. But, you know, the problem I have here is, if someone is on the right ideologically and says, "Look, the Government shouldn't be involved in healthcare, shouldn't get involved in health insurance, people are on their own," if you said that then I would say, "OK, I understand. You know, you want to get rid of all the health

insurance, you want to get rid of all this, this is not the Government's role."

But the problem is, I hear my colleagues on the other side, including the President, suggest otherwise. That they want to cover everyone. That they want to help people get health insurance. Well, I don't see that at all. I think, if you look at this practically and not ideologically, it is clear that fewer people have health insurance, that their essential benefits are being cut back, they are not being covered. So to suggest that somehow they are not responsible for that, I think, is not true. They are responsible. It is a concerted effort to cut back on people's health insurance, their benefits, what kind of coverage they have.

And our witness today is the Administrator for the Centers for Medicare & Medicaid Services, CMS, Seema Verma, who is the administration's point person on these actions. I think she has a difficult record to defend. During her time as the Administrator, healthcare costs have gone up and health insurance coverage has gone down. And thanks to the administration's policies, the number of uninsured Americans increased by nearly 2 million people from 2017 to 2018, rising to 27.5 million uninsured.

And between December 2017 and this June, more than 1 million children lost health coverage through either Medicaid or the Children's Health Insurance Program, and these are, you know, bipartisan programs. Why is this administration making it more difficult for people to get coverage, and particularly kids?

These are very disturbing trends, and unfortunately they could get even worse if CMS and the Trump administration are successful in pushing their harmful policies. The Trump administration is actively supporting a lawsuit that would overturn the Affordable Care Act. This would strip health insurance away from tens of millions of Americans and would allow insurance companies to once again discriminate against people with preexisting conditions.

The administration has expanded junk insurance plans that are not required to cover essential health benefits like hospitalization, prescription drugs, and emergency care services. The Trump administration is also placing extremely burdensome, in some cases illegal, hurdles in front of Medicaid beneficiaries. These unnecessary roadblocks are certainly causing pain for low-income families, as more than 1 million children lost health insurance coverage through either Medicaid or CHIP between December '17 and June of this year.

These disturbing numbers show that the Trump administration's policies to drive people off Medicaid, tie them up in red tape, or scare them into not even applying for insurance in the first place are working. And I am deeply concerned by the Trump administration's ongoing attempts to impose illegal work requirements waivers on Medicaid beneficiaries. These requirements are not only cruel and costly, but they are a clear violation of both Medicaid statute and longstanding congressional intent.

And, fortunately, these illegal actions have been rightfully defeated in the courts, but the Trump administration refuses to give up. And the Trump administration is also not giving up in its ongoing attempts to sabotage the healthcare of millions of Americans through the ACA. In some instances, the proposals have been so

extreme that even Administrator Verma has raised the red flag. In an internal memo dated August 2018, she wrote that several administration proposals at the time would, and I am quoting, “cause coverage losses, further premium increases, and market disruption.” And the memo concluded that 1.1 million Americans could lose their coverage.

And I have repeatedly requested Ms. Verma provide the underlying analysis discussed in that memo. If the Trump administration is pursuing a policy that would have harmful impacts on millions of Americans, Congress and the American people have a right to know what exactly that analysis shows. To date, I have received a one-and-one-half-page response that answers none of my questions.

So under Ms. Verma’s leadership, CMS is following the rest of the Trump administration in stonewalling legitimate congressional oversight requests, and I am appalled by the flimsy, nonresponsive letters this committee has received back from CMS, many times well past the deadline. As I wrote in a letter to both Secretary Azar and Administrator Verma last week, obstruction of the committee’s legitimate exercise of its oversight responsibilities is unacceptable and if continued may necessitate the use of additional measures, including compulsory process.

So, Administrator, you cannot flout this committee’s constitutional duty to conduct oversight. I appreciate you being here today. That certainly says a lot that you are here, and I don’t want to take away from that. But the stonewalling of our oversight requests have to end.

And with that, Madam Chair, I will yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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Our witness today is the Administrator for the Centers for Medicare & Medicaid Services (CMS), Seema Verma, who is the administration’s point person on these actions. She has a difficult record to defend: During her time as the Administrator, healthcare costs have gone up and health insurance coverage has gone down.

Thanks to the administration’s policies, the number of uninsured Americans increased by nearly 2 million people from 2017 to 2018—rising to 27.5 million uninsured. And between December 2017 and this June, more than 1 million children lost healthcare coverage through either Medicaid or the Children’s Health Insurance Program.

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These disturbing numbers show that the Trump administration's policies to drive people off Medicaid, tie them up in red tape, or scare them into not even applying for insurance in the first place, are working.

I am also deeply concerned by the Trump administration's ongoing attempts to impose illegal work requirements waivers on Medicaid beneficiaries. These requirements are not only cruel and costly, but they are a clear violation of both Medicaid statute and longstanding congressional intent. Fortunately, these illegal actions have been rightfully defeated in the courts, but the administration refuses to give up.

The administration is also not giving up on its ongoing attempts to sabotage the healthcare of millions of Americans through the ACA. In some instances, the proposals have been so extreme that even Administrator Verma has raised the red flag. In an internal memo dated August 2018, Ms. Verma wrote that several administration proposals at the time would, "cause coverage losses, further premium increases, and market disruption." The memo concluded that 1.1 million Americans could lose their coverage.

I have repeatedly requested Ms. Verma provide the underlying analysis discussed in that memo. If the administration is pursuing a policy that will have harmful impacts on millions of Americans, Congress, and the American people, have a right to know what exactly that analysis shows. To date, I have received a one-and-one-half-page response that answers none of my questions.

Under Ms. Verma's leadership, CMS is following the rest of the Trump administration in stonewalling legitimate Congressional oversight requests. I am appalled by the flimsy non-responsive letters this committee has received back from CMS, many times well past the deadline. As I wrote in a letter to both Secretary Azar and Administrator Verma last week, obstruction of the committee's legitimate exercise of its oversight responsibilities is unacceptable and, if continued, may necessitate the use of additional measures, including compulsory process.

Administrator Verma, you cannot flout this committee's constitutional duty to conduct oversight. I appreciate you being here today, but the stonewalling of our oversight requests must end. With that, I yield back.

Ms. DEGETTE. The Chair now recognizes the ranking member of the full committee, Mr. Walden, for 5 minutes for purposes of an opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Well, good morning. Good morning, Madam Chair and Chairman of the full committee.

Ms. Verma, thank you for being here. We really appreciate it, and we have enjoyed working with you over the years on many of these issues, and I am glad you are here.

CMS, as we have talked about, is the largest administrator of health benefit programs in the United States. It is estimated in fiscal year 2020 over 145 million Americans will receive their benefits from programs administered by CMS. So you have got a big job, and we appreciate the work you are doing. That includes Medicare, Medicaid, and Children's Health Insurance Program, also known as CHIP.

And under Republican leadership and with the support of this administration and, frankly, in opposition to votes on the floor by Democrats, we not only extended CHIP for 5 years and then 6 years, we did it for 10. We did it for 10 years, fully locked in, Children's Health Insurance, and a lot of Democrats, if not all, voted against this almost every step of the way, and especially on the House floor. And I don't want to get into this partisan back-and-forth, I hadn't planned to today, but it is just unfortunate because there are issues here that we need to focus on together.

And I think about the meetings I have had with the President, with you and others. I have not seen a President who has leaned in more to get drug prices down. Now we may have agreements and disagreements to policy, but I wish you could have been here during our markup when nearly every Democrat was holding up posters of what President Trump had said about bringing down drug prices. And while we may have some disagreements about the policy, they were certainly the President's advocates last week when we were dealing with drug costs.

In surprise medical billing, the chairman and I are working shoulder-to-shoulder with this administration, I believe, on a way to protect consumers from surprise medical billing. Because I tell you, what I run into out in my part of the world is people are so concerned about the high cost of healthcare and in the Affordable Care Act—and we have had our debates about what the best policies are there—it did not deliver as promised to bring down premiums 2,500 bucks. In fact, I can't find anybody in my district that has seen that level of reduction in their premiums.

But what they have seen is an increase in deductibles and copays, and insurance by name is not insurance in function if the deductible and copays are so high you really can't afford to access the care. And so, there are issues there in terms of the Affordable Care Act and all, and there are things we, frankly, as Republicans supported that became part of the Affordable Care Act. Not the overall bill, but a lot of things contained in there, including protecting people with preexisting conditions, letting your kids stay on until they are 26, there is a whole host of things.

And then we have done a lot of work together, and it was referenced earlier today about the SUPPORT Act. As chairman of the committee, I helped steer that through the legislative process here. We had an open session where Members of Congress could come and make their case. Tomorrow marks the 1-year anniversary. I just left a meeting, bipartisan, in the Senate with the First Lady and Secretary Azar. Well, we were celebrating what we accomplished together as a Congress, and almost unanimously as I recall, to address this horrible scourge of opioids.

Now when it comes to first times, we are glad you are here, the first time for the committee. The other first time would be to have a hearing in this committee on Medicare for All. We were talking about, my colleagues were talking about how the Trump administration, their allegations, chipping away at ACA. I would argue that their presidential candidates are taking a chainsaw massacre approach to it, because they want to throw out the whole thing and go with a government-run system that wipes out Medicare and Medicaid, VA, all private health insurance, and they are having a fight over how to pay for it or whether to even talk about how to pay for it. And so, working Americans are going to lose their insurance under their plan, and I have asked for a hearing before this committee since the first of this Congress, and we have yet to have one on their Medicare for All proposal.

So there is a lot of debate to be had here. There are also areas we should be working together on, and so we are glad you are here.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you. I'd like to welcome the witness for today's hearing—Seema Verma, Administrator of the Centers for Medicare and Medicaid Services (CMS). We are pleased that you are here today to discuss the operations of CMS.

CMS is the largest administrator of health benefit programs in the United States. It is estimated that in Fiscal Year 2020, over 145 million Americans will receive benefits from programs administered by CMS—including Medicare, Medicaid, the Children's Health Insurance Program, also known as CHIP, and the Exchanges. CMS' budget request for Fiscal Year 2020 was nearly \$1.7 trillion, and two of the programs administered by CMS—Medicare and Medicaid—are estimated to account for 86 percent of all projected spending in 2020 for the U.S. Department of Health and Human Services (HHS).

Given the breadth of programs administered by CMS, and that these programs represent a substantial financial obligation for the Federal Government and the States, it is important that this committee conduct oversight of the agency that administers those programs. Last Congress, under my leadership as chairman, we conducted oversight on a range of issues that fall under CMS' purview. It was this subcommittee that conducted the necessary oversight to help ensure that programs operate effectively, tax dollars are spent appropriately, and that Americans who benefit from these programs receive the quality of care that they deserve.

Specifically, the committee conducted oversight over programs such as Medicaid, looking at data integrity and innovation, the 340B Drug Pricing Program, hospital accrediting organizations, and nursing homes, to name a few. The oversight of these programs consisted of letters, document requests, hearings, briefings, roundtables, meetings with stakeholders, and in some cases, reports with recommendations on ways to improve the administration and oversight of these programs.

But oversight hasn't been our only focus. Last Congress, this committee worked tirelessly on legislation to improve some of the programs and services administered by CMS. For example, we led the effort to pass the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment—or SUPPORT—for Patients and Communities Act.

Everyone knows someone impacted by the opioid crisis. Everyone pictures a different face when they think of it. There are many people who come to mind for me from stories shared at roundtables I held across Oregon—like a mother I met earlier this month in La Pine who shared a poem about the son she had recently lost to an overdose. Whether it be parents, physicians, or law enforcement officials—everyone I've talked to has a story to tell, and everyone has urgency in their eyes to stop this epidemic.

Tomorrow marks the 1-year anniversary of the SUPPORT Act becoming law, which is a point of pride for this committee and the administration. But we must also remain vigilant in our efforts to combat the opioid crisis and continue to help patients and communities move "forward with support."

Among other things, the SUPPORT Act included provisions to strengthen law enforcement, public health, and healthcare financing and coverage, including under the Medicare and Medicaid programs. For example, under Section 1003, CMS, in consultation with another division within HHS, is conducting a 54-month demonstration project to increase the treatment and capacity of Medicaid providers to deliver substance use disorder treatments and recovery services. CMS' first step to implement this section just occurred in June, when the agency announced a Notice of Funding Opportunity that provides State Medicaid agencies with information to apply for planning grants that will aid in the treatment and recovery of substance use disorders.

In addition, the 21st Century Cures Act (Cures), signed into law in December 2016, made numerous changes to Medicare and Medicaid policies, including, but not limited to, provisions impacting infusion drug reimbursement, durable medical equipment policies, telehealth, hospital readmissions, long-term care hospitals, and reimbursement policies for hospital outpatient departments.

It is critical that we continue to have a dialogue and conduct oversight of CMS to ensure that the implementation of the SUPPORT Act, Cures, and other legislation passed by this committee are implemented and administered as intended, and on schedule. It is also important to continue our work to ensure proper administration and oversight of other programs administered by CMS.

I, again, welcome Administrator Verma and thank you for being here today. I look forward to listening to your testimony.

Mr. WALDEN. I am going to yield now to the ranking member of the Health Subcommittee, Dr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding. I would like to do something I don't normally do, which is quote from the Washington Post. In the Health 202 article yesterday by Paige Cunningham, it states, "Obamacare premiums will become more affordable next year—despite the dire predictions by Democrats that the Trump administration would destroy the insurance marketplaces." She goes on to say, "The improvements are striking, considering that Democrats have spent the last few years blasting the Trump administration for peeling away Obamacare regulations."

Quoting Alex Azar, "President Trump, the President who was supposedly trying to sabotage the law, has been running it better than the guy who wrote it." Quoting President Trump himself, "Once we got rid of the individual mandate it made it better, but Obamacare doesn't work—but it works at least adequately now. And we had that choice to make. And politically it is probably not a good thing that I did, but it's the right thing to do for a lot of people," he said in July." So I will just submit this entire article for the record. I ask unanimous consent to do so.

Ms. DEGETTE. Without objection.

[The information appears at the conclusion of the hearing]

Mr. BURGESS. And we will carry on. I yield back. Thank you.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Administrator Verma, thank you for being here today. I appreciate your willingness to engage with me and with the Energy and Commerce Committee over the course of your tenure at the Centers for Medicare and Medicaid Services.

I especially want to thank you for your work on providing coverage of cardiac stenting in ambulatory surgical centers. I would also like to mention that the proposed Stark Law and Anti-Kickback Statute reforms as a step in the right direction for patients and physicians. You have been a great partner in shifting our payment system to reward value over volume, and I look forward to continuing to work together.

Ms. DEGETTE. The gentleman yields back. The gentleman yields back. The Chair now asks unanimous consent that Members' written opening statements will be made part of the record. Without objection, they will be entered.

I would now like to introduce our witness for today's hearing, Hon. Seema Verma, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services.

Administrator Verma, thank you so much for coming today. You are aware, I know, that the committee is holding an investigative hearing, and when doing so we have the practice of taking testimony under oath. Do you have any objections to testifying under oath?

Ms. VERMA. I do not.

Ms. DEGETTE. Let the record reflect the witness responded no. The Chair then advises you, under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel. Do you desire be accompanied by counsel today?

Ms. VERMA. I do not.

Ms. DEGETTE. Let the record reflect the witness has responded no. If you would, then, please rise and raise your right hand so that you may be sworn in.

[Witness sworn.]

Ms. DEGETTE. You may be seated. Let the record reflect the witness responded affirmatively. And you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the U.S. Code.

The Chair now recognizes the witness for a 5-minute summary of her written statement.

In front of you is a microphone and a series of lights. The light turns yellow when you have a minute left, and it turns red to indicate your time has come to an end.

You are now recognized.

STATEMENT OF SEEMA VERMA, ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. VERMA. Thank you. Chair DeGette, Ranking Member Guthrie, and members of the subcommittee, thank you for the invitation to discuss efforts by the Centers for Medicare & Medicaid Services to transform and improve the United States healthcare system. When I came to CMS, our goal was to improve quality, lower costs, and improve the healthcare experience not only for the beneficiaries of our programs but for all Americans.

In 2017, this administration inherited a chaotic and declining individual health insurance market. The relief promised by proponents of the Affordable Care Act never materialized. Quite the opposite. Premiums in States using the Federal exchange more than doubled from 2013 to 2017, the final year the previous administration oversaw the program. Issuers were fleeing the market, and we were scrambling to prevent bare counties.

But after just over 2½ years as Administrator, I am happy to report that our market-based reforms have delivered lower premiums on the exchanges for the first time since the law started. Yesterday, we announced that for 2020 the average premium for a benchmark Silver plan will drop by 4 percent in States using the Federal exchange platform. This is on top of the decreases we saw last year.

In some cases, the decline in premiums is substantially higher, with 6 States experiencing double-digit percentage decreases, including a 20 percent drop in Delaware, a 15 percent drop in North Dakota, and a 14 percent drop in Oklahoma. On top of this, more issuers are entering the market, and the number of States with just a single monopoly issuer is declining. Only 2 States will have a single issuer in 2020, compared to 5 this year and 10 last year. This is success.

Despite this progress, it was inevitable that Obamacare's affordability crisis would eventually increase the number of uninsured, and that is exactly what the latest census data show. The fact is, 85 percent of the 1.9 million newly uninsured in 2018 occurred among people with incomes higher than 300 percent of the Federal poverty level. These are people who do not qualify for large ACA

subsidies and represent a new class of uninsured, those that can't afford Obamacare's premiums.

Our work to lower premiums hasn't stopped with the exchanges. Under the President's leadership, we have strengthened Medicare, seeing similar success in Medicare Advantage and Part D. Medicare beneficiaries have more choices, with about 1,200 more Medicare Advantage plans available in 2020 than in 2018. Average monthly premiums in Medicare Advantage are the lowest they have been in 13 years, and in Medicare Part D, the lowest they have been in 7 years.

Across the board in Medicare and the exchanges, premiums are lower. All of our work at CMS focuses on making healthcare more affordable and accessible to the American people. We are using every lever and our large footprint to tackle longstanding issues and problems in the healthcare system. We are executing on our vision to transform care by putting patients first and focusing 16 strategic initiatives grounded in empowering patients, promoting competition, and unleashing innovation. CMS is committed to moving to a system of competition and value and giving patients the choice and control they want, the affordability they need, and the quality they deserve.

While my written testimony provides more details, I will highlight a few of our efforts on these initiatives. We are empowering patients with the information they need to make decisions about their healthcare. We have efforts underway around price transparency, quality transparency, and ensuring that beneficiaries' medical records can travel with them while keeping the data private and secure.

We're addressing issues that drive up healthcare costs, especially administrative costs. After becoming Administrator of CMS, one of my first actions was to launch the Patients over Paperwork initiative. Across our programs we have made commonsense changes to our regulations and guidance. Just last week, for example, we released a proposed rule to modernize and clarify the regulations that interpret the Stark Law. Our new policies will save providers an estimated 4.4 million hours a year previously spent on paperwork, with savings projected to be approximately \$8 billion dollars over the next 10 years.

We're also working to bring our programs into the 21st century. Last year, the administration launched the eMedicare and the MyHealthEData initiatives to modernize Medicare and meet the growing needs of a number of tech-savvy beneficiaries. This includes releasing two new cost calculator tools and the first redesign of Medicare Plan Finder in a decade. And as part of MyHealthEData, Blue Button 2.0 is already giving Medicare beneficiaries the ability to securely connect their claims data to apps and other tools developed by innovators.

We have launched several historic efforts to improve quality and safety in nursing homes and across the healthcare system to improve rural health, to transform our program integrity efforts and to foster innovation throughout the American healthcare system, bringing new technology and breakthrough treatments to our beneficiaries. And we're also focused on transforming the Medicaid program around three pillars: flexibility, integrity, and accountability.

Our goal is to restore the Federal-State partnership in Medicaid and allow States to resume their role as laboratories of innovation.

We are approving groundbreaking waivers and doing it at a faster pace, and we are holding States accountable for results, including through our new Medicaid scorecard. At CMS, we are putting patients first——

Ms. DEGETTE. The gentlelady's time has expired, if you can wrap up, please, Administrator.

Ms. VERMA. At CMS, we are putting patients first as we move forward with transforming the healthcare system and providing all Americans with an access to a variety of affordable coverage options.

Ms. DEGETTE. Thank you.

Ms. VERMA. I greatly appreciate the opportunity today.

[The prepared statement of Ms. Verma follows:]

STATEMENT OF

SEEMA VERMA

ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

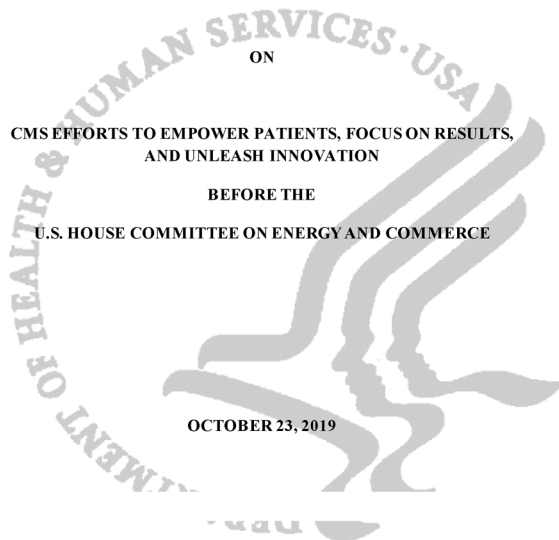
ON

CMS EFFORTS TO EMPOWER PATIENTS, FOCUS ON RESULTS,
AND UNLEASH INNOVATION

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY AND COMMERCE

OCTOBER 23, 2019



Chair DeGette, Ranking Member Guthrie, and distinguished Members of the Subcommittee, thank you for the opportunity to discuss the record of success at the Centers for Medicare & Medicaid Services (CMS) under this Administration. I am excited to share with you the incredible progress we have already made and ongoing efforts to build upon this progress. At CMS, we are putting patients first. We are committed to focusing on results instead of process, empowering patients to make their own health care decisions, and unleashing innovation to tackle the unsustainable rising costs of health care.

I continue to work hand in hand with Secretary Azar, under the leadership of President Trump, to carry out the Department's top priorities. During my time at CMS, I have been able to meet with many Members of this Committee, and it is clear that we share many priorities, including bringing down the costs of prescription drugs, increasing choices for all Americans, and putting patients at the center of our health care policies. I look forward to continuing to work with you all on our shared interests.

For too long, government health insurance programs focused on regulating processes, overwhelming providers with burdensome rules and paperwork. CMS oversight plays a critical role in improving the quality of care and our requirements need to be developed and implemented in a way that streamlines regulations and allows providers to focus on their patients, not their paperwork.

Soon after I arrived at CMS, I began extensive listening sessions with experts in the U.S. health care system, along with the talented staff at CMS, on ways to transform the U.S. health care system. This resulted in a strategic vision with 16 core principles (*Figure 1*). Across our programs, we make sure our efforts are building upon this guiding vision.

Patients Over Paperwork

After becoming Administrator of CMS, one of my first actions was to launch the Patients Over Paperwork initiative, which is in accord with President Trump's Executive Order directing federal agencies to "cut the red tape" to reduce burdensome regulations.

Through Patients Over Paperwork, CMS established an internal process to evaluate and streamline regulations to reduce unnecessary burden and increase efficiencies. On a national listening tour, we gathered feedback from over 2,000 customers across 23 states and, using this

information, made common-sense changes to regulations and guidance. I have often heard that unnecessary regulations are increasing costs on providers, and they are losing time with patients as a result. Recently, CMS released the Omnibus Burden Reduction (Conditions of Participation) Final Rule, which is estimated to save providers 4.4 million hours previously spent on paperwork annually, with overall total provider savings projected to be approximately \$8 billion over the next 10 years, giving doctors more time to spend with their patients.¹

Physician Self-Referral Regulations

On October 9, CMS announced proposed changes to modernize and clarify the regulations that interpret the Physician Self-Referral Law (“the Stark Law”) by providing greater certainty for health care providers participating in value-based arrangements and providing coordinated care for patients. Specifically, the proposed rule would create new, regulatory exceptions to the Stark Law for value-based arrangements, other new exceptions, and guidance and clarification on existing requirements. This rule would create new opportunities for coordinated care across the industry, while maintaining strong safeguards to protect patients and programs from fraud and abuse.

¹ Final Rule available at: <https://www.federalregister.gov/documents/2019/09/30/2019-20736/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and>

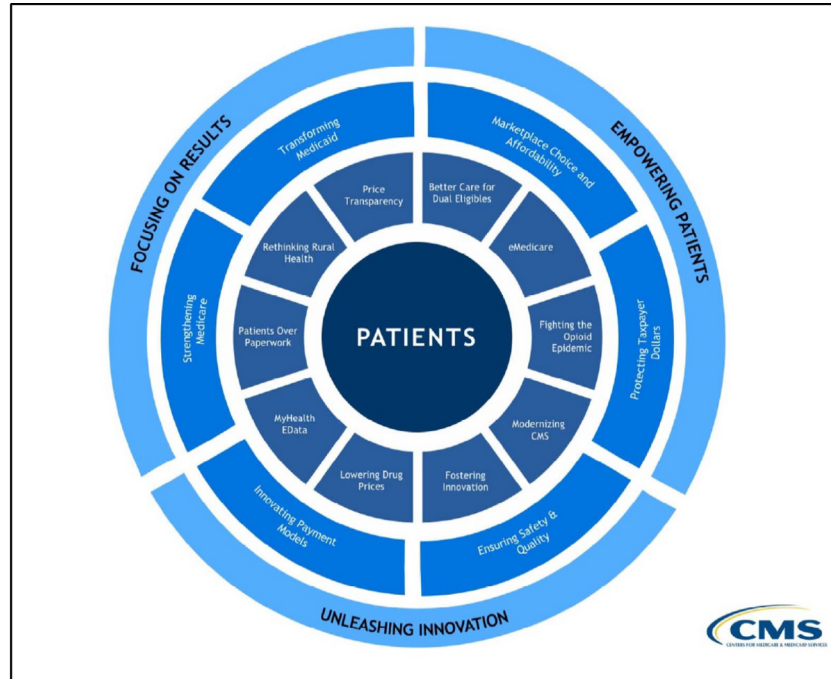


Figure 1

One of my priorities has also been to engage with our federal partners to leverage their expertise, coordinate efforts, and work together efficiently and effectively. One example is our work with the Government Accountability Office (GAO) and the Department of Health and Human Services' Office of Inspector General (HHS-OIG). Since I arrived at the agency, I have placed a renewed focus on implementing their recommendations quickly and in a thoughtful manner, and I am proud to report that we have closed more than half of the backlog I inherited, and we look forward to continuing to work with our federal partners.

Lowering Drug Prices

This Administration has done more than any other in history to combat the rising costs of prescription drug prices, and CMS—along with our partners across the federal government—plays an important role in these efforts.

In May 2018, President Trump released the “American Patients First Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs,” which outlines four key strategies for addressing challenges in the American drug market: improved competition, better negotiation, incentives for lower list prices, and lower out-of-pocket costs.²

CMS is doing our part to execute that strategy, and we are already seeing results. Over the past three years, average part D basic premiums have decreased by 13.5 percent, and the projected average premium for plan year 2020 is the lowest it has been since 2013.

Improved Competition

Promoting innovation can lead to increased competition and lower costs. Many of the highest-cost medicines that Medicare pays for are biologics, and CMS is looking to increase the availability of biosimilars to encourage competition with biologics. By providing biosimilars with separate payment codes in Medicare Part B and lowering the amount of cost sharing paid for biosimilars by low-income beneficiaries in Medicare Part D, CMS has been encouraging companies to invest in bringing more biosimilars to market, which would increase competition and reduce costs.

CMS also finalized policies to increase competition among Medicare Advantage and Part D plans. Previously, when an issuer wanted to offer multiple plans in the same region, they had to prove that each plan was “meaningfully different,” in terms of enrollee out-of-pocket costs. This led to concerns that issuers were reducing the benefits of some plans to meet the meaningful difference requirements. We removed a requirement that certain Part D plans have to “meaningfully differ” from each other, increasing competition and making more plan options available for consumers.³

Strengthened Negotiation

Market-based negotiation is an important part of our efforts to lower drug prices. In May 2019, CMS finalized a policy that facilitates a Medicare Advantage plan’s ability to negotiate prices for Part B physician-administered medicines by allowing the plan to institute step therapy when

² “American Patients First Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs,” <https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf>

³ Final rule available at: <https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf>

beneficiaries first start on the medicines.⁴ By strengthening a plan's ability to negotiate with prescription drug companies, plans can deliver better value for a patient's medical needs.

Beginning in plan year 2020, plans can use indication-based formulary design and management as a new negotiation tool.⁵ Currently, when a plan covers a drug for one indication approved by the Food and Drug Administration (FDA), it has to cover all other FDA-approved indications. This can mean that a more appropriate or more affordable drug may not be covered because the plan has already been required to cover a therapeutic alternative. Allowing indication-based management will mean more tailored choices for patients and more power for Part D plans to bring down drug prices.

Incentivizing Lower List Prices through Increased Transparency

In the "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Out-of-Pocket Expenses" final rule issued in May 2019, CMS implemented a provision in the Know the Lowest Price Act of 2018 (P.L. 115-262) to codify the existing prohibition of "gag clauses."⁶ Under the rule, Part D sponsors may not include "gag clauses" in contracts with pharmacies that prohibit or penalize pharmacists from disclosing to an enrollee if he or she would pay a lower price if they paid in cash rather than going through their insurance.

CMS has also advanced price transparency through the release of interactive, online dashboards that show spending per dosage unit on prescription drugs for the Medicare Part B and Part D programs as well as Medicaid.⁷ In March 2019, we updated these dashboards to include data through 2017. By 2021, we are requiring Part D plans to implement one or more real-time benefit tools that can provide prescribers with information through the prescriber's electronic health record or e-prescribing system on a patient's out-of-pocket costs for different prescription drugs, so they can discuss this information with patients at the time a prescription is written. Also effective January 1, 2021, CMS will require the Explanation of Benefits that Part D plans send to beneficiaries to include drug price increases and lower cost therapeutic alternatives. By

⁴ <https://www.govinfo.gov/content/pkg/FR-2019-05-23/pdf/2019-10521.pdf>

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Downloads/HPMS-Memos/Weekly/SysHPMS-Memo-2018-Aug-29th.pdf>

⁶ Final rule available at <https://www.federalregister.gov/documents/2019/05/23/2019-10521/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses>

⁷ CMS Dashboards available at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/information-on-prescription-drugs/index.html>

empowering patients with more information on the cost of their prescription drugs at the point of prescribing, our rule will help ensure that pharmaceutical companies have to compete on the basis of price.

Modernizing Part D

Part D plans are the primary source of outpatient prescription drug coverage for 43.9 million Medicare beneficiaries, and in May 2019, CMS finalized policies that will give enrollees greater information on the cost of prescription drugs.

Earlier this year, we announced the testing of a new payment model and transformative updates to an existing model tested by the CMS Center for Medicare and Medicaid Innovation. Under the Medicare Part D Modernization Model—which begins in 2020—participating plans take a higher risk for spending once a beneficiary hits the catastrophic phase of Part D, creating new incentives for plans, patients, and providers to choose drugs with lower list prices.

More work must be done to lower prescription drug prices, and CMS is committed to doing our part. As the largest payer for health care in the U.S., Medicare policies can have a wide-reaching impact on health care spending, including prescription drug costs. That is why we are continuing to take steps to reduce prescription drug prices by unleashing innovation and empowering patients through increased transparency across the program.

Choice and Affordability on the Exchanges

We are empowering patients by addressing choice and affordability on the Exchanges. When I began my tenure as CMS Administrator, it was clear that the status quo was not working for far too many Americans, and the individual market was in a state of crisis because of the Patient Protection and Affordable Care Act (PPACA). In 2017, the average premium for plans offered through the Federally-facilitated Exchanges was more than double the average overall individual market premium recorded in 2013; issuers were dropping out of the individual market and rates were rapidly increasing.⁸

Under President Trump's direction, the Administration acted to promote market stability, increase competition, and provide states additional tools and flexibility to meet the needs of their

⁸ <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>

residents and promote more affordable coverage. For example, we finalized the Market Stabilization Rule in 2017 and later went on to finalize other rulemaking to give states new tools and flexibility in regulating their insurance markets. And as a result of increased efficiency, the Administration was able to reduce the user fee charged to issuers on the Federally-facilitated Exchanges and State-based Exchanges using the Federal Platform, a reduction that will be passed on to consumers in the form of lower premiums. But we know we still have more to do—premiums are too high, and unsubsidized consumers are fleeing the individual market—so we have not stopped focusing on encouraging innovation.

Promoting State Innovation

Section 1332 of the PPACA permits states to request waivers of certain rules under federal law to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance.

Last October, the Administration issued new guidance to provide states with significant opportunities to chart a different course for their markets by expanding state flexibility through State Relief and Empowerment Waivers.⁹ Previous guidance significantly restricted the innovative approaches states could pursue and made it difficult for states to address the specific needs of their residents. The October 2018 guidance works within the existing law to empower states to address problems with their health insurance markets and increase coverage options for their residents while at the same time encouraging states to adopt innovative strategies to reduce future overall health care spending.

As of September 30, 2019, we have approved waivers in 13 states, and all but one of these waivers have been for states to create their own reinsurance programs. While some states are still working to implement their waiver, other states have estimated that these reinsurance programs have reduced average premiums 6 to 30 percent.

To be approved, waiver plans must meet the four statutory guardrails relating to comprehensiveness, affordability, coverage, and federal deficit neutrality. Importantly, the October 2018 guidance maintains the same strong protections for people with pre-existing conditions, and the law does not permit states to waive these protections, among other certain

⁹ <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>

PPACA requirements. This Administration remains firmly committed to maintaining protections for all Americans with pre-existing conditions, and we believe that states can develop waiver plans that improve upon the status quo while also providing necessary support for people with pre-existing or chronic conditions.

CMS has worked closely with states to unleash the potential of 1332 waivers. We have published numerous resources to help states design and submit applications for waivers that use the new flexibilities in the October 2018 guidance, including waiver concepts, application templates, and checklists.¹⁰ In May 2019, we issued a request for information to gather further feedback and ideas on how states could use the flexibilities provided by the new guidance to provide their residents with a variety of choices for affordable health insurance.¹¹

Marketplace Choice and Affordability

In Plan Year 2018, more than half of the counties across America had only one issuer offering individual market coverage on the Federal-facilitated Exchanges. For Plan Year 2019, this dropped to 35.3 percent, and we expect this trend to continue for Plan Year 2020.¹² While we work to increase consumer choice, we are committed to increasing transparency and empowering consumers to make informed health care decisions. Our initiatives put patients at the center of our policies and are aimed toward better serving those Americans who have been left behind and priced out of health insurance under the PPACA.

Short-Term, Limited-Duration Insurance

This Administration's efforts to expand access to affordable coverage, including short-term, limited-duration insurance, provide needed options, particularly for many middle-class Americans without employer-sponsored coverage who are not eligible for subsidies under the PPACA. Average individual market Exchange premiums in the 39 states that used HealthCare.gov increased by 105 percent from 2013 to 2017.¹³ Recent reports show a decline of

¹⁰ State application tools and resources available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers.html#Application%20Tools%20and%20Resources

¹¹ <https://www.federalregister.gov/documents/2019/05/03/2019-09121/request-for-information-regarding-state-relief-and-empowerment-waivers>

¹² <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Final-2019-County-Coverage-Map.pdf>

¹³ CMS, "Individual Market Premium Changes: 2013 - 2017," May 23, 2017.

<https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>

1.3 million unsubsidized people covered by individual market health insurance plans in 2017, and another 1.2 million fewer unsubsidized people in 2018.¹⁴ Many state individual markets experienced far more dramatic declines, with unsubsidized enrollment dropping by more than 40 percent in six states, including a 73 percent decline in Arizona.¹⁵

Short-term, limited-duration insurance has existed for decades—including after the enactment of the PPACA under the previous Administration—offering flexible and affordable coverage for American individuals and families. This Administration has expanded the availability of such insurance by extending its maximum initial contract term from less than 3 months to less than 12 months, and by permitting renewal of coverage under a policy for up to 36 months. At the same time, we instituted more robust notice requirements for informing consumers about the potential limits of this insurance than the previous Administration.¹⁶ Short-term, limited-duration options are more affordable, in part because they generally do not have to cover all the mandated benefits and meet all of the requirements imposed under the PPACA. The Congressional Budget Office predicted that, for consumers with low expected health care costs who are ineligible for a subsidy to purchase PPACA-compliant insurance on the Exchange, premiums may be as much as 60 percent lower than the lowest cost bronze plans, depending on an individual's health characteristics.¹⁷

These plans are not for everyone, but for many Americans, access to short-term, limited-duration insurance may mean the difference between some insurance and no insurance at all. Ultimately,

¹⁴ CMS, “Trends in Subsidized and Unsubsidized Enrollment,” August 12, 2019, <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf>

¹⁵ *Id.*

¹⁶ 83 FR 38212 at 38224 (Aug. 3, 2018). Specifically, issuers of short-term, limited-duration insurance must prominently display the following notice in the contract and in any application materials provided in connection with enrollment in short-term, limited-duration insurance:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

¹⁷ https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf

we believe Americans should be allowed to make their own decisions when buying coverage that works for them and their families.

Expanding Health Coverage Options for Businesses

CMS, together with the Departments of Labor and the Treasury, issued a new policy that will provide employers, and American workers with more options for health insurance coverage. The Departments issued a final regulation that will expand the use of health reimbursement arrangements (HRAs). When employers have fully adjusted to the rule, it is estimated this expansion of HRAs will benefit approximately 800,000 employers, including small businesses, and more than 11 million employees and family members, including an estimated 800,000 Americans who were previously uninsured.

Under the rule, starting in January 2020, employers will be able to use individual coverage HRAs to provide their workers with tax-preferred funds to pay for the cost of health insurance coverage that workers purchase in the individual market, subject to certain conditions. These conditions include employer flexibility and guardrails meant to protect the individual market against adverse selection and include a notice requirement to ensure employees understand the benefit. Individual coverage HRAs are designed to give working Americans and their families greater control over their health care by providing an additional way for employers to finance health insurance for their employees.

Improving the Consumer Experience

Quality Rating System for Qualified Health Plans on Exchanges

In August 2019, we announced that—for the first time—CMS will require the display of the five-star Quality Rating System (or star ratings) nationwide for health plans offered on the Health Insurance Exchanges. Consumers will be able to compare health coverage choices using a five-star quality rating of each plan on Exchange websites, including HealthCare.gov, similar to other CMS star rating programs, such as the Hospital Compare and Nursing Home Compare websites and Medicare Advantage.

Enhanced Direct Enrollment

In November 2017, CMS launched a new enhanced direct enrollment pathway for consumers to enroll in health insurance coverage through the Federally-facilitated Exchanges. This pathway allows CMS to partner with the private sector to provide a more user-friendly and seamless

enrollment experience for consumers by allowing them to apply for and enroll in an Exchange plan directly through an approved issuer or web-broker without the need to be redirected to HealthCare.gov or contact the Exchange Call Center.

Our primary goal for Open Enrollment is to provide a seamless experience for HealthCare.gov consumers, ensuring that those who want Exchange coverage can enroll in a plan. For the last two Open Enrollment Periods, the Exchange Call Center has maintained a consumer satisfaction rating of over 90 percent, and we are committed to maintaining this success.

Strengthening Medicare

We welcome thousands of enrollees a day to the Medicare program, and we have to protect Medicare to make it sustainable for future generations. CMS is modernizing the program to increase choices and unleash private sector competition and innovation. This includes bringing Medicare into the 21st century by empowering beneficiaries with tools to meet modern consumer expectations and new types of benefits from private plans.

We have also worked to strengthen the Medicare program through our proposed rulemaking, including our efforts to increase patient choice and lower beneficiary out-of-pocket costs by making sure Medicare does not pay substantially more for visits at a hospital outpatient department than a clinic visit and expanding the services that can be paid for at ambulatory surgery centers; requiring hospitals to publish price information so beneficiaries are able to do an apples-to-apples comparison on the price of procedures across hospitals; adding new values for evaluation and management coding to increase Medicare payments to reward the time that doctors spend with patients; and implementing a new home infusion benefit for beneficiaries, increasing home-based care.

Enhancing Access to Value-Based Care and Payment Models

We are proud of our ongoing work to test innovative payment and service delivery models at the Center for Medicare and Medicaid Innovation (Innovation Center), which has introduced or updated 15 models and solicited comments on a potential Part B drug payment model.

Primary Care Transformation

Building on knowledge gained from previous models, I announced new CMS Center for Medicare and Medicaid Innovation payment models that aim to transform primary care and deliver better value for patients throughout the health care system. The CMS Primary Cares Initiative will reduce administrative burdens and overall health care costs by providing primary care practices and other providers with five new payment options under two paths: Primary Care First and the Direct Contracting Model.

Kidney Care Transformation

Delivering on President Trump's Advancing American Kidney Health Executive Order, I announced new CMS Center for Medicare and Medicaid Innovation payment models that aim to transform kidney care so that patients with chronic kidney disease have access to high quality, coordinated care.¹⁸ And we released a proposed rule that would encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with End-Stage Renal Disease (ESRD) through the required ESRD Treatment Choices Model. These historic initiatives aim to improve the quality of life for kidney disease patients by preventing disease progression, encouraging transplants over dialysis, and, if dialysis is needed, promoting more convenient home-based dialysis to improve health outcomes.

Medicare Advantage Value-Based Insurance Design

Since January 2017, the Medicare Advantage Value-Based Insurance Design model has been testing innovative delivery approaches by allowing eligible Medicare Advantage plans to offer reduced cost sharing or additional supplemental benefits to enrollees with select chronic conditions. We have enhanced this model over the years, increasing both the number of participating plans and the number of chronic conditions they are allowed to focus on. In 2020, the model will be further expanded, to include the ability for plans to offer increased access to “non-primarily health related” items and services for enrollees, based on chronic condition or socioeconomic status. In 2021, the model will test allowing Medicare Advantage plans to offer Medicare's hospice benefit.

¹⁸ Advancing American Kidney Health Executive Order available at: <https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health/>

Better Care for Dually Eligible Beneficiaries

Approximately 12 million Americans are simultaneously enrolled in both Medicaid and Medicare, relying on the state and federal governments to separately administer their health coverage. A lack of coordination can lead to fragmented care for individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all. CMS and states spend over \$300 billion per year on the care of dually eligible individuals, yet still have room for improving health outcomes.¹⁹

In the 2020 Medicare Advantage and Part D final rule, we implemented provisions of the Bipartisan Budget Act of 2018, including policies that would create standards to better integrate Medicare Advantage dual eligible special needs plans, as well as a new Medicare-Medicaid integrated appeals process for beneficiaries in fully integrated plans.²⁰

We are also driving innovation in integrated care through CMS models and demonstrations. In December 2018, we sent a letter to state Medicaid directors highlighting ten opportunities to improve care for dually eligible individuals, and in April 2019, CMS opened up models to all states to participate in our Medicare-Medicaid Financial Alignment Initiative.

Fostering Innovation

CMS is committed to strengthening the Medicare program by ensuring that beneficiaries have access to new and potentially lifesaving treatments. In August of this year, CMS finalized an alternative new technology add-on payment pathway for medical devices that receive FDA marketing authorization and are part of the Breakthrough Devices Program. The FDA's Breakthrough Devices Program can help expedite the development and review of transformative new devices that meet the program criteria (e.g., provide for more effective treatment of serious or irreversibly debilitating diseases or conditions for which there are unmet medical needs). Under an expedited timeframe, it can be challenging for innovators to gather evidence demonstrating the device's "substantial clinical improvement," which is required to qualify for Medicare new technology add-on payments. To address this issue, CMS finalized an alternative new technology add-on payment pathway in which Breakthrough Devices would no longer be

¹⁹ https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf

²⁰ Final Rule available at: <https://www.federalregister.gov/documents/2019/05/23/2019-10521/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses>

required to demonstrate evidence of “substantial clinical improvement” to qualify for new technology add-on payments.

CMS also finalized an alternative new technology add-on payment pathway to improve access to new antimicrobial therapies specifically designed with the intent of addressing resistant infections. Drug-resistant infections are a public health crisis, affecting more than 2 million Americans each year and resulting in thousands of deaths annually.²¹ To help secure beneficiary access to antimicrobials, CMS will no longer require new antimicrobial drugs to meet the “substantial clinical improvement” criterion and will increase the maximum add-on payment from 50 percent to 75 percent.

Innovators are taking notice of the Trump Administration’s commitment to unleashing innovation and creating transparency for innovators to navigate complex government processes. We have seen the number of new technology add-on payment applications nearly double since 2016. Starting this October, we will be paying for a record-breaking 18 new technologies in total. These new technologies include some used in treatment for many types of cancer, including prostate and bladder cancers, and leukemia.

Chimeric Antigen Receptor T-cell Therapy

In August, CMS finalized a national coverage determination on coverage of FDA-approved Chimeric Antigen Receptor T-cell, or “CAR T-cell” therapy, which is a form of cancer treatment that uses a patient’s own genetically-modified immune cells to fight disease. As the first type of FDA-approved gene therapy, CAR T-cell therapies are an important scientific advancement in this promising new area of medicine and provide treatment options for some patients who had nowhere else to turn.

Protecting Taxpayer Dollars through Enhanced Medicare Program Integrity

CMS’s goal is to make sure our programs pay the right amount, to the right party, for the right beneficiary. The Trump Administration’s program integrity activities saved Medicare an estimated \$15.5 billion in FY2017, for an annual return on investment of \$10.8 to \$1. The 2018 Medicare fee-for-service improper payment rate was 8.12 percent, the lowest since 2010.

²¹ <https://www.cdc.gov/drugresistance/about.html>

New Medicare Cards

Our effort to issue new, more secure Medicare cards was an important step to protect beneficiaries from becoming victims of identity theft. For the first time, CMS now has the ability to terminate a Medicare number and issue a new number to a beneficiary if their Medicare number has been compromised, without impeding access to care. Beneficiaries have received a new card featuring a unique, randomly assigned Medicare number known as a Medicare Beneficiary Identifier to help protect against personal identity theft and fraud. While beneficiaries can continue to use their old card through the end of 2019, most Medicare patients are already successfully using their new cards.

Provider Screening and Enrollment

As the gateway to the Medicare program, provider screening and enrollment is the key to preventing fraudulent providers and suppliers from entering the program. In September 2019, CMS issued a final rule, “Program Integrity Enhancements to the Provider Enrollment Process,” that creates several new revocation and denial authorities to bolster CMS’s fraud-fighting capabilities.²² Importantly, a new “affiliations” authority in the rule allows CMS to identify individuals and organizations that pose an undue risk of fraud, waste or abuse based on their relationships with other previously sanctioned entities.

Fraud Prevention System

One of the most important improvements CMS has made in its approach to program integrity over the last several years is our enhanced focus on prevention. CMS is using a variety of tools, including innovative data analytics, to keep fraudsters out of our programs and to uncover fraudulent schemes and trends before they drain the Trust Funds. In 2018, we announced a new version of the Fraud Prevention System (FPS) that runs predictive algorithms nationwide against Medicare fee-for-service claims on a continuous basis prior to payment in order to identify, prevent, and stop potentially fraudulent claims. The updated version modernizes system and user interface, improves model development time and performance measurement, and aggressively expands CMS’s program integrity capabilities. Based on the leads generated by the FPS during FY2017, HHS took administrative action against 949 providers and suppliers.

²² Final Rule available at: <https://federalregister.gov/d/2019-19208>

Coordination with Law Enforcement

We are committed to working with our partners in law enforcement to ensure the safety of beneficiaries and the protection of taxpayer dollars. CMS has begun a Major Case Coordination initiative that includes HHS-OIG and the Department of Justice. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads.

CMS provides support to law enforcement as they take coordinated actions. In April 2019, the Department of Justice charged 24 defendants—including executives associated with five telemedicine companies, the owners of dozens of durable medical equipment companies, and three licensed medical professionals—for their alleged participation in health care fraud schemes involving more than \$1.2 billion in losses, as well as the execution of over 80 search warrants in 17 federal districts. CMS took swift action to suspend payments to 130 providers, likely preventing millions of additional dollars in losses. Every dollar saved is critical to the sustainability of our Medicare program and the needs of our beneficiaries. We look forward to continuing to work collaboratively with our partners at the Department of Justice and HHS-OIG to identify, investigate, and eliminate waste, fraud and abuse in our federal health care programs.

Transforming Medicaid

CMS is determined to continue our work ushering in a new era of state flexibility in the administration of the Medicaid program. Our vision for the future of Medicaid is to reset and restore the federal-state relationship, while modernizing the program to deliver better outcomes for the people it serves. I believe that fostering state innovation and pairing it with enhanced accountability and integrity will improve health outcomes for beneficiaries. This commitment will help states achieve the flexibility they need to promote the health and well-being of their most vulnerable citizens and help them rise out of poverty.

Providing States Flexibility to Design Their Medicaid Programs

CMS is offering states unprecedented flexibility to design health programs that meet the needs of their residents. We have taken action through a number of changes that make it easier than ever before for states to design innovative approaches to improving quality, lowering costs, and delivering value to our beneficiaries.

Empowering states to advance the next wave of innovative solutions to Medicaid's challenges is a key part of our vision for the future of the program. To make changes to their Medicaid program, a state must apply to CMS for either a state plan amendment (SPA) or one of several waivers authorized by statute. Changes can also be tested under a demonstration project.

Improving the State Plan Amendment and Section 1915 Waiver Review Process

Under my leadership, CMS adopted new strategies for more efficient processes for approval of SPAs and waiver and adjudication under Section 1915 of the Social Security Act, as well as implementing other long term process improvements.²³ CMS also introduced new procedures to prevent formation of a backlog of pending SPAs in instances where CMS has not received a state response to a formal request for additional information within 90 days of issuance.

A key goal of this initiative was to develop a process improvement strategy that enhanced the efficiency of the SPA and 1915 waiver review process by reducing the administrative burden and processing times for states. We collaborated closely with states and the National Association of Medicaid Directors to identify the issues that impact SPA and 1915 waiver processing and jointly developed a number of process improvement strategies, and this effort is resulting in more efficient and timely processing of SPA and 1915 waiver actions:

- Between calendar year 2016 and the first quarter of 2018, there was a 23 percent decrease in the median approval time for Medicaid SPAs.
- Eighty-four percent of Medicaid SPAs were approved within the first 90 day review period in the first quarter of 2018, a 20 percent increase over calendar year 2016.
- Between calendar year 2016 and the first quarter of 2018, median approval times for 1915(b) waivers decreased by 5 percent, 1915(c) renewal approval times decreased by 38 percent, and 1915(c) amendment approval times decreased by 54 percent.

Waivers and State Plan Amendments

Section 1115 of the Social Security Act gives the Secretary authority to approve experimental, pilot or demonstration projects that the Secretary finds are likely to assist in promoting the objectives of the Medicaid program. These demonstrations are intended to evaluate state-specific policy approaches to better serve Medicaid populations. I have invited states to bring forward their best, most innovative ideas, and this Administration has been responsive to state priorities

²³ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/cjb081618.pdf>

in a way that previous Administrations have not been, approving more than 30 groundbreaking Medicaid demonstration projects.

In 10 states, CMS approved reforms to test how Medicaid can be designed to improve health outcomes and lift individuals from poverty by connecting coverage to community engagement. On January 11, 2018, CMS sent a letter to state Medicaid directors designed to help states test whether Medicaid beneficiary health and well-being is improved through section 1115 demonstration projects that incentivize work and community engagement among adult Medicaid beneficiaries who are not elderly, pregnant, or eligible for Medicaid because of a disability.²⁴ Well-designed community engagement incentives have great potential to promote better mental, physical, and emotional health in furtherance of Medicaid program objectives, and we believe targeting certain health determinants, including productive work and community engagement, may improve health outcomes.

CMS has approved community engagement requirements only when a state's demonstration design includes important exemptions for people who are eligible for Medicaid disability or pregnancy. These demonstrations also include protections and exemptions for individuals determined by the state to be medically frail and individuals with acute medical conditions validated by a medical professional that would prevent them from complying with the requirements.

Under this Administration, CMS also took the historic step of approving the first ever 10-year extension under the Medicaid program demonstration extension to provide further coverage of family planning services in Mississippi, allowing the state to administer this longstanding Medicaid program without the need for routine approvals from CMS. Since then, CMS has approved a 10-year extension of waivers in three states. This action is one in a series of improvements CMS has instituted to reduce regulatory burdens, increase efficiency and promote transparency in the review and approval of waivers and SPAs.

Amplifying and Spurring Innovation on Maternal Mortality

Maternal mortality is a critical issue for Americans across the country, including those in rural areas. While rural communities share a disproportionate share of the negative outcomes, we have

²⁴ Letter available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

seen some rural communities find ways to improve outcomes. Since CMS pays for nearly half of the births in this country, we are working on ways to amplify the existing solutions that are working and exploring every lever at our disposal to improve maternal health outcomes. On June 12 of this year, CMS co-hosted a forum in collaboration with other federal and private partners looking at ways to improve maternal health access, quality, and outcomes for rural communities.

Protecting Taxpayer Dollars through Enhanced Medicaid Program Integrity

CMS takes seriously our responsibility to protect the fiscal health of our programs to ensure their sustainability for the future. We have seen a rapid increase in Medicaid spending in recent years, and with this growth comes an increasing and urgent responsibility to ensure sound stewardship and oversight of our program resources. While it is critical for states to have the necessary flexibility to design health programs that meet the needs of their residents, this groundbreaking new flexibility must be balanced with appropriate accountability.

Enhanced Medicaid Program Integrity Strategy

In June 2018, we released a Medicaid Program Integrity Strategy²⁵ to protect taxpayer dollars while enhancing the financial and programmatic integrity of the Medicaid program.²⁶ The strategy includes enhanced initiatives that will create greater transparency and accountability for Medicaid program integrity performance, including increased beneficiary eligibility oversight, stronger audit functions, and enhanced enforcement of state compliance with federal rules.

Since 2014, the Medicaid program has added more than 15 million new working-age, adult enrollees who primarily qualify as part of the PPACA's Medicaid expansion. Earlier this year, CMS released renewed guidance addressing concerns raised by recent audits conducted by the HHS-OIG and others that found that some states did not always determine Medicaid eligibility for the expansion population in accordance with federal and state requirements.²⁷ The guidance emphasizes CMS's expectations for states that may be considering or that have implemented the Medicaid expansion.

²⁵ Medicaid Program Integrity Strategy available here: <https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf>

²⁶ Medicaid Program Integrity Strategy available here: <https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf>

²⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf>

Medicaid and CHIP Scorecard

Ultimately, states and the federal government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both federal and state dollars. In June 2018, CMS released the first ever CMS Medicaid and CHIP Scorecard, a central component of the Trump Administration's commitment to modernizing and strengthening transparency of the Medicaid and CHIP programs by allowing every American to evaluate how the Medicaid and CHIP programs are improving the lives of beneficiaries.²⁸

As part of CMS's overall commitment to robust and transparent public reporting of quality and administrative metrics that drive performance improvement, the agency is also working to enhance the functionality of the Scorecard as part of a comprehensive annual update expected to be published later this year.

Medicaid Provider Screening and Enrollment

While states are responsible for screening and enrolling Medicaid and CHIP providers, we have taken numerous steps to support and streamline state efforts. Several states already use CMS's data compare service, whereby the state can submit their provider enrollment file to CMS and CMS will match the state's file with Medicare's provider enrollment file. For providers that were already screened by Medicare, the state can rely on Medicare's screening results. CMS is working to expand this service to additional states, as well as looking at ways to screen Medicaid-only providers on behalf of states.

Unleashing Innovation

Health care innovation is driving better quality of care, enhanced access to care, increased efficiency, and lower healthcare costs. CMS is embracing technology and innovation by identifying and implementing effective payment models and removing regulatory barriers.

Modernizing Medicare

CMS is improving our online Medicare tools to meet the needs of a growing number of tech savvy beneficiaries. However, Medicare's traditional customer service options remain, and

²⁸ <https://www.medicaid.gov/state-overviews/scorecard/index.html>

beneficiaries will continue to have access to paper copies of the Medicare & You handbook and can access help over the phone using 1-800-MEDICARE.

eMedicare Initiative

CMS launched the eMedicare initiative in 2018 to deliver simple tools and information to current and future Medicare beneficiaries. Since I started this initiative, CMS has moved quickly to develop and implement numerous new tools to deliver personalized and customized information that Medicare beneficiaries prefer. Our “What’s Covered” app—available for download on most smart phones—gives users coverage information at their fingertips. To help beneficiaries make informed decisions about providers, we developed a price transparency tool that lets consumers compare Medicare payments and copayments of certain procedures performed in both hospital outpatient departments and ambulatory surgical centers, as well as an online service available on our website that lets people quickly see how different coverage choices will affect their estimated out-of-pocket costs. CMS also redesigned the Medicare.gov homepage and refreshed the personalized MyMedicare.gov portal to create a more seamless, easy to navigate, personalized online experience.

Medicare Plan Finder

As part of the eMedicare initiative, in August 2019 CMS released a modernized and redesigned Medicare Plan Finder for the first time in a decade. This tool allows users to shop and compare Medicare Advantage and Part D plans.²⁹ In 2018, approximately 25 percent of Medicare beneficiaries accessed Medicare Plan Finder on mobile devices, an increase of 40 percent from 2017.

The updated Medicare Plan Finder provides a personalized experience through an easy-to-read design that will help beneficiaries and caregivers learn about different options and select coverage that best meets their health needs. It includes new features that will make it easy for consumers to build a personal drug list to find Part D coverage that best meets their needs and compare coverage options on their smartphones and tablets. The new Plan Finder walks users through the Medicare Advantage and Part D enrollment process from start to finish and allows

²⁹ Medicare Plan Finder available at: <https://www.medicare.gov/plan-compare/>

people to view and compare many of the supplemental benefits that Medicare Advantage plans offer.

MyHealthEData

Last year, the Administration launched the MyHealthEData Initiative, a government-wide initiative spearheaded by the White House Office of American Innovation with participation from CMS and other federal agencies. A key goal of this initiative is to empower patients by giving them the ability to move from health plan to health plan and from provider to provider while having both their clinical and administrative information follow them. Patient data belongs to the patient; every American should be able, without special effort or advanced technical skills, to see, obtain, and use all electronically available information that is relevant to their health, care, and choice—of plans, providers, and specific treatment options.

Medicare Blue Button 2.0

In support of the MyHealthEData initiative, last year, CMS announced the launch of Blue Button 2.0, our first secure, standards-based Application Programming Interface (API) that allows Medicare beneficiaries to access and share their Medicare Part A, B and D claims data with applications and services that help them manage their health, in addition to sharing this information with their doctors or caregivers.

Through Blue Button 2.0, Medicare beneficiaries can select third party applications to access their data and use their electronic health information. There are now 30 Blue Button apps available, which are posted on Medicare.gov, and 2,000 developers are currently working on many more.

Ensuring the privacy and security of beneficiary data in Blue Button 2.0 is a top priority for CMS. Blue Button 2.0 applications use existing CMS standards for beneficiary authorization, and the applications must use clear and plain language to alert beneficiaries that they are sharing their data. Additionally, CMS offers a user-friendly dashboard on MyMedicare.gov that allows beneficiaries to turn off data access for any application at any time.

Interoperability and Patient Access Proposed Rule

On March 4, 2019, CMS issued a proposed rule on Interoperability and Patient Access to help move the health care market toward interoperability.³⁰ This proposed rule demonstrates our commitment to the vision set out in the 21st Century Cures Act and Executive Order 13813 to improve access to and the quality of information for Americans to make informed health care decisions. The proposed rule would enable more patients to access their health information electronically by requiring the payers subject to this proposed rule to share health claims and clinical information electronically with their enrollees starting in 2020, much like CMS is already doing for Medicare beneficiaries through Blue Button 2.0. The proposed rule would also facilitate data exchange to allow greater access to patient health information—like event notifications at the moment of hospital admission, discharge or transfer—for health care providers and suppliers, including doctors and hospitals, regardless of where the patient may have previously received care. We are reviewing comments from the stakeholder community on these proposals as we prepare the final rule.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a requirement that eligible clinicians and hospitals demonstrate that they have not knowingly and willfully taken action to limit or restrict the compatibility or interoperability of certified electronic health record technology. CMS implemented these policies through attestation requirements in our Promoting Interoperability Programs. We believe it would benefit patients and caregivers, to know if individual clinicians, hospitals, and critical access hospitals have submitted a “no” response to any of the three attestation statements regarding the prevention of information blocking. In our proposed rule, we propose including an indicator on the Physician Compare website for eligible clinicians participating in the Quality Payment Program, and to post information on a CMS website available to the public for eligible hospitals and critical access hospitals participating in the Medicare Promoting Interoperability Program, who submitted a “no” response to any of the three attestation statements regarding the prevention of information blocking.

³⁰ Proposed rule available at: <https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicare-programs-patient-protection-and-affordable-care-act-interoperability-and>

Expanding Telehealth and Virtual Services

Telehealth services enable patients to become active members of the care continuum outside of a hospital setting and promotes long-term engagement between patients and practitioners.

Expanding telehealth services would improve care for patients across the country, particularly for those in rural areas that are characterized by great distances and a limited number of healthcare providers and specialty services. CMS is committed to supporting and furthering the use of telehealth services, and under policies finalized in 2018, Medicare patients receiving home dialysis are now able to receive their monthly clinical assessments via telehealth, and patients experiencing symptoms of an acute stroke will be able to receive telehealth services from mobile stroke units. In April 2019, CMS issued a final rule bringing an innovative telehealth benefit to Medicare Advantage, allowing private Medicare Advantage plans to include additional telehealth benefits for enrollees in bids for basic benefits starting in plan year 2020.³¹ We have also taken historic steps to expand vital services through the use of telecommunications technology. For the very first time, starting last January, Medicare now pays for virtual check-ins, remote evaluation of pre-recorded images and video, and virtual consultations between physicians to determine whether an office visit is warranted. For example, a patient could now connect with their doctor by phone or video chat to ask questions, or text a picture of a mole on their skin to a dermatologist for examination, and decide together whether an office visit is needed.

Rethinking Rural Health

Approximately 60 million Americans live in rural areas—including millions of Medicare and Medicaid beneficiaries. CMS recognizes the many obstacles that rural Americans face, including living in communities with disproportionately higher poverty rates, having more chronic conditions, being uninsured or underinsured, as well as experiencing a fragmented healthcare delivery system with an overworked and shrinking health workforce, and lacking access to specialty services. The Trump Administration has placed an unprecedented priority on improving the health of Americans living in rural areas, and last year, CMS furthered this commitment by introducing the agency's first Rural Health Strategy.

³¹ Final rule available at: <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

Leveling the Playing Field for Rural Hospitals

Because of financial pressures and changing demographics, rural hospitals across the country have been closing, eliminating essential services, reorganizing, or transitioning to new types of facilities. In an effort to ensure that rural Americans have access to needed care, CMS finalized changes to the way we calculate the hospital wage index, which adjusts inpatient payment rates to account for local differences in hospital labor markets. Our new policy, issued in August of this year, temporarily addresses distortions in the wage index that may benefit struggling rural hospitals by better positioning them to attract and maintain a highly skilled workforce, strengthen competition, and lead to greater choice for patients in rural areas.

Developing a long-term sustainable strategy for improving rural health is a key priority for CMS. We are pushing ourselves to think more creatively about how to provide rural areas with the flexibility, resources, and innovative tools they need to transform their health care systems to deliver better quality and more accessible services.

Ensuring Safety and Quality in Nursing Homes

CMS is charged with ensuring that every nursing home serving Medicare and Medicaid beneficiaries is meeting federal requirements to keep its residents safe and provide high quality care, and we take this responsibility seriously. In April 2019, I announced a five-part approach that CMS is using to guide our work, including: strengthening oversight; enhancing enforcement; increasing transparency; improving quality; and putting patients over paperwork.

Strengthening Oversight

CMS works in partnership with State Survey Agencies (SSAs) to oversee nursing homes, since these agencies are generally also responsible for state licensure. The SSAs visit and survey every Medicare and Medicaid participating nursing home in the nation at least annually to ensure they are meeting CMS's health and safety requirements as well as state licensure requirements. To be effective, SSAs must be fair and consistent in applying CMS rules.

In recent years, we have found wide variation across SSAs in the identification of issues and the application of penalties. Residents deserve consistent nursing home quality, regardless of location, so CMS is revising our oversight of SSA performance. For example, CMS recently

streamlined the guidelines for determining Immediate Jeopardy used by surveyors.³² Information about these kinds of findings and associated enforcement actions are available on Nursing Home Compare.

Enhancing Enforcement

CMS is strengthening our enforcement of facility compliance with basic health and safety standards to ensure patient safety and quality care. As part of this effort, we're developing new ways to root out bad actors and repeat offenders.

CMS has long identified staffing as essential for quality care. CMS collects staffing data from nursing facilities through the payroll-based journal system based on payroll and other verifiable and auditable data, as required by law.

We are also taking steps to curb the inappropriate use of antipsychotic drugs in nursing homes through our work with the National Partnership to Improve Dementia Care in Nursing Homes (National Partnership). Between 2011 and the third quarter of 2018, our work with the National Partnership helped decrease the national prevalence of antipsychotic medication use among long-stay nursing home residents by 38.9 percent to a national prevalence of 14.6 percent. Additionally, in March, we announced enhanced oversight and began imposing stricter sanctions on the 1,500 nursing homes that have not improved their antipsychotic medication utilization rates for long-stay nursing home residents since 2011, or "late adopters."³³

We are also committed to working with Congress to strengthen nursing home enforcement. In President Trump's FY2020 budget, we have asked Congress to provide us the authority to adjust the frequency of mandatory nursing home surveys so we can focus more time and resources on nursing homes that are poor performers and respond to complaints. The FY2020 Budget also requests a \$45 million increase from the previous year for Survey and Certification, which would enable CMS to continue to meet the statutory survey requirements while dealing with the increase in volume and severity of complaints, and rising survey costs.

³² CMS, QSO-19-109-ALL. Revisions to AppendixQ, Guidance on Immediate Jeopardy, March 5, 2019. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf>

³³ Announcement available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-07-Enhanced-Oversight-and-Enforcement-of-Non-Improving-Late-Adopters.pdf>

Increasing Transparency

CMS is empowering consumers, their families, and their caregivers by giving them the resources they need to make informed decisions, and key to our effort is our Nursing Home Compare website. In April 2019, we made improvements to the Nursing Home Compare website to strengthen this tool for consumers to compare quality between nursing homes. These improvements include revisions to the inspection process, enhancement of new staffing information, and implementation of new quality measures. Beginning on October 23, Nursing Home Compare will feature a new alert icon to identify nursing homes that have been cited for incidents of abuse, neglect, or exploitation.

Special Focus Facilities

When a survey finds a nursing home deficient in any way, the public has a right to know. That is why we have taken steps to empower residents and their families with more information on underperforming nursing homes that are participants or candidates of our Special Focus Facility (SFF) program. Nursing homes designated as an SFF are inspected by survey teams twice as frequently as other nursing homes.

Apart from providing increased oversight, CMS is making information regarding SFF participants and candidates available to consumers. We have published information on our methodology for selecting SFF participants and candidates online so consumers can know more about why a particular facility made the list. Each month, CMS provides a full list of SFF program participants on our website. In May 2019, we began publishing a list of candidates for the SFF program alongside the participants list. Consumers can easily identify an SFF participant on Nursing Home Compare because they are marked with a yellow caution symbol under a facility's "overall rating."

Improving Quality

CMS is actively keeping patients safe by helping nursing homes improve. We are unleashing our expertise in quality measurement to address serious quality issues like healthcare-associated infections, and we are looking at how we can better spend civil money penalty dollars on the most critical quality issues.

In addition to other enforcement remedies, CMS can fine nursing homes that do not comply with our requirements, and we recently launched an initiative to reinvest these civil money penalty

dollars in efforts to reduce adverse events, improve staffing quality and improve quality of care for residents with dementia.

Reducing Provider Burden and Placing Patients Over Paperwork

Ensuring access to high quality nursing home care is our priority, and we strive to hold facilities accountable for resident outcomes without overburdening providers with unnecessary paperwork. More regulation is not necessarily better regulation, nor does it always translate into better care or outcomes. High administrative costs can make it difficult for facilities to operate, and in rural America, a shuttered nursing home can present serious access to care problems. We want to make sure providers spend time caring for residents instead of completing unnecessary paperwork.

Our work will never stop. We are focused on ensuring America's nursing homes are keeping residents safe by rewarding quality and value, making outcomes transparent, and reducing unnecessary paperwork that detracts from patient care, and we will not hesitate to use every tool at our disposal to complete our mission.

Working with Congress

CMS greatly appreciates the important work of Congress as it endeavors to pass legislation that will support us in our mission to improve access, increase competition and unleash innovation

Legislative Proposals in the President's FY2020 Budget

President Trump's FY2020 Budget proposal includes numerous legislative ideas that would give CMS additional flexibility and resources that would complement administrative actions.

Protecting the health and safety of nursing home residents is one of the most important responsibilities CMS has. Today, there are over 15,000 nursing homes in America, but the allocated funds from which CMS funds all of our survey and certification activities, including oversight of state survey agencies, has remained flat for over five years. As mentioned above the President's FY2020 Budget requests an increase in funds for survey and certification activities and to allow CMS to more efficiently use these resources by adjusting statutorily required survey frequencies for top performing nursing homes.

A range of proposals for lowering drug prices are also included in the President's FY2020 Budget, including proposed reforms to CMS programs. These proposals are consistent with the four key strategies for addressing challenges in the American drug market outlined in the "American Patients First Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs," released in May 2018 including improved competition, better negotiation, incentives for lower list prices, and lower out-of-pocket costs.

The President's FY2020 Budget also includes a proposal that would strengthen CMS's ability to recoup Medicaid improper payments related to states' inaccurate beneficiary eligibility determinations. The proposal would give CMS authority to recover overpayments from states that receive federal resources for ineligible or misclassified beneficiaries. Specifically, for incorrect eligibility determinations, it would permit CMS to issue disallowances outside of the current improper payment rate measurement process and allow CMS and HHS-OIG to extrapolate findings on beneficiary eligibility to ensure federal recovery of overpayments.

CMS stands ready to work with Congress as it considers these and other proposals in the President's Budget.

Moving Forward

At CMS, we are putting patients first as we move forward with the strategic initiatives described in this testimony. This transformative vision for the agency drives our decision making every day, and we look forward to continuing to share updates on our progress with Congress.

Ms. DEGETTE. It is now time for Members to ask you questions, and I will recognize myself for 5 minutes.

Administrator Verma, as I stated in my opening and as you mentioned in your statement, we saw the number of uninsured people in this country increase last year for the first time since the ACA was passed to about 1.9 million people, is that correct?

Ms. VERMA. That is correct.

Ms. DEGETTE. And about half of those people were children, is that right?

Ms. VERMA. I don't think that number is correct, no.

Ms. DEGETTE. OK. What is the correct number then?

Ms. VERMA. I think the number's around 400,000.

Ms. DEGETTE. Four hundred thousand, thank you. Now, in the *Texas v. United States* case, that is the case that the administration has requested that the ACA be struck down, is that correct?

Ms. VERMA. That is correct.

Ms. DEGETTE. And so, any day now the court will rule, and if the court rules the way the administration has asked, then the entire ACA will be invalidated, is that correct?

Ms. VERMA. That is correct.

Ms. DEGETTE. OK. So now, if the ACA was invalidated, about 21 million people would lose their health insurance, is that correct?

Ms. VERMA. I think what's clear—

Ms. DEGETTE. Yes or no will work.

Ms. VERMA. No.

Ms. DEGETTE. No, OK. How many people would lose their health insurance if the ACA was struck down, do you know?

Ms. VERMA. The President has made clear that we will have a plan in action to ensure that Americans have access.

Ms. DEGETTE. OK. I am going to get to that in a minute. But if the ACA was struck down, isn't it true 12 million people would lose their insurance?

Ms. VERMA. The President has made clear—

Ms. DEGETTE. No. Yes or no will work. Do you know how many people would lose their insurance?

Ms. VERMA. The President has made clear—

Ms. DEGETTE. OK, you are not going to answer that. Now let me ask you this. Let me ask you this: If the ACA was struck down, then also the provision of the preexisting conditions would be struck down since it is part of the ACA, is that right?

Ms. VERMA. The President has made clear that we will do everything we can to ensure that Americans with preexisting conditions maintain the protection that they have today.

Ms. DEGETTE. Well, let me just say then, since you are not answering my question: The ACA, if it was struck down, this is what would happen. Twenty-one million people who are insured under the ACA would lose their insurance. That includes 12 million people on Medicaid and 9 million who have ACA protection. There are currently 133 million people with preexisting conditions who under the ACA get protections.

Now there is about—I will ask you this. Maybe—I am sure you will give the same answer, but there are 2.3 million adult children under the age of 26 who because of the ACA are able to stay on their parents' insurance. Now, I will ask you this: If the ACA was

struck down, would those 2.3 million adult children still have their insurance?

Ms. VERMA. The President has made clear——

Ms. DEGETTE. OK.

Ms. VERMA [continuing]. That we will maintain what works, and we will try to address the problems that we're having with the ACA.

Ms. DEGETTE. So did the administration file some kind of a motion in the *Texas* case to say that the preexisting conditions should be maintained? Yes or no will work.

Ms. VERMA. Individuals that have preexisting conditions today——

Ms. DEGETTE. Yes.

Ms. VERMA [continuing]. That do not receive a subsidy, I would argue that they don't have the protections today. I mean if we give you an example of the 55——

Ms. DEGETTE. So you don't think the ACA is protecting people with preexisting conditions?

Ms. VERMA. If you can't afford your health insurance, if you can't afford health insurance and you have a preexisting condition, then you don't have protections.

Ms. DEGETTE. OK. What about the adult children? Did the Trump administration file a motion with the court to say they should still be able to stay on their parents' insurance until age 26? Yes or no.

Ms. VERMA. The President has made clear that we will have a plan in action to make sure that Americans have access to affordable coverage. We do not have that today. There are many Americans today, if they are not getting a subsidy, can't afford health insurance today.

Ms. DEGETTE. I totally understand your position, Administrator Verma. You are not answering my questions because, frankly, if the ACA was struck down the preexisting, people with preexisting conditions, the adult children, all of those provisions of the ACA would be reversed. So you are telling me, Administrator, that the Trump administration has told people they will be protected. Can you produce for me right now the Trump administration's plan to protect the people? Can you produce that plan right now?

Ms. VERMA. So today, a 55-year-old couple making \$60,000 a year——

Ms. DEGETTE. No, no. That is not my question.

Ms. VERMA [continuing]. In Nebraska——

Ms. DEGETTE. My question—excuse me. My question is, do you have a copy of the plan that will replace the ACA? Yes or no.

Ms. VERMA. I'm not going to get into any specifics of a plan, but the——

Ms. DEGETTE. OK, you are not going to answer the questions. In that case, the Chair will yield back, and she will recognize the ranking member for 5 minutes.

Mr. GUTHRIE. Thank you, Administrator. Do you want to finish your comments you were just making?

Ms. VERMA. Thank you. So a 55-year-old couple making \$66,000 a year in Grand Island, Nebraska, could face an annual premium of over \$31,000, and that's on top of a \$12,000 deductible. In that

same situation in Colorado, that premium would be \$32,800. In New Jersey, the premium would be almost \$16,000. So we're talking about people having to spend a third to a half of their income on premiums, and that doesn't even include the deductibles.

And so, if those individuals or that couple have a preexisting condition, they don't have any protections today.

Mr. GUTHRIE. So I was going to talk about the lowering premiums, but you are lowering for minority very high premiums that increased since the ACA was passed. So the lower—but you have made efforts and put into place the lowering. What challenges remain to further lowering premiums?

Ms. VERMA. Well, I think one of the things that we need to do is focus on lowering the cost of care. There's been so much discussion about throwing more money, you know, at the problem, having more government control, but what we're focused on is lowering the cost of healthcare. Many of the initiatives that we have at CMS, whether it's around drug pricing, whether it's getting rid of administrative burdens that are getting in the way of doctors spending time with their patients and actually increasing costs, whether it's focusing on efficiencies in the system like interoperability and making sure that patients have access to their healthcare records, we are trying to focus on actions that are going to lower the cost of care for Americans. If we do that, more people will be able to afford healthcare.

Mr. GUTHRIE. Thanks. And I want to switch a little bit. I have some Kentucky hospitals that have contacted me about the star rating system before, and their question is they understand the purpose, but it doesn't adequately, or—reflect the quality that they produce at their hospitals. So I know CMS decided to change the hospital star rating methodology, and so my question is that some stakeholders requested CMS remove or suspend star ratings from Hospital Compare website until the hospital star rating methodology is updated, but what does CMS plan to use the current methodology to update star ratings in early—can you, an estimate for the fix of this?

Ms. VERMA. Sure, and I appreciate the question. So, first of all, let's start with as we are focusing on lowering healthcare costs. We think that price transparency is very important, and along with price transparency quality transparency is important, and that's what the hospital star ratings are all about.

I appreciate the comments and the concerns that hospitals have raised about their methodology, and we've made it clear that we want to work with them so we can make sure that Americans have access to quality information that's going to give them the best understanding of what type of hospital and what kind of issues that hospital may have, so we are dedicated to working with them. In the meantime, though, we want to be able to use what we have because we think it's important for patients to have that information.

Mr. GUTHRIE. Thank you very much.

Ms. VERMA. But we will work with them.

Mr. GUTHRIE. Thank you very much. And last week or the week before last, I think, last week we had a markup on a drug pricing bill here. And then the big concern that I have had, and one of the great things that has been bipartisan was the Cures Act, the things

that we moved here. And being in DC, when I talk to people back home that things are working and things are moving forward, it is the blockbuster drugs that are coming out, the blockbuster procedures. In the bill that was—the CBO estimated that 10 to 15 remedies or cures would not come forward because of the impact of the bill.

And there were a couple of Members on the other side, one that said 10 to 15 would be something to, you would just have to sacrifice for the fact of being able to negotiate lower drug prices. One said that, well, if we have these blockbuster cures, we can't afford them, then what good are they, so essentially they are not—the bill is better than those cures. And I just, my comment was, well, let's come up with the blockbuster cures and figure out how to pay for them and not lose them, because what if that one is Alzheimer's, diabetes, I mean all the things that are out there.

So my question is I get to—is one of the ways is value-based arrangements, and I know there are certain things such as Stark Law and other things that kind of get in the way of trying to do the value-based arrangements. Could you talk about value-based arrangements and pay, value-based arrangements for dealing with expensive cures?

Ms. VERMA. Sure. Well, I appreciate the question, and I think we are seeing the advent of new high-cost drugs. We've seen drugs priced at a half a million dollars, a million dollars, two million dollars. I mean, those are providing hope for so many patients because these new medications can actually cure diseases and can actually prevent some downstream costs for the healthcare system over the long term, so they can actually reduce costs.

That being said, I don't think that our system is set up to handle this. In the Part B program, we pay the average sales price plus an add-on of right now it's about 4½ percent with a sequester. But it's an add-on payment, so if you think about paying an average sales price of a million to two million dollars, plus an add-on, I don't think the system can handle it. That being said, we do need to think about value-based.

Ms. DEGETTE. The gentleman's time has expired. The chair now recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes.

Ms. SCHAKOWSKY. Thank you.

Administrator Verma, your testimony before us, you said that "the individual market was in a state of crisis because of the ACA." But in reality, it is you and the Trump administration who have done everything you can to sabotage the ACA and reverse the law's historic gains in health coverage. So let's go over some of the record of the past 3 years, your record.

On his—and the President's. On his first day in office, the President signed an executive order directing Federal agencies to undermine the ACA "to the maximum extent permitted by law." Days later, CMS pulled the funding for outreach and advertising for the final days of 2017 enrollment, an action estimated to have reduced enrollment by a half a million people.

You cut the number of days people could sign up for coverage by half. You spent funds meant for promoting the enrollment on a public relations campaign to undermine the law. HHS changed its

website, HealthCare.gov, making it more difficult for consumers to obtain appropriate health coverage. For 2018 open enrollment, you cut the outreach advertising budget by 90 percent, which resulted in as many as 1 million fewer people gaining access to coverage.

You ordered the regional directors to stop participating in open enrollment events. In 18 cities, including my hometown of Chicago, you terminated contracts for in-person assistants who guide applicants through the ACA enrollment process and was designed to help them sign up for insurance, and those are now gone. You slashed funding for nonprofit navigator groups that help people shop for better coverage and you stopped making cost sharing reduction payments to insurers even though CBO warned that failure to make these payments would increase—that would increase premiums by 20 percent and add nearly \$200 billion to the national debt.

And time and time again this administration, including you and President Trump himself, have used inflammatory rhetoric to spread falsehoods and misinformation about the ACA. And though you have slashed funding for ACA enrollment outreach, you have certainly pushed taxpayer funds elsewhere. According to a press report, you personally approved the awarding of millions of dollars of Federal contracts to Republican communications consultants who write your speeches, polish your brand, and travel with you across the country. This calls into question your stewardship of critical CMA resources that could be put to good use to give people coverage.

Administrator Verma, it is simply your tenure that has focused on undermining the ACA. We received a report yesterday that premiums will go down by 4 percent in 2020, but imagine how much more money Americans could have saved if you were uplifting the ACA and helping them to get coverage. President Trump has said that his only plan is to “let Obamacare fail.” But you have gone further than that. You are actually sabotaging the law. You have led the effort, Administrator Verma. And, you know, you say—we have heard for 10 years now, well, actually since the passage of the ACA, that Republicans wanted to repeal and replace the law. Now you are telling us if there is a court decision very soon that overturns the Affordable Care Act, that you have a plan.

Where is the plan? Do you have a plan that you can present to us or is this another pie-in-the-sky promise—

Ms. DEGETTE. The gentlelady’s time has expired.

Ms. SCHAKOWSKY [continuing]. That we have heard for many years?

Ms. DEGETTE. The Chair now recognizes the gentleman from Texas, Mr. Burgess, for 5 minutes.

Mr. BURGESS. I thank the Chair for the recognition. Just a point, here. For plan year 2017, navigators received \$62.5 million in grants and enrolled 81,000 individuals. There was a group of 17 navigators who enrolled less than 100 people, costing the taxpayers \$5,000 per enrollee. Contrast: agents and brokers are able to enroll people at a much more cost-effective rate. We have had this discussion many times before in this committee.

Ms. DEGETTE. Will the gentleman yield?

Mr. BURGESS. No, I will not. You know my time is limited. You have a quick gavel.

So, let me just ask you this: Which is the more cost-effective way of enrolling people? Is it navigators, or is it agents and brokers?

Ms. VERMA. I think the answer to that is agents and brokers. What we have found with the navigator program is that, when we looked at the numbers, we found that the navigator programs weren't meeting their goals. And that, in fact, despite the spending they were actually enrolling less than 1 percent of all the enrollments. And when we did the math, sometimes we were spending \$5,000, \$7,000 per person for these navigator programs.

And so, we felt like there was a better way. If we looked at the previous administration, they had doubled their advertising budget, and even after they doubled the advertising budget, enrollment went down, and so we sought for a more cost-effective way. And all of our contracts at the agency are focused on promoting the work of the agency, and we focused on finding new and cost-effective ways of enrolling people, like digital ads, and those have been proven to be effective.

Under our administration, premiums are lower. There are more choices. We have a 90 percent satisfaction rate at our call center for open enrollment, which has not happened before. It has only happened under our tenure. And because of the changes that we've made, because we've had a more efficient program, we're even actually able to use those savings to lower the user fees. We did that last year, and I hope to be able to do that again in the future.

Mr. BURGESS. That is an incredible figure about the call centers. And when the implementation of the Affordable Care Act came online in October of 2013, I did not take the special deal that Members of Congress afforded themselves. I went through HealthCare.gov, and that phone interaction took 4 months to actually accomplish, and it was one of the most miserable experiences I had ever been through in my life. So thank you for improving the customer experience at that end. A lot of times people don't care about the politics, they just need the deliverable, and it sounds like you are working hard on that.

Thank you for your commitment to Mr. Guthrie on—we will be working on the next version of the Cures bill at some point over the coming months and, really, we do want to involve you and your office, members of the agency, in some of these fantastic gene therapies and self-therapies that are coming down the pike where a single shot may cure some significantly costly disease. And Mr. Guthrie is right. We have to have a way with value-based purchasing or amortizing that cost over a longer period of time, and certainly look forward to your help as the committee develops—no good to develop the cure if no one can afford to take it.

Let me just ask you a question, if I could, on prior authorization. I get a lot of comments from my physician colleagues about prior auth. What are you doing to make the prior authorization, your Patients over Paperwork, how are you trying to reduce the burden of prior auth?

Ms. VERMA. Well, that is a issue that I hear a lot about from providers on the front line. We did a national listening tour, and I will say that was one of the number-one issues that physicians are com-

plaining about, with good cause. As part of our Patients over Paperwork initiative, we've put out RFIs and we've heard from both sides on this.

I can tell you right now that I have a group of individuals at the agency that's working on how we can figure out how to ensure that we have the appropriate protections in place for program integrity, because that's necessary. We want to make sure that evidence-based treatment is being provided to our beneficiaries, but at the same time the process can be burdensome.

Mr. BURGESS. Yes.

Ms. VERMA. And it can get in the way of providing good patient care. It can create delays in care. So we're working on it, and you can expect to see some action this year on that.

Mr. BURGESS. I appreciate that. Let me just try to get one additional question. We have had a lot of discussion in this subcommittee and Health Subcommittee both last Congress and this Congress on the issue surrounding maternal mortality. Had a very good hearing the other day with Dr. David Nelson, the residency director at Parkland Hospital, where I trained, in talking about his experiences at Parkland. Are there any tools that CMS does not currently have that would be helpful in addressing maternal mortality?

Ms. VERMA. Well, this is something that I started my career on, working on the area of maternal and child health, so it's a very important issue to me. We've had a conference on this issue. Some of the things that we're working on is streamlining eligibility, so as women are on Medicaid and then moving to the exchanges that we can make that process work better.

Ms. DEGETTE. The gentleman's time has expired. The Chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Madam Chair. And I just want to pick up on the statement, you know, the questions you said about the administration's decision to ask the courts to strike down the ACA and the Republican lawsuit that is seeking to declare the entire ACA invalid. Obviously, if the district court ruling is upheld, Ms. Verma, you will be responsible for the largest coverage loss in U.S. history, or at least the President would be responsible for the largest coverage loss in U.S. history. Over 20 million Americans would lose their coverage, raising consumer costs and making lifesaving healthcare unaffordable for American families.

Now, again, you know, as I said in my opening, if, you know, everybody on the right said, "Oh, that is fine because we don't want the Federal Government to do anything about people's healthcare"—but that is not what I hear from Trump or my Republican colleagues. They say they want to provide health insurance even though they are sabotaging everything.

So I wasn't here, but I want to know, does the President have a plan, and what is the plan? I mean, it sounds almost like there is some kind of secret plan that he doesn't want to reveal. Could you just tell us? What is the President's plan? Some information about his plan in the event that he is successful in this awful lawsuit, what is the plan?

Ms. VERMA. Well, I am not going to get into any specifics of the plan, but what I will say is that the President's healthcare agenda has been in action from day one. Our commitment to lower the cost of healthcare—

Mr. PALLONE. No, but I am not asking about that. You know, I disagree with you that he has had a plan so far other than to sabotage the ACA. But what I am asking is, if the court strikes down the ACA in this lawsuit, what happens then? What is he going to do next? What is his plan to deal with the reality that all these people wouldn't have health insurance?

Ms. VERMA. We have planned for a number of different scenarios, but we need to hear from the courts. The President has made his commitment clear that he wants to make sure that people with preexisting conditions have protections, that Americans have access—

Mr. PALLONE. Well, I know. But you are not giving me any details other than saying that he is going to give us something. So, look, I think that the administration—

Ms. DEGETTE. Will the gentleman yield?

Mr. PALLONE. Sure.

Ms. DEGETTE. In the court, the administration asked for the entire Affordable Care Act including—

Mr. PALLONE. Right.

Ms. DEGETTE [continuing]. The preexisting conditions and the kids to 26 and the gender disparities and everything, they asked for the entire thing to be struck down.

Mr. PALLONE. Right, right.

Ms. DEGETTE. They didn't ask for certain portions of the ACA to be retained.

Mr. PALLONE. But you see, this is my problem. And I want to move on to another topic, but my problem is, again, if the administration—if the President was honest and said, "Look, I am just going to—I want to get rid of the ACA. I don't have anything else. I don't think people, you know, the Federal Government should be involved in healthcare, you are on your own," then I would say, "OK, that is your ideology. I don't agree with it, but I understand that is where you are coming from." I just think it is so deceptive, though, to suggest that somehow we are going to cover everybody and we are going to do something better, but not give us anything. And you are not giving us anything.

But let me go back to my other issue with, that I mentioned before about not being responsive. In June I sent you and Secretary Azar letters requesting—oh, I am going back to this memo.

In April, you finalized a marketplace rule that changed the formula for ACA's subsidies despite your own objections to the policy, and I appreciate your objections. In fact, in an internal memorandum to Secretary Azar dated August 2018, you wrote that, I quote, "I recommend not moving forward with this policy and that such a policy would cause coverage losses, further premium increases, and market disruption." And you cautioned that if the policies under consideration are adopted, and I quote, "exchange enrollment would decline by 1.1 million," and you wrote that these actions could result, I quote, "potentially, in bare counties or States with no subsidized coverage available."

My question is, do you still believe that this policy would likely result in families losing coverage?

Ms. VERMA. I think there are several policies in that memo. I am comfortable with the final rule and where we came out, and I think that the evidence is clear that premiums are lower.

Mr. PALLONE. All right.

Ms. VERMA. We have more choices available on the exchanges, so the actions that we have taken have resulted in Americans having more choices about their healthcare—

Mr. PALLONE. Well.

Ms. VERMA [continuing]. And have lower premiums for the first time since the Affordable Care Act started.

Mr. PALLONE. All right, I understand that. That—in June I sent you and the Secretary letters requesting the underlying analysis that is discussed in the memo and the analysis of the impact of those policies conducted by CMS Office of the Actuary, and last week I sent you and Secretary Azar a followup letter reiterating my request. I requested a complete response to my letter by October 30th, but so far, as I have said, I have received a one-and-a-half-page response that answers none of my questions, not a single document. Your response has been unacceptable, and Congress and the American people have a right to know what exactly the analysis shows.

So, again, would you commit to providing those documents to my letter by October 30th?

Ms. VERMA. CMS is a subagency. We are under HHS, and all of the documentation requests are handled by HHS, and so I would refer your question to the agency.

Mr. PALLONE. Well, I mean that is a really poor excuse.

Ms. DEGETTE. The gentleman's time is expired.

Mr. PALLONE. Thank you.

Ms. DEGETTE. The Chair now recognizes the gentleman from West Virginia, Mr. McKinley, for 5 minutes.

Mr. MCKINLEY. Thank you, Madam Chairman.

Administrator, I think we virtually owe you an apology for the way you have been treated here. I have been—I go home every weekend, and I talk to the people. West Virginia, yes, is a red State. I was in Indiana the weekend before, a red State. But I was in Boston for a meeting up there, and I heard the same thing from people on the street, and we talked to the waitresses at how people—what is going on in Washington. And they talked about the tone, the accusatory language that is used, the lack of civility.

And today I think it has hit a new point by this word “sabotage.” Probably been, we are 42 times already today it has been used, like someone found it in a new dictionary that they want to use to try to stir up things. People are appalled by this, and they want us to work together, and to accuse you and this administration the way they have, I apologize for that.

Ms. VERMA. Thank you.

Mr. MCKINLEY. Now, let me ask you a couple questions, however, and that is in West Virginia and Appalachia we are disseminated with the opioid crisis, and we are trying to find ways of can there be something set up. So I am going to go away from what they want to—their sandbox they want to play in. I want to—what are

ways that we can provide some additional funding or something for nonopioid rehabilitation treatment? Because we have got—there are incentives all for using opioids, but what about some of the other nonopioids?

Could you come back with—when you all put together your rule, there is nothing in there about that, the nonopioid treatment, and I really hope that we can do that. Can we work together, Administrator, on that?

Ms. VERMA. Sure. CMS has worked with State Medicaid programs. We've actually approved 26 State Medicaid 1115 demonstrations, which permit States to expand services for care for substance use disorder in institutions for mental disease and we have actually been working to implement all the sections of the SUPPORT Act that relate to CMS.

In relation to your question, I will have our Office of Legislation reach out to you and your staff to work on that.

Mr. MCKINLEY. If you could, I would like to follow up with that. And the other is, and it began, again, I am not going to trash this administration and I am not going to trash the previous administration. We just have difference of opinions, but we can talk to each other. But what we asked under the Obama administration was, where did the—for the rehabilitation, for the Medicaid, Medicare, 28 days—where did that come up with? And no one has ever gotten back to us on that with—so, I am curious, to you, do you have an opinion? Is—and it is a trick question here, is 28 days enough for rehabilitation for someone deep in drugs?

Ms. VERMA. Well, I'd like to consult with our agency experts, and I'll have our department of legislation reach back out to you.

Mr. MCKINLEY. Wouldn't you be suspicious? Because we have had to deal with this pretty severely. We have 52 deaths per hundred thousand in West Virginia. We are leading the country on this. Every rehabilitation center I go to asks me that question: Where did the 28 days come up from? And I have asked that back under the previous administration, and I am asking it now under the—can we consider at least maybe a pilot project that maybe goes for 120 days or 180 days to find out?

Because the impression I am getting under both administrations is that we are looking for quantity of people getting treatment, not quality, and if we put someone in a treatment facility for 120 days, I think the outcome is going to be far better than 28 days. So I really hope that you can get back to me on another time. Is that fair to say?

Ms. VERMA. That's fair to say, and we'll have our legislative folks reach out to you. But thank you for your question.

Mr. MCKINLEY. Thank you. And again, I apologize for the way you have been treated in this committee so far, OK. Thank you. I yield back my time.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the gentleman from Massachusetts, Mr. Kennedy, for 5 minutes.

Mr. KENNEDY. Madam Administrator, thank you for being here. In Arkansas, more than 18,000 Medicaid recipients lost coverage after CMS approved a work requirement in that State, and in New Hampshire it was nearly 17,000. Both States, the evidence sug-

gests that a large number of these people were either working or eligible for exemptions, but they lost coverage or would have lost coverage because of red tape.

Now, you might try to tell us that those people found jobs and employer-sponsored coverage, but a recent study from the New England Journal of Medicine found that Arkansas' work requirement increased uninsured rates without increasing employment. Madam Administrator, are you aware of that study?

Ms. VERMA. So, first of all, community engagement—

Mr. KENNEDY. Ma'am, yes or no. Are you aware of the study? I have 5 minutes.

Ms. VERMA. I'm sorry. Can you repeat the question?

Mr. KENNEDY. Are you aware of the New England Journal of Medicine study that says that people lost healthcare because of work requirements in Arizona—or excuse me, in Arkansas?

Ms. VERMA. I'm aware of the article.

Mr. KENNEDY. OK. So in November of last year, MACPAC, a nonpartisan agency that makes recommendations on issues affecting Medicaid, said that low-level reporting in Arkansas was “a strong warning that the current process may not be structured in a way that provides individuals with an opportunity to succeed with high stakes with beneficiaries who fail.” And they called on you to pause disenrollments in order to make adjustments to the program.

CMS did not pause disenrollments. Instead, you approved the work requirements in additional States. Why did you approve work requirements in additional States and not respond to the concerns of MACPAC?

Ms. VERMA. Community engagement requirements are about improving the lives of people in the Medicaid program—

Mr. KENNEDY. Ma'am, can you point to me to one study that says that a work requirement makes people healthier? One?

Ms. VERMA. So I have worked with the Medicaid program for over 20 years—

Mr. KENNEDY. Ma'am, one. I asked Secretary Azar this question, first question last year. I am certain you were prepped.

Ms. VERMA. There are many studies that talk about how employment has a positive impact on health outcomes. There are numerous studies.

Mr. KENNEDY. Ma'am, excuse me. No, excuse me. That is—once again, Secretary Azar, I asked this question to him 8 months ago. He gave the exact same answer. You guys run healthcare programs in this country. I am certain you understand the difference between correlation and causation. Healthier people might work. Work doesn't necessarily make people healthier. You are imposing policies on millions of people across this country. Can you show me one study that says that that is a good policy?

Ms. VERMA. I've spoken to many people on the Medicaid program—

Mr. KENNEDY. I will take that as a no.

Ms. VERMA [continuing]. Living in poverty and none of those individuals want to—

Mr. KENNEDY. Reclaiming my time, ma'am, so—

Ms. VERMA. [continuing]. Stay where they are. They want to find a pathway out of poverty.

Mr. KENNEDY. I am sure they do. So let's talk about Adrian McGonigal, who lost his Medicaid coverage in Arkansas because of the onerous work requirement that you approved. Without Medicaid, his medication was going to cost him \$800, so he did what anyone would do, he left it at the pharmacy, did his best to ignore preventable pain and suffering. He failed, the illness caused him to miss a few days of work, and he got fired. Your work requirements caused him to lose a job and his healthcare.

And again, do you consider that a success, yes or no?

Ms. VERMA. I think it's premature to draw conclusions about Arkansas. The program—

Mr. KENNEDY. Is it premature to draw the conclusion for Mr. McGonigal?

Ms. VERMA. The program was in effect for 10 months. What I will say about—

Mr. KENNEDY. Eighteen thousand people lost their healthcare. How many more people have to lose their healthcare before you can make a determination?

Ms. VERMA. Community engagement is about giving people a pathway out of poverty. People don't want to live in poverty.

Mr. KENNEDY. Show me the data that says that—no one wants to live in poverty. Show me the data that this actually lifts people out of poverty. One study. One.

Ms. VERMA. Again, there are studies that show that when we're looking at the social determinants of health and we look at—

Mr. KENNEDY. Ma'am.

Ms. VERMA [continuing]. Improving somebody's health status—

Mr. KENNEDY. You are not going to spin me—

Ms. VERMA [continuing]. Just giving them insurance—

Mr. KENNEDY. You are not going to spin me for the 5 minutes.

Ms. VERMA [continuing]. Is not going to solve the problem.

Mr. KENNEDY. I'm going to reclaim my time, so—

Ms. VERMA. We need to address holistic issues.

Mr. KENNEDY. Ma'am, are you aware—you talked about the financial aspects of trying to deliver healthcare in a fiscally responsible manner. Are you aware of how much Kentucky is planning on spending to implement its work requirements?

Ms. VERMA. I have recused from the Kentucky matter.

Mr. KENNEDY. I will answer it for you. It is \$190 million over 2 years. Do you know what per capita annual expenditure on CHIP in Kentucky is?

Ms. VERMA. So States are making investments—

Mr. KENNEDY. Two thousand dollars.

Ms. VERMA [continuing]. Trying to improve the lives—

Mr. KENNEDY. Two thousand dollars.

Ms. VERMA [continuing]. Of the people they serve, and those are one-time implementation costs.

Mr. KENNEDY. Ma'am.

Ms. VERMA. And that if—

Mr. KENNEDY. Reclaiming my time. Are you—

Ms. VERMA [continuing]. That are spread over the costs of the—

Mr. KENNEDY. A contract that——

Ms. VERMA [continuing]. That relate to the program.

Mr. KENNEDY. A contract that was made for your PR speech-writing and events services was referenced already earlier in this hearing. Are you aware that one of the line items was for a confidante of yours named Marcus Barlow, who is scheduled to receive \$425,000 over the life of that contract, 1 year?

Ms. VERMA. All of the contracts that we have at CMS are based on promoting the work of CMS.

Mr. KENNEDY. So——

Ms. VERMA. When we use contractors, we use them for two reasons. One reason would be when we require specialized expertise that we may not have in-house.

Mr. KENNEDY. Ma'am, specialized expertise to write speeches. Are you aware that for that same cost 2,000 kids could have—excuse me, 200 kids—in CHIP, eligible for CHIP in Kentucky, could have kept their healthcare?

Ms. VERMA. The contracts that we have——

Mr. KENNEDY. What is a better use of those healthcare dollars, of U.S. taxpayer dollars: to employ an additional communications person underneath CMS that already has dozens, if not hundreds, or 200 more kids that could get access to healthcare? What is a better stewardship of those taxpayer dollars?

Ms. VERMA. The use of our contracts are to promote the programs that we have in place. We use contractors——

Mr. KENNEDY. At the expense of those 200 kids?

Ms. VERMA. Those contracts are consistent with what previous administrations have done.

Mr. KENNEDY. At the expense of those 200 children.

Ms. VERMA. Those contracts that we have in place are consistent with how the agency has used resources in the past, and they're focused on promoting the work. One of the things that we want to do is make sure that people understand——

Ms. DEGETTE. The gentleman's time has expired.

Mr. KENNEDY. That is a shame.

Ms. DEGETTE. The Chair recognizes the gentleman from Virginia for 5 minutes.

Mr. GRIFFITH. Thank you very much.

Did you wish to finish your answer?

Ms. VERMA. Yes. So what I was trying to say is that the contracts that we have in place are about promoting the work of the agency. One of the things that I wanted to do when we came to CMS is make sure that the American people understand the things that we're doing. We've had a historic number of initiatives, 16 initiatives, and it's important that the American people understand that. We did not have that expertise in-house at the time.

And the other thing that we use contractors are for is when we have something that we cannot do in-house, so that's one reason, or we need some short-term help. My job at the agency is to set the vision and set the agenda, and it's up to other staff members to determine whether that work can be done in-house or whether we need to hire contractors.

Mr. GRIFFITH. And in relationship to CHIP, wouldn't you agree that the Championing Healthy Kids Act was a major step forward?

Ms. VERMA. It absolutely was. I think it's very important that children have access to healthcare coverage, very important to their development.

Mr. GRIFFITH. And would you be surprised to learn that a number of members of this committee voted no, particularly those on the other side of the aisle?

Ms. VERMA. That would be very concerning.

Mr. GRIFFITH. I understand. Also, I find it interesting, just cleaning up some stuff here, that CBO estimates that 2.6 million more people have employer-funded insurance today than before President Trump took office. Were you aware of that?

Ms. VERMA. Yes. I think that our agency's success and the success of the administration is clear. Premiums are lower not only in the exchanges but also in Medicare. There are more choices for people in Medicare and in the exchanges, more than what we had when we came into office.

Mr. GRIFFITH. Now, we have heard a lot today about sabotage, and my friend, the gentleman from West Virginia, Mr. McKinley, talked about the fact that sabotage has been used a lot. But I would have to say to my colleagues on the other side of the aisle that, when you write a bill such as Obamacare and you put in there 3,033 times the words "the Secretary" appears and 974 times the words "the Secretary shall" appear. And off the top of his head, Dr. Burgess indicated there were about 262 times that you, if you kept going out, you know, "shall determine," "the Secretary shall determine" appear, roughly, and we will have to double check that one, but that is off the top of his head.

Wouldn't you think it would be unfair to say that the law had been sabotaged when the Congress—now, remember, that was a bill passed, Obamacare passed specifically and only by Democrats. No Republicans in the House voted for it. So, if it was sabotaged, it was sabotaged because they gave too much power to the administrative branch of government, and today they find themselves with an administrative branch of government that has a different philosophical outlook and, therefore, if it were in fact sabotaged, it was sabotaged at its initiation in the passage of that bill. Would you agree with me on that?

Ms. VERMA. I would agree and the results speaks for themselves. Premiums are lower. When I got into my role, premiums were going up, a hundred percent in some cases, some 200 percent in some cases. This is for the first time that we've actually seen premiums go down. They went down last year. They're going down again. We've put out over 12 reinsurance waivers, and in some cases you've seen double-digit decreases, 30 percent.

So for all the work that we're doing, I don't know how we measure that, but to me that looks like success.

Mr. GRIFFITH. Yes, ma'am. And now, so let's get to something else I need to talk about. Earlier this year it came to my attention that CMS planned to include noninvasive ventilators in Medicare's competitive acquisition program for durable medical equipment. In June, Mr. Welch and I led a letter signed by 180 of our colleagues expressing concern about that decision.

I support the goal of ensuring financial responsibility in healthcare, but I am not convinced that this method is appropriate

in every situation. Until we know that access to a critical piece of medical equipment won't be compromised, I don't think we should be making monumental changes to the acquisition process. And I just got your letter—it arrived late yesterday afternoon—in response to that letter, where you said we are not going to do it on invasive.

But here is the problem I have. I have a rural district, as does my friend Mr. Welch. And what happens is, is that if you go to this cost-only issue, in those rural areas you are going to make somebody drive 45 minutes, an hour. I remember talking to one of my suppliers about a case where the lady lived on top of one of the two highest peaks in Virginia, and he took her oxygen up there to her and made sure that she had what she needed for her ventilator supplies, noninvasive.

She is not coming down the mountain, particularly not in the wintertime, to get what she needs if now the low-cost supplier is only located in the town. And if it becomes a point where they have to get to Bristol, you are talking about even more time. But just to get down the mountain to Marion, it is going to take a lot of time. So I would ask you all to really take a look at that because I am afraid that in the rural districts our folks are not going to get served. I yield back.

Ms. DEGETTE. The gentleman's time has expired. The Chair now recognizes the gentleman from California, Mr. Ruiz, for 5 minutes.

Mr. RUIZ. Thank you. This administration has made clear from day one that they will not protect people with preexisting conditions or protect access to affordable healthcare for Americans. They continue to repeal the ACA first through legislation, and when that failed through the courts. And in lieu of complete repeal, they have done everything they can to chip away at the protections that it provides.

Repealing the protections harms patients but helps insurance companies make greater profits. It gives them power to deny and delay care for people who really need it. And as a physician I took an oath to do no harm, and trying to take affordable coverage away from millions of Americans flies in the face of that oath. I practiced medicine before the passage of the Affordable Care Act, and I saw what that meant for patients.

So let me tell you a little bit about what that was like. In fact, even when I was in medical school, during my medical school graduation at Harvard Medical School, my whole family—I have a big family, and they came from everywhere. And we were in my tiny little apartment and we were getting ready for my ceremony, and my little sister curls over in excruciating abdominal and flank pain, excruciating, shaking.

And we were so very concerned, but she refused to go to the Emergency Department. It wasn't necessarily because she was going to miss my graduation, she didn't want to be a burden to us for that, but primarily she didn't have health insurance and she couldn't afford it and she was so afraid, so she just endured it. And that is what families do throughout our country, they endure this pain. Well, she was 22. Now, she could have been on her parents' health insurance.

The second story is like a man 55 years old from Palm Springs with HIV positive status. Before the Affordable Care Act, infections after infections, life-threatening, very concerned he wasn't going to live past, you know, 58 or something. And now, because of the Medicaid expansion, he is happy. He is living well. He finally can get the care and the medications and everything that he can have, and he is living that life that he has always wanted to.

It is like that young mother of two who came into my Emergency Department with the chief symptom of "a lump in my breast." And I am thinking, a lump in your breast? Why are you coming during the holidays for a lump in your breast? She didn't have any primary care. She didn't have insurance. She knew it was growing, it was the size of a lemon. It was irregular in form, it was painless. Her sister forced her because they knew what they were afraid of. And, sure enough, it was most likely cancer. I was able to connect her with post-Emergency Department care.

But, because of the Affordable Care Act, that preventive mammogram is now covered, and that she couldn't afford it and now she potentially had cancer metastasized to her body. That is why we are angry. It is for those patients that we are standing up. It is for the American people who are today scared that we are going to go back to a time where they are going to be denied and delayed, that they are going to endure pain, that they are going to potentially lose their life and leave their children behind, that they are going to suffer infections, and that is why we are pressing you and this administrations for those questions.

Because this administration is encouraging the Supreme Court to strike down the ACA in its entirety, all of it. There is no defense in court to protect people with preexisting condition. There is no defense in court for the young people to stay on their parents' health insurance. There is no defense of the Medicaid expansion. There is no defense of protections for preventive care that help my constituents, my patients, and my family.

There is no defense for the American people in those protections for them. And to make matters worse, you have no plan. You can't produce a document. You can't give us a detail. You are skirting the issues, and all we are getting is only spin and talking points. The American people deserve better. I yield back my time.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the gentlelady from Indiana, Mrs. Brooks, for 5 minutes.

Mrs. BROOKS. Thank you. And thank you, Administrator Verma, for being here today.

Actually, the stories that you have heard from my colleagues, I assume that in your role for the last 3 years, you have mentioned that you have been having roundtable discussions. And that wasn't what I was originally going to ask you, and I do want to save a little time for what I want to talk about with you. But can you share very briefly, how you do stay connected with the patients and the people you are trying to serve?

Ms. VERMA. Well, I appreciate that. We've done a national listening tour, and we talk to people all over the Nation.

Mrs. BROOKS. People who—can you share who these people—

Ms. VERMA. People who are having trouble—

Mrs. BROOKS. Yes, the type of people you talk to?

Ms. VERMA [continuing]. Affording Obamacare. And so, in the examples that were used previously, I'm scared for those people too, because if they don't have a subsidy they often cannot afford health insurance under Obamacare. Obamacare structure is so expensive that the middle class can't afford health insurance, and that's why we're seeing increases in the number of uninsured, because premiums have gone up a hundred percent, 200 percent.

And while this administration has stabilized the market—premiums are going down—they are still too expensive, and if you do not have a subsidy and if you have a preexisting condition, you do not have protections today. And that's why this administration is trying to advance efforts to try to make sure that every American has access to affordable coverage. That is not the case today.

Mrs. BROOKS. Thank you. I want to pivot and focus on, you talked about the role of technology and innovation in the healthcare system. Medical error is the third-leading cause of death in the United States, responsible for claiming over 400,000 lives, and millions of dollars are wasted on duplicative and unnecessary tests and procedures. We know that patients want their up-to-date medical information at their fingertips.

Congresswoman Clarke, a colleague of mine across the aisle, and I introduced the Mobile Health Record Act, and it directs CMS to do more to promote the use of secure medical records approved by CMS through the Blue Button 2.0 program. The proposed CMS Interoperability and Patient Access rule is to be published before the end of the year, requiring Medicare Advantage plans first and Medicaid plans next, to offer open APIs for their plan enrollees to access their medical data with their mobile application of choice.

And you mentioned, more and more patients are tech-savvy and want this type of access, but I remain concerned about the lack of public promotion or awareness of the CMS Blue Button program and its Medicare-approved apps for the 60 million Medicare beneficiaries. And, in fact, a recent survey showed that only three out of a hundred Medicare Advantage members are even familiar that the Blue Button 2.0 program exists.

Knowing how important this is, what more can be done to reach new enrollees? It is very complicated to get through your websites and process to find the Blue Button, and yet people want to have their medical records in their hands. So can you talk to us about what your plans are to improve access to our own medical records?

Ms. VERMA. I appreciate the question, and I agree with you that we can do more to make sure that people understand what's available. The issue of patient records—and if you'll indulge me for a second, I'll tell you a story, because I think it sort of sums up the issue of patient access.

My family was traveling, they were headed home. I was headed back to DC when my husband had a cardiac event. He had a major seizure. My daughter called me and handed the phone to the paramedics, and they said, "Ma'am, your husband's not breathing, and we need to understand his health history. Is there anything in his health history?"

And at that moment—

Mrs. BROOKS. How long ago was this?

Ms. VERMA. This was about 2 years ago, in 2017. And so, at that time, you know, obviously I'm in a panic, but I did not have that information. My family didn't have that information, and my husband was in no condition to tell us about his health history. And I scrambled for about 2 hours in the time that it took me to get to my kids and get to my husband to try to find this information.

In the end, the hospital had to do a number of tests because they couldn't figure out what was wrong. Luckily, he's OK and he survived something that maybe less than 1 percent of people survive, so he was very lucky. But when I left the hospital, I asked the staff there, can I have a copy of all the tests that you performed, so I had a complete medical record to give back to his doctors in Indiana, and unfortunately all they could give me was a CD-ROM.

So after our Federal Government spent \$36 billion on electronic health records, all I got was a CD-ROM, which really only had a record of one test, and so that really spoke to me of the issues. Patients need to have access to their complete medical records so that we can understand the issues that we face.

Mrs. BROOKS. Can I interrupt? Are you going to dedicate more people to this, and how are you going to fix this?

Ms. VERMA. This is one of our main priorities. We have several rules. One is about making sure insurers are providing claims data to patients. We are giving incentive payments to physicians to make sure that they're providing data to their patients. Hospitals are facing penalties.

Ms. DEGETTE. The gentlelady's time has expired. The Chair now recognizes the gentlelady from New Hampshire, Ms. Kuster, for 5 minutes.

Ms. KUSTER. Thank you. And thank you, Ms. Verma, for being with us today.

A quick yes-or-no question before we start. I understand, yesterday, Secretary Azar said that the reason he is not concerned about the court decision ending the ACA overnight is that he is relying upon an appeal to the Supreme Court. Is that your position? Is that why you don't have a plan to tell us today?

Ms. VERMA. We have planned for a number of different scenarios.

Ms. KUSTER. But are you expecting—

Ms. VERMA. I think what the Secretary is speaking to is that this is going to take some time for the courts to resolve, but we have planned for a variety of different scenarios.

Ms. KUSTER. Including an appeal to the Supreme Court?

Ms. VERMA. Correct.

Ms. KUSTER. So—because I am a little confused today by your testimony and particularly by the testimony of our colleagues. I have been in Congress for 7 years. I voted 55 times not to repeal the Affordable Care Act because our colleagues were so persistent about week after week, month after month voting over and over again to repeal the Affordable Care Act in its entirety. And now this administration is in court asking to repeal the Affordable Care Act in its entirety. And yet, you sit here today singing the praises of the Affordable Care Act and how proud you are of your work to bring down the rates, but at the same time you are cutting access for 400,000 children. That was your testimony this morning.

So I just want to move to a particularly important part for my constituents, which is the issue of preexisting conditions. And you will recall that, before the Affordable Care Act, Americans could be denied their health insurance coverage if they had any kind of a preexisting condition. I think about it in my family. I will just start at the beginning of the alphabet: asthma, allergies, Alzheimer's, cancer, diabetes, the list goes on and on. And, in fact, over 50 percent of Americans have a deniable condition.

In New Hampshire, that is 54 percent of our citizens have a deniable condition, and yet your administration, in fact your own actions with the short-term limited duration health plans—by the way, a classic Washington, DC doublespeak, short-term limited duration health plans—have threatened families with preexisting conditions. And, in fact, you have encouraged States to promote junk plans through their waivers in order to circumvent essential health benefits and protections for preexisting conditions.

I was very proud to lead bipartisan legislation. It passed the House, Protecting Americans with Preexisting Conditions, last May, and it will ensure that people with preexisting conditions are covered. But let me ask you, do you believe, Ms. Verma, that allowing individuals to once again be discriminated against or have their coverage declined due to preexisting conditions is moving America in the right direction for their healthcare? Just yes or no.

Ms. VERMA. None of the actions that we have taken do anything to undermine the protections for people with preexisting conditions.

Ms. KUSTER. Well, encouraging junk plans that do not cover Americans with preexisting—we heard the testimony right here. We had families right in front of us, and they had no idea. There was no requirement that they be warned of that, and instead of 3 months, these were a year and they could be re-upped multiple times. So I think your testimony is not actually truthful to us today, and I regret that.

According to a 2019 study by the Kaiser Family Foundation, half of Americans, as I mentioned, have a declinable condition. Did your agency conduct an analysis to evaluate the effects of the implementation of your guidance on these families and their access to affordable health insurance? Yes or no.

Ms. VERMA. I'm sorry. Which guidance are you referring to?

Ms. KUSTER. The guidance that you provided about the waivers and the junk health plans. Did you analyze the impact on American families that had preexisting conditions? Yes or no.

Ms. VERMA. So in the issue of the 1332 guidance that we put out for States, I can tell you that States have had an enormously difficult time——

Ms. KUSTER. Just a quick question.

Ms. VERMA [continuing]. Experiencing the double-digit rate——

Ms. KUSTER. Did you——

Ms. VERMA [continuing]. Increases. And we wanted to——

Ms. KUSTER [continuing]. Analyze what would happen to families with preexisting conditions? Yes or no.

Ms. VERMA. The way the guidelines work is, we give basically direction to States about how they can develop plans to make health insurance more——

Ms. KUSTER. I am asking if your office analyzed the impact of your guidance. Yes or no. This is not difficult.

Ms. VERMA. So we have to impact—we would have to review the proposals. And so for every proposal—

Ms. KUSTER. And can you provide that to this committee, your analysis?

Ms. VERMA. Every proposal that comes in under 1332 is analyzed around the four guardrails around comprehensive coverage.

Ms. KUSTER. And could you provide that analysis to this committee? My time is up. Yes or no.

Ms. VERMA. So every single proposal that comes in—

Ms. KUSTER. Yes or no, you'll provide that analysis to this committee?

Ms. DEGETTE. The gentlelady's time has expired.

Ms. KUSTER. My time is up.

Ms. DEGETTE. The Chair now recognizes the gentleman from South Carolina, Mr. Duncan, for 5 minutes.

Mr. DUNCAN. Thank you, Madam Chairman.

Administrator Verma, I will let you finish answering her question if you need to.

Ms. VERMA. Sure. So let me start with short-term limited duration plans. These are plans that have been available before Obamacare started and during Obamacare. They used to just be available for 3 months, and we extended the period of time. We also made sure and we strengthened these protections, which were not in place under the previous administration, to make sure that people understood what type of plan that they were buying and what the limitations were of these plans.

But there are so many Americans today that cannot afford coverage under Obamacare when rates have gone up a hundred to 200 percent, and I gave you some examples of a couple in Nebraska. They are 55 years old, and the premiums that they would have to pay are anywhere between a third to half of their income. Short-term limited duration plans provide a lifeline. They can provide coverage at rates that are perhaps 60 percent lower than what they could find under Obamacare, so it provides an alternative.

There's many people that are in between jobs that cannot afford Obamacare, and this is an alternative. And our administration has done everything that we can to ensure that there are protections in place and that those plans clearly articulate the limitations of what they may or may not cover.

Mr. DUNCAN. Yes. Thank you for that. I apologize for how some of my colleagues have treated you today.

Let me say I appreciate the multiple conversations we have had regarding some of the nursing home issues occurring across the Southeast Region. We have touched on topics including inconsistencies and civil monetary penalties, citations given among the regions, and how facilities in Region 4 have been especially hit. We have also touched on the important need for specific guidance to be provided for abuse reporting rules.

Another thing I would appreciate you looking further into is the red consumer alert icon that could be placed next to nursing homes that have been cited for incidents of abuse and the Nursing Home Compare website. I understand this initiative goes into effect

today. However, I feel CMS needs to fully solve the CMP and abuse reporting issues, first, before we go negatively labeling facilities online. If facilities in the Southeast Region don't get relief soon, we are going to be in a tight spot.

So can you and your staff please comment or at least commit to revisiting the issue of consumer alert icon being implemented?

Ms. VERMA. Well, we've put out a five-part strategy on strengthening oversight, enhancing enforcement, increasing transparency, improving quality, and putting patients over paperwork. One of the things that we've done is we have clarified immediate jeopardy guidelines. And I agree with you that there has been inconsistency in how CMS and State agencies have implemented the guidance, and so that's why we've created a new performance standard system so that we can monitor what's going on in the local level to ensure that we have consistency in how we are clarifying immediate jeopardy in cases of abuse and neglect.

In terms of the icon, there's about maybe 5 percent of nursing homes that will be impacted by this, and it only alerts those in which we've had cases of abuse and neglect. And, you know, if there's other types of issues that have come up, they're sort of, I would say, not high-level areas of abuse and neglect, in those areas we only use the icon if they have been repeat offenders.

So this isn't really going to impact very many nursing homes. There are many nursing homes that provide high-quality care, but there are some out there—and we think it's important to make sure that the American people have the information that they need to make the decisions that work best for them.

Mr. DUNCAN. In the essence of time, we will move on. We will be watching some of the reforms and how they impact the nursing home facilities.

I want to touch base on one other thing, and that is the exchange program integrity Section 1303 in the Affordable Care Act. We have asked—we talked yesterday about this. You say that the ruling finalization is supposed to be in HHS's hands now. Open enrollment period begins November 1st, and I think clarification on this is important. We sent a letter July 1, me and many, many of my colleagues signed this, asking for Secretary Azar to approve that.

I want to submit that, if we can, to the record, Madam Chair. And also want to urge my colleagues, I am going to send another letter today, if you would like to sign on to that, on the 1303 urging fast implementation.

Ms. DEGETTE. Without objection, the letter will be entered.

[The information appears at the conclusion of the hearing.]

Mr. DUNCAN. I would also like to add a letter from some of the care providers that have urged us to take action as well, for the record.

Ms. DEGETTE. We will review that letter. I haven't seen that letter.

Mr. DUNCAN. Thank you. It is important that this rule get finalized, and it was proposed November of 2018. That is almost a year later, and it still hasn't been. Can you speak to the work CMS has done to help finalize this rule and what the current status is? We know it is in Azar's hands, but if you would like to touch base on that in 10 seconds.

Ms. VERMA. We share your commitment to getting that rule finalized, and we'll be doing everything that we can to bring that to fruition.

Mr. DUNCAN. OK. If any colleagues want to sign on to that letter to Secretary Azar today by close of business, you can contact my office. I yield back.

Ms. DEGETTE. The Chair will admit the second letter that the gentleman referenced.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. The Chair now recognizes the gentlelady from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Thank you, Madam Chair. And thank you, Administrator Verma, for being here today.

The Trump administration has made numerous policy changes that increase the costs on families across this country, increase health insurance premiums, and erode coverage for preexisting conditions, preexisting conditions like cancer and diabetes. We had all hoped that this fight was over, but we are going to continue to have to work to make sure that families who have preexisting conditions get their coverage.

You stated earlier in your testimony that the Trump administration policies have stabilized costs. There is no evidence of that. A recent study by the Kaiser Family Foundation estimates that 2019 premiums are 16 percent higher than they otherwise would be due to the Trump administration's actions. And a report out of your own agency has established that the various sabotage policies of the Affordable Care Act has increased costs on families who are not eligible for tax credits.

And one of the most egregious policies that has increased costs is the expansion of the junk health insurance plans, the short-term limited duration plans, because what has happened, after the Trump administration and the GOP failed to repeal the Affordable Care Act and dramatically cut health services under Medicaid, they turned to a very insidious plan to cut outreach and enrollment, weaken the health insurance pool by eliminating navigators, and then marketing, allowing these junk insurance plans to roll out, to the detriment of the families we represent.

These junk insurance plans do not have to cover preexisting conditions. They don't have to cover hospital ER care or prescriptions drugs. They don't have to cover mental health services. And when Secretary Azar was here, Madam Administrator, we asked him, I asked him specifically, "Are you aware that these plans can exclude coverage for preexisting conditions or decline to offer coverage to individuals with preexisting conditions, yes or no?" And he responded, "Yes, that's correct."

Do you disagree with him that these junk insurance plans don't have to cover preexisting conditions, or you agree with Secretary Azar?

Ms. VERMA. Short-term limited duration plans provide more flexibility. And under our administration, premiums—

Ms. CASTOR. Well, by flexibility are you saying—you agree, then, they don't have to cover preexisting conditions. That is—see, this is very dangerous because we are about to enter into an open en-

rollment period, right, the open enrollment under the Affordable Care Act dates are—what date?

Ms. VERMA. They start November 1st.

Ms. CASTOR. And run through?

Ms. VERMA. They go through December 15th.

Ms. CASTOR. OK, so be careful, consumers, families across the country. If you go online and you type in “I am looking, shopping for health insurance” sometimes what will come up will be one of these junk insurance plans. The Federal Trade Commission has already had to act and shut down some of these fly-by-night health insurers, calling it a bait-and-switch scheme.

So when you are shopping for your health insurance, be careful. A lot of these companies are going to market a plan that says, oh yes, we will cover you, we will cover your preexisting condition, and then they find it is not covered. In fact, the nonpartisan Congressional Budget Office confirmed in a report that short-term plans have large coverage gaps that expose consumers to catastrophic costs, especially for folks with preexisting conditions. For example, a woman who enrolled in a short-term plan and was then diagnosed with breast cancer could face between \$41,000 and \$111,000 in out-of-pocket costs. That is from the CBO and the American Cancer Society Action Network.

Another one of the insidious sabotage efforts has been to our independent navigators across the country. And there is a lot of misinformation coming out that, oh, navigators aren’t effective. Well, if you go to the Kaiser Family Foundation report and the Government Accountability Office report from the past few months, they said, wow, HHS is pedaling false information. These navigators are—brokers are fine, but navigators do not have allegiance to an insurance company, they have an allegiance to the consumer, often help them sort through all of their affordable options.

So it is really unwise to eliminate navigators on one hand, market junk plans, cut outreach and enrollment—all of these things undermine a health insurance pool that helps keep costs down for families.

Ms. DEGETTE. The gentlelady’s time has expired.

Ms. CASTOR. Thank you very much. I yield back my time.

Ms. DEGETTE. The Chair now recognizes the ranking member of the full committee, Mr. Walden from Oregon, for 5 minutes.

Mr. WALDEN. Good morning, Madam Chair. And, Ms. Verma, thank you again for being here. We appreciate your leadership at the agency and your sitting through these discussions.

I want to talk about the navigators, because in the CMS report that I believe is from 2016, which is before the Trump administration, for plan year 2017, navigators received \$62.5 million in Federal grants, they enrolled 81,426 individuals, which, if I understand that right, equates to \$767 per person is the math if you divide the total number enrolled versus the total amount spent. Now also, according to CMS from the Obama administration data, 17 navigators enrolled less than a hundred people each at an average cost of \$5,000 per enrollee, and 78 percent of the navigators failed to achieve their enrollment goals.

So this is from the CMS information that is from 2016 for plan year 2017, and when did you become administrator?

Ms. VERMA. In March 2017.

Mr. WALDEN. Yes. So in 2017, then, CMS announced that it would start awarding funding to navigators based on their ability to meet their enrollment goals. That sounds like pretty standard business practice.

Ms. VERMA. That's right. We have a duty to taxpayers to make sure that our programs are cost effective.

Mr. WALDEN. And so, as a result, CMS reduced the funding for the program by 10 million for 39 organizations in 2018. Why? Why did you do that?

Ms. VERMA. We did that because the navigator program was not producing the types of results that we would expect to see. My goal is to make sure that consumers using HealthCare.gov or our call centers have a very smooth experience, and we felt like there were more different ways. When a program is new, it does require a lot of intensive investment in terms of outreach and enrollment.

Mr. WALDEN. Sure.

Ms. VERMA. But looking at the Affordable Care Act, it had been in place, and we were looking, reviewing the types of investments that have been made. We had seen from the previous administration that they had actually doubled their advertising budget to a hundred million dollars, but actually enrollment went down, so we knew that those types of things weren't effective.

And the same thing with the navigator program. When we did the math, it just didn't add up when you are spending \$5,000 per person. So what we tried to do is invest in more cost-effective ways, digital ads, more of those types of things, and I think our results have been effective. We had a 90 percent customer satisfaction rate for people that used our call centers.

We haven't seen the dire predictions in terms of enrollment going down. We've had minor fluctuations, which I think can be attributable to the Trump economy where things are move—are so good that people don't necessarily—

Mr. WALDEN. Well, let me ask you that. And I am sorry to interrupt you, but on that very point, aren't—how many more people are now covered by private insurance as a result of the strong economy?

Ms. VERMA. Well, because of the strong economy, what we're seeing is that people aren't relying on public programs as much. We are seeing, however, some of the individuals, though, that aren't subsidized, that they're having trouble affording health insurance and that the increase in the number of uninsured is actually for people that are 300 and 400 percent of the poverty level.

And so, what that shows us is that they can't afford health insurance premiums because of the way Obamacare is structured, and so people that are subsidized, we're seeing their enrollment go up, but it's the unsubsidized population where we're seeing problems. We've seen a 40 percent decrease.

Mr. WALDEN. So this is kind of the middle class—

Ms. VERMA. That's right.

Mr. WALDEN [continuing]. That is caught right there. Not getting a subsidy, can't afford the health insurance they are stuck with, and you are trying to give options and have States involved. My

State has come to you and gotten relief from certain Federal requirements, right?

Ms. VERMA. That's correct. We've been doing reinsurance waivers, and I think the short-term limited duration plans and association plans, those are efforts of the administration to give people alternatives because we know the middle class cannot afford expensive Obamacare. So we're trying to provide more choices and let the American people decide what benefit plan is going to work best for them, not a one-size-fits-all government approach, which is expensive. We think Americans should make those decisions themselves.

Mr. WALDEN. When we had a big debate on the floor on some healthcare issues, and a number of my friends on the other side of the aisle had amendments directing the navigators do a whole bunch of things—reach out to rural areas—and I raised the issue then, and I think we followed up with a letter to you recently. That told me the system is broken with the navigators, because they were having to have amendments directing the navigators to do all these different things. And so, is that system broken?

Ms. VERMA. Yes. And I also think that, you know, we look at—we do open enrollment for the Medicare program every year, and what we do there is we use a system of volunteers to help individuals.

Mr. WALDEN. Are their navigators paid from, like, Medicare Part D or Medicare?

Ms. VERMA. No. We use a system—

Mr. WALDEN. All right.

Ms. VERMA [continuing]. Something we called our SHIP volunteers, and they do an incredible job of helping seniors through the open enrollment process. So I think there's better ways and more cost-effective ways.

Mr. WALDEN. Thank you. My time has expired. Thank you, Madam Chair.

Ms. DEGETTE. Thank you so much. The Chair now recognizes the gentlelady from New York, Ms. Clarke, for 5 minutes.

Ms. CLARKE. I thank you, Madam Chair, and I thank our ranking member.

Administrator Verma, Hubert Humphrey, he was the namesake of the building that you work in, said, "The moral test of government is how the government treats those who are in the dawn of life, the children." This quote is even inscribed on the wall as you walk through the front door of HHS. On your watch, it is safe to say that this administration has failed that moral test.

This administration inherited historically low uninsured rates among children, but thanks to this administration's sabotage and mismanagement of healthcare, those rates have gone up from 3.6 million uninsured in 2016 to 4.3 million uninsured children in 2018. You have said you want to preserve Medicaid for those who truly need it. Are low-income children among those who truly need Medicaid? This is a yes-or-no question.

Ms. VERMA. As a mom—I have two children—I think having health insurance for children is extremely important to their development.

Ms. CLARKE. Very well. So the New York Times has reported yesterday that, since 2017, more than a million children have lost cov-

erage in Medicaid and CHIP. Further, the Census Bureau reported that on your watch the children's uninsured rate increased to 5.5 percent, largely because of the deadline in coverage under Medicaid and CHIP.

Administrator Verma, do you agree with the findings of your administration's own Census Bureau? Yes or no.

Ms. VERMA. There's a couple of—there's two separate issues here.

Ms. CLARKE. Yes or no. Yes or no. Do you agree? Have you—

Ms. VERMA. It's not a yes-or-no question.

Ms. CLARKE. It is a yes-or-no question. Either you agree with what the Census has presented to you or you don't.

Ms. VERMA. I believe that the Census data is accurate.

Ms. CLARKE. Do you agree with it? Yes—it is accurate, so that is a yes. You have previously claimed that the children who lost Medicaid have transitioned into private coverage, but if that were true, we would see an increase in the enrollment in private coverage. However, your own Census Bureau says that that is not the case, that there has been no increase in the number of children covered under private insurance.

Administrator Verma, can you explain why the rates of children enrolled in Medicaid CHIP are declining while private insurance coverage has remained flat?

Ms. VERMA. So, if we look at the number of uninsured children, which I'm deeply concerned about, the biggest drop is for families that are earning above 400 percent of the poverty level. And so what's happening is, under the Trump economy, the economy is the best that we've had in 50 years, unemployment is down.

Ms. CLARKE. I don't want to hear your talking points.

Ms. VERMA. There's less people living in poverty.

Ms. CLARKE. Reclaiming my time. The New York Times story talked about a little boy in Texas named Elijah whose family didn't know that he had been kicked off Medicaid until he was admitted to intensive care for a respiratory virus. Texas has the highest number of uninsured children in the country and conducts more frequent eligibility checks than any other State. Data shows that, of the 50,000 children in Texas kicked off Medicaid, more than half regained their coverage within 12 months, which means these children were dropped erroneously.

In Tennessee, tens of thousands of children lost coverage because of late or incomplete paperwork. Until recently, Tennessee used an application that could be up to 47 pages long that one Medicaid expert called "daunting."

Administrator Verma, we all agree that the program integrity is a critical part of any Federal program, but would you agree that the program integrity requirement should not be weaponized to kick children off of Medicaid? That is a yes or no.

Ms. VERMA. I think it's important that children have coverage, first of all. In terms of program integrity, unfortunately, we're seeing that there are major problems in Medicaid eligibility. We're hearing cases all the time. I can tell you I saw data yesterday which is concerning.

Ms. CLARKE. I understand your concern. But you should be far more concerned about the decline or the increase in the numbers of children who are uninsured. You talked about being a parent

and what you want for your children. What about low-income children across this Nation? That is your responsibility. So you can say you want to preserve Medicaid for those who truly need it, but on your watch over a million children have lost Medicaid and CHIP coverage and the children's uninsured rate has reversed years of gains. The numbers don't lie and are clearly going in the wrong direction. You have failed the most vulnerable amongst us. You have failed the American people.

With that, Madam Chair, I yield back.

Ms. DEGETTE. The Chair now recognizes the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. TONKO. Thank you, Madam Chair.

Administrator Verma, CMS has promoted and expanded the availability of short-term limited duration insurance plans that are not required to comply with the comprehensive consumer protections of the Affordable Care Act. These junk plans undermine protections for people with preexisting conditions, increase costs, and leave American families with less financial protection and more exposure to fraud.

Now I want to follow up on Representative Castor's questioning. Administrator Verma, isn't it true that these plans are allowed to exclude coverage for preexisting conditions?

Ms. VERMA. Short-term limited duration plans provide——

Mr. TONKO. Yes or no. Yes or no.

Ms. VERMA [continuing]. An alternative. There's a——

Mr. TONKO. Yes or——

Ms. VERMA. It depends on the plan.

Mr. TONKO. Yes or no.

Ms. VERMA. It depends on the plan.

Mr. TONKO. Isn't it true that these plans are allowed to exclude coverage, are allowed to exclude coverage? Yes or no.

Ms. VERMA. Short-term limited duration plans have more flexibilities than——

Mr. TONKO. I am asking for a yes or no. I have 5 minutes, so I want to get——

Ms. VERMA. It depends on the plan. There are different types of short-term limited duration plans.

Mr. TONKO. I am asking if these plans are allowed to exclude coverage. That is a yes-or-no question.

Ms. VERMA. Short-term limited duration plans have the flexibility around benefit design.

Mr. TONKO. So it is a yes.

Ms. VERMA. But it depends on how that plan is structured.

Mr. TONKO. But they are allowed to exclude coverage?

Ms. VERMA. Not all of the plans will do that. It depends on the plan.

Mr. TONKO. Are they allowed to?

Ms. VERMA. And what we have done is to ensure——

Mr. TONKO. You are not answering the question, ma'am.

Ms. VERMA [continuing]. That there are the appropriate protections in place for consumers so they understand the type of coverage they are buying.

Mr. TONKO. Ma'am, I mean, you are eating up the clock. I am asking if they are allowed to exclude coverage for preexisting conditions.

Ms. VERMA. They have flexibility around benefit design.

Mr. TONKO. So that is—I believe that is a yes answer. Administrator Verma, isn't it true also that people on these plans can be charged higher premiums without limit based on their health status, gender, age, and other factors? Yes or no.

Ms. VERMA. The CBO said that the short-term limited duration plans could be 60 percent lower than the Affordable Care Act plans.

Mr. TONKO. Yes or no, can they be charged higher premiums without limit based on their health status, gender, age, and other factors?

Ms. VERMA. They have the flexibility. They do not have to comply—

Mr. TONKO. They have the flexibility, so that is a yes.

Ms. VERMA [continuing]. With the Obamacare plans.

Mr. TONKO. Thank—

Ms. VERMA. But that's why they're priced lower.

Mr. TONKO. I don't want to use any more time.

In addition to excluding coverage of preexisting conditions, charging people more based on their health status, I am concerned by the failure of these plans to cover basic healthcare services.

Administrator Verma, isn't it true that junk plans can refuse to cover essential health benefits like hospitalization, maternity care, prescription drugs, mental healthcare, and preventive care? Yes or no.

Ms. VERMA. You know, I was talking to a family the other day that they lost—

Mr. TONKO. Well, yes or no. It is OK that you had that—

Ms. VERMA [continuing]. Their health insurance. They lost their job.

Mr. TONKO. Ma'am. Ma'am, yes or no. It is my time. Is it true that these can refuse, these plans can refuse to cover those essential benefits?

Ms. VERMA. There's a variety of different plans that are offered under short-term limited duration, and it depends on the plan.

Mr. TONKO. You are not answering the question.

Ms. VERMA. It depends on the plan.

Mr. TONKO. It depends on the plan, but can—again, the question is, can they refuse to cover essential health benefits like those I mentioned?

Ms. VERMA. They have flexibility on benefit design.

Mr. TONKO. So that is a yes. They have flexibility. Even if some of these plans might cover some essential health benefits, I am concerned that what might happen should people get sick while they have a junk plan.

Administrator Verma, isn't it true that these plans can impose lifetime and annual limits on coverage and are not subject to cost-sharing limits?

Ms. VERMA. If there were more affordable options available under Obamacare, people wouldn't have to make compromises. But unfortunately, premiums have gone up—

Mr. TONKO. I don't want—don't filibuster on me.

Ms. VERMA [continuing]. So much that there's no alternative.

Mr. TONKO. Please. Please. I am asking for a yes or no. Isn't it true that these plans can impose lifetime and annual limits on coverage?

Ms. VERMA. Yes, they can.

Mr. TONKO. OK. Thank you for the yes. These plans seem to have very little utility if you need healthcare or don't want to be one sickness away from bankruptcy. That is exactly why the ACA was passed. It was to make sure that people had comprehensive coverage and were not one illness away from bankruptcy.

So, Administrator Verma, I am curious. What are people with these junk plans supposed to do when they need vital healthcare services that are not covered by these junk plans?

Ms. VERMA. Well, what are they supposed to do when they have to spend half of their income on the Obamacare premiums and then another 10 to 12 thousand dollars on the high deductibles? They have no alternative. And what our administration is trying to do is to provide more choices where there aren't any. And so, when people are forced to pay half of their income or a third of their income on a premium plus a deductible, they can't afford health insurance, and short-term limited duration plans may give them a different option. It's better than having no insurance at all.

And in absence of no solution by Congress to address—

Mr. TONKO. I am going to reclaim my time.

Ms. VERMA [continuing]. Unaffordable premiums, there is at least something for people.

Mr. TONKO. Well, I believe that the statistics with one in three people being able to afford something with the subsidies that we provide are an encouraging statistic. And with that I yield back.

Ms. VERMA. And many people don't get subsidies.

Mr. TONKO. And I would just ask that you put children first. And with that, I yield back.

Ms. DEGETTE. The gentleman's time has expired. The Chair now recognizes the gentlelady from Washington State, Mrs. McMorris Rodgers, for 5 minutes.

Mrs. RODGERS. Thank you, Madam Chair. I would like to begin just by giving the Administrator a chance to answer anything that you didn't get to answer in the last questions since you were being cut off repeatedly.

Ms. VERMA. Thank you. I appreciate that. You know, first of all, Obamacare has become affordable—unaffordable for so many families, for the middle class, they can't afford the premiums, and if they're not getting a subsidy, they have no alternative. Short-term limited duration plans provide an alternative. I was just talking to a family where, you know, the husband lost his job. They have two kids in high school. And they couldn't afford—they couldn't afford premiums under Obamacare, and so they looked at a short-term limited duration plan. It met their coverage needs. They reviewed the benefits and felt like it was going to work for their family, and so they were able to buy this plan.

You know, these plans can be 60 percent lower than what's on the exchanges, and so it gave them an alternative. You know, they may not need it for a long period of time, but it's important that

we have alternatives. In absence of a solution, we're trying to do something for the American people, for the middle-class Americans that can't afford Obamacare.

Mrs. RODGERS. I want to say thank you. I want to say thank you for your leadership. I want to say thank you for your commitment to making sure that we keep the promise, especially to those on Medicare, our seniors that are depending upon Medicare, for those on Medicaid, some of the most vulnerable in our country. I just want to say thanks for the work that you are doing.

I also applaud you for the work you are doing to ensure that we continue to lead the world in innovation and thinking of how we ensure that we have a healthcare system that is going to provide access and quality at an affordable price for everyone. And I think the flexibility is so important. I think that offering a variety of plans is so important to meet an individual's or a family's need, particular needs. Certainly, Medicare and Medicaid are critical safety nets, and we must keep, fulfill the promise that we have made to those that are depending upon Medicare and Medicaid.

I am committed also to making sure that those with preexisting conditions have the confidence and the certainty that they will always have quality, access to quality and affordable healthcare. I have a son with special needs with disabilities, and I remember during the debate on Obamacare that I was concerned about the impact that it was going to have on those with disabilities within Medicaid. According to the Kaiser Family Foundation, they have reported that more than 450,000 individuals with developmental disabilities are on a waiting list today for Medicaid in this country—450,000 individuals with disabilities.

When I was, during the debate when I was—when I said I am concerned about people with disabilities being put on a waiting list for Medicaid, I was laughed at. Today in Washington State, 15,000 individuals with disabilities are on a waiting list. This is Washington State that expanded Medicaid to the furthest degree possible. We have hundreds of thousands of people with disabilities that are waiting for care. I cochair the Rural Health Coalition. I have visited hospitals and healthcare facilities all throughout my district in Eastern Washington. It is heartbreaking when I hear from providers and hospitals that are having trouble keeping their doors open because of the low reimbursement rates and the high populations of Medicare and Medicaid.

So Washington State is at the highest level, 130 percent of Federal poverty level are covered under Medicaid. The income threshold is even higher for children, at 210 percent of the Federal poverty level. We need to make sure that we are protecting current beneficiaries because they need to have that certainty.

I wanted to ask you, could you just talk to me about CMS and what you are doing to track those that are on waiting lists and how do we ensure that the populations, some of the most vulnerable in our communities, are actually getting the care that we have promised to them?

Ms. VERMA. Well, I share your commitment to the vulnerable populations in the Medicaid program. Many of these individuals have no place to turn, and Medicare is a vital safety net that is so critical to improving their lives, the quality of care, and their

day-to-day lives. One of the things that we're very concerned about is program integrity within the Medicaid program. We're seeing some alarming data that is showing that States aren't necessarily putting the right people on the program, and that we have some high cases and problematic eligibility systems that are putting people on the program that don't belong.

And so, we'll be taking action to make sure that we can ensure that the people on the program actually belong on the program, because if we don't do that, we're failing taxpayers and people that deserve to be on the program.

Ms. DEGETTE. The gentlelady's time has expired. The Chair now recognizes the gentlelady from Delaware, Ms. Blunt Rochester, for 5 minutes.

Ms. BLUNT ROCHESTER. Thank you, Madam Chairwoman.

And thank you, Administrator Verma, for joining us today. Today's hearing is critically important because CMS is tasked with overseeing the implementation of the Affordable Care Act, the landmark law that allowed thousands of Delawareans as well as millions of Americans to be protected and not be denied coverage based on a preexisting condition or removed from their parents' health plan at the age of 26, just to name a few. It is one of the significant reasons why I came to Congress, was to protect this because I know it gave hope to so many people, particularly people with preexisting conditions.

And, unfortunately, Delaware's enrollment in the exchanges began dropping in 2016. And that is not a surprise when you factor in the administration's decisions to, number one, shorten significantly the enrollment period; number two, cut the navigator program by 84 percent, causing many people to be confused and not have the help and support that they needed to navigate, which—a sometimes incredibly difficult system for anybody, private sector or public sector; and three, cut outreach funds by a whopping 90 percent for a program that doesn't have the longevity of a Medicare or the name recognition. With less time to apply and fewer resources to do it, you can understand why people believe that these actions are deliberate attempts to unilaterally repeal the ACA.

Administrator Verma, after cutting the Federal funding to facilitate enrollment in HealthCare.gov, you were quoted as saying, "This decision reflects CMS's commitment to put Federal dollars for the federally facilitated exchanges to their most cost-effective use in order to better support consumers through the enrollment process."

I would like to focus on two parts of your statement. One, supporting consumers during the enrollment process and, secondly, the cost-effectiveness. According to a former senior advisor at CMS, Joshua Peck, who previously oversaw the ACA marketing program, the outreach and marketing programs that have been dramatically scaled back were working and they were cost effective.

I have been informed that there is data on how Federal dollars should be effectively spent in order to reach Americans who need health insurance. Specifically, a July 2018 general Government Accountability Office report on HHS outreach and enrollment efforts in the individual marketplace cites an HHS study on the most effective forms of advertising for new and returning enrollees.

In March, I along with 29 of my colleagues wrote from this committee, reached out to you to ask for this study because we wanted to really fully understand and get to the bottom of what ACA marketplace outreach strategies were actually working. After a follow-up, because I didn't receive a letter after that one, we wrote another letter. I received a letter back which, unfortunately, did not give us a direct answer, you know, and I would like to submit—I would ask unanimous consent to submit the three pieces of correspondence into the record.

Ms. DEGETTE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. BLUNT ROCHESTER. Administrator Verma, my colleagues and I just wanted to understand how CMS can most effectively help our constituents enroll in ACA-compliant health coverage. And this one really is a yes-or-no question. Will you commit to releasing any and all documents, studies, relevant data created from 2014 onward related to marketing and outreach efforts for the Affordable Care Act so that we on the committee and particularly in our oversight role can have the information and understand that rationale? Yes or no.

Ms. VERMA. All document requests are handled by Health and Human Services, and so I would refer your request to the Department.

Ms. BLUNT ROCHESTER. So the letter that we originally sent was actually sent to the Department. And it would be great to also have your commitment, I mean, I am assuming you had to have made the decision, so therefore you either had information or you didn't. You—I mean, you made the decision, so it would be really great to have that information so that we could make these decisions.

Again, would you support the turning over of that information?

Ms. VERMA. All document requests are handled by the Department of Health and Human Services, and I would refer your request to them.

Ms. BLUNT ROCHESTER. So I have 10 seconds left, and in my 10 seconds I am going to just say, for many years I got to serve in public service just like you, deputy secretary of Health and Social Services, State personnel director. It is important that people have confidence and faith in these institutions, and the way we answer questions exhibits that confidence and faith.

Just answer the questions. Just work with us, because we all want to see people have healthcare.

Ms. DEGETTE. The gentlelady's time has expired.

Ms. VERMA. And if I have the time—I would be happy to answer your questions.

Ms. DEGETTE. The Chair now recognizes the gentleman from Indiana, Mr. Bucshon, for 5 minutes.

Mr. BUCSHON. First of all, thank you, Administrator Verma, for being here today and thank you for the great work that you are doing at CMS, a difficult agency to lead, as I would imagine.

First off, I want to thank you for your recent proposal to reform Stark Law. As a long-term advocate for reforming the Stark Law, I am pleased that CMS has proposed real reform to the law. The Stark Law is a dated regulatory structure designed for a fee-for-service payment model that has inhibited the value-based care and coordinated care arrangements that many physicians are eager to

take advantage of in order to provide better and more efficient care for their patients. As we rapidly move to value-based care payment models, your proposal to modernize Stark Law will remove legal barriers that currently prevent physicians from entering into coordinated care and innovative payment models, which I believe can lead to better outcomes for patients and keep costs down.

So I would like to bring up the DME fee-setting provisions of the proposed rule by CMS that was proposed in July, and there are some concerns, as you know, that the proposed rule will place authority in the hands of CMS staff to set Medicare rates for medical devices in ways that, number one, will expand disparities between private payor and Medicare reimbursement and, number two, inhibit the availability of innovative medical devices for Medicare beneficiaries.

In particular, do you think that a developer of a breakthrough medical device with fairly robust sales in a non-Medicare market could review the regulations and then calculate with reasonable certainty the fee that might be set by Medicare?

Ms. VERMA. You know, one of the things that we're trying to do around innovation is provide more transparency for innovations so people understand what they're going to face in terms of coverage decisions, coding decisions, and also reimbursements. So we have tried to—we've actually proposed some regulations that would give more flexibility so that we can look at the private market and bring in what they may expect to be reimbursed in the private market as part of our decisionmaking.

Mr. BUCSHON. Thank you. I very much appreciate that. And so, do you think that in this space that the Medicare fee will be roughly equivalent to the non-Medicare price?

Ms. VERMA. It depends on the particular product. Our goal with durable medical equipment is to make sure that our beneficiaries have access to the equipment that they need and make sure that we have a competitive environment.

Mr. BUCSHON. Thank you very much. So I appreciate your consideration on these issues as you work towards finalizing that rule.

Another one is a little bit in the weeds but is important. It is the issue as it relates to Medicare beneficiaries who are on Coumadin therapy for atrial fibrillation and other medical problems that require anticoagulation—for example, a heart valve replacement. As you know, weekly blood tests are required to keep these patients in the safe treatment range.

And the concern here is, is that this year's proposed physician payment rule includes a 20 percent reduction in INR, the International Normalized Ratio, which is a test of anticoagulation. That is being reduced for 20 percent and is being reduced for the third year in a row. And so, I would like to ask if we could hit the pause button and really reconsider that. Freezing the reimbursement paired with work over the next year to figure out what is a sustainable path forward will help ensure that these vulnerable Medicare beneficiaries can receive the care they need. So I hope that we can take a look at that and revisit that.

And then, finally, I wanted to thank you for your letter that your office sent in response to the bipartisan letter that I sent on September 27th with 24 of my colleagues regarding the CY20 Physi-

cian Fee Schedule proposed rule. My colleagues and I have concerns with the agency's proposal not to apply a payment adjustment to the evaluation and management or E&M code component of global surgical codes even though the agency is proposing to update the E&M code values for standalone office visits. And as the agency works to finalize the rule, I appreciate your ongoing input and collaboration on that issue.

I have 48 seconds left. Do you have anything else that you feel like you haven't been able to say during the hearing that you might want to tell the American people about your work?

Ms. VERMA. Well, I would appreciate the opportunity to be able to answer some of the questions that have been posed before, but we haven't had time. One of the things that I do want to talk about are the numbers on—the number of people on Medicaid and the declines there as well as what we're seeing on the uninsured. When we look at the Medicaid program, it is natural to see fluctuations in enrollment. As the economy does better, we can expect to see lower enrollment. We've seen that in the Clinton administration. There's an urban study report on this as well.

And so, because we are in a booming Trump economy with the lower unemployment, less people on poverty, we are going to see that impact in the Medicaid program. That being said, our administration is committed to addressing children and making sure all kids have access to coverage.

Mr. BUCSHON. Thank you very much, and I will be submitting some other questions for the record. I yield back.

Ms. DEGETTE. The Chair now recognizes the gentleman from California, Mr. Cárdenas, for 5 minutes.

Mr. CÁRDENAS. Thank you very much, Madam Chairwoman. I appreciate this opportunity to have an open and public discussion about such an important program to millions and millions of Americans.

One of the fundamental gains under the Affordable Care Act was the historic increase in coverage thanks to Medicaid expansion. Approximately 12 million people gained coverage for essential healthcare services thanks to this expansion, and it continues to be one of the most important payors for healthcare in this country. Studies have made clear that Medicaid expansion has greatly benefited Americans who gained coverage.

Researchers from the Census Bureau, NIH, UCLA, and the University of Michigan recently found, and I quote, "Medicaid expansions substantially reduced mortality rates among those who stood to benefit the most." They estimated that due to the States' Medicaid expansion in States that there were over 19,000 fewer American deaths in the first 4 years alone. And the failure of other States to not expand Medicaid resulted in an estimated over 15,000 additional American deaths over the same period.

Administrator Verma, are you aware of that particular research?

Ms. VERMA. I'm aware of it.

Mr. CÁRDENAS. OK, thank you. Other studies also show gains in access to quality and affordable care as well as positive health outcomes. And in the midst of the opioid crisis, Medicaid expansion has increased access to medication-assisted treatment for opioid addiction.

My question to you, Administrator Verma, is, is it true that substance use disorder treatment is a top healthcare priority for HHS?

Ms. VERMA. I believe it is, yes.

Mr. CÁRDENAS. OK. That is good to hear. In fact, HHS has stated that its number-one strategy to combat the opioid crisis is “access, better prevention, treatment, and recovery services.” And as we know, Medicaid has been integral for increasing access to those services in expansion States. The American Medical Association has reported, and I quote, “Medicaid is on the front lines and often provides more comprehensive care for substance use disorders than the commercial insurance market does. There may be opportunities to extend Medicaid successes to commercial coverage. Expanding Medicaid would help even more patients.”

So, Administrator Verma, do you agree with the AMA that Medicaid is critical for providing comprehensive care for substance disorder to Americans and that expanding Medicaid would help more American people who are suffering from addiction?

Ms. VERMA. Thank you. A couple things. One, on Medicaid programs, CMS has approved 26 State Medicaid 1115 demonstrations to expand.

Mr. CÁRDENAS. How many States in the union?

Ms. VERMA. There’s 50 States in the union, 26 States.

Mr. CÁRDENAS. OK, thank you. So just over half.

Ms. VERMA. But those are the ones that have applied, and if they’ve applied we’ve approved them. So we have tried to ensure that people with substance use disorder have a full array of options available to them and more places to receive treatment.

Mr. CÁRDENAS. So the States that have applied and are providing that service, are they doing better than the States that are not applying in this category?

Ms. VERMA. These waivers, we just started granting them probably late 2017, and so we’re still evaluating those waivers.

Mr. CÁRDENAS. When do you anticipate having evaluations that you could report to Congress?

Ms. VERMA. We’ll be happy to share any information that we can with you.

Mr. CÁRDENAS. About when? Is it 2019, 2020, 2030?

Ms. VERMA. You know, it depends on when it comes in. These are 5-year waivers.

Mr. CÁRDENAS. OK, 5-year.

Ms. VERMA. And so it would take us at least that, and it depends on when they started their waiver.

Mr. CÁRDENAS. OK. Thank you so much.

As we know, the Trump administration is rooting for the ACA’s demise by asking the court to strike down the entire law. But if that happens, Medicaid expansion would be reversed. Therefore, 12 million American people would lose coverage literally overnight.

Administrator Verma, if the administration gets its way in the *Texas v. United States* lawsuit, what will happen to those 12 million vulnerable people who suddenly find themselves without coverage?

Ms. VERMA. Well, we’re rooting for all Americans to have coverage, and under the Affordable Care Act, the middle class can’t afford Obamacare’s coverage.

Mr. CÁRDENAS. I asked you specifically about that lawsuit and what would happen to those 12 million Americans.

Ms. VERMA. And we've been very clear, the President's been very clear he wants to make sure that people with preexisting conditions would have protections and we want to make sure that all Americans would have access to affordable coverage.

Mr. CÁRDENAS. OK, thank you. Reclaiming my time. That is not the answer to the question I specifically asked.

I would like to state for the record that the Trump administration and Administrator Verma are paying lip service to caring about American people with these issues, but it is clear that not taking the steps to encourage the best thing a State can do to immediately improve the lives of millions of American residents of those States that it expands—that it should be expanding Medicaid.

I am out of time, Madam Chair. I yield back.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the gentleman from Montana, Mr. Gianforte, for 5 minutes.

Mr. GIANFORTE. Thank you, Madam Chair. And thank you, Administrator Verma, for being here today to testify in front of our committee.

Last year, Congress removed Medicare reimbursement restrictions in five areas, including telestroke services. Do you think telehealth would be useful and effective in other critical care scenarios, especially for rural hospitals like I have in my district that may not have specialists in these small communities?

Ms. VERMA. Absolutely. And I think that's one of the things that we're trying to focus on in the Medicare program and part of the reason why I have some concerns when you hear about proposals to put everybody into the Medicare program. Unfortunately, the Medicare program often is very slow to respond to new technology. That being said, our administration has focused on telehealth services. We've expanded the number of telehealth services that are available in rural communities and we've also provided remote communication technology to the entire program so our beneficiaries can easily access care.

Mr. GIANFORTE. OK, I want to dig into this a little more. The Federal Government is among the most prolific users of telehealth and virtual care technologies, including the VA, DOD, IHS, NASA. Unfortunately, just one-quarter of 1 percent of Medicare fee-for-service beneficiaries used telehealth in 2016. Meanwhile, the Government has funds, grants, projects through HRSA, SAMHSA, FCC, and others. We know that some grants may be duplicative across HHS operating divisions, and it is often difficult for healthcare providers and patients to understand how they can better access telehealth services.

With limited resources available for telehealth adoption, it is important that we spend all these funds wisely. Can you help us understand how these different entities across the Federal Government coordinate policy development, Federal funding opportunities, and best practices as it relates to telehealth?

Ms. VERMA. Sure. One of the things that we have going on at Health and Human Services is the Secretary has convened a Rural Health Committee. And so we have—he's bringing together all of

the agencies under HHS to focus specifically on rural health, and as part of those discussions we're talking about how we can expand telehealth services to make sure not only people in rural communities but even urban communities can access those services.

Mr. GIANFORTE. OK. And do you believe there is opportunities to exist to improve coordination and efficiencies further?

Ms. VERMA. Absolutely.

Mr. GIANFORTE. OK. Are you aware of any national telehealth strategy and, if not, should one exist?

Ms. VERMA. I think there's been some focused effort on this in rural communities to make sure that—you know, a lot of the problem is, even if telehealth services are available, they may not have broadband access, and so the administration has focused on that as well. You know, telehealth is a great example of innovative technology that can really go a long way to improve access and to improve healthcare and outcomes, and so would love to continue to work with you on that issue.

Mr. GIANFORTE. Well, it is a real area of attention for us given I represent the State of Montana. We have a lot of space and not many practitioners. We don't have specialists. Telehealth is one way to bring those to these rural communities so they can maintain the viability of our critical access hospitals and others. So I appreciate all that CMS has done to increase access to telehealth services.

The Federal Government has a commitment to keep to our seniors and ensure they have access to high-quality, affordable healthcare. Congress should focus on leveraging both Federal funds and lessons learned so that those who need access most have it, particularly folks in rural areas. We should prioritize efforts to expand telehealth access and fully realize the potential it has to provide services to all our seniors with access to reliable, quality healthcare.

I have a minute left. Is there anything else you would like to tell the American people that hasn't been addressed today?

Ms. VERMA. I would like to focus on some of our efforts around rural health because I think it's an important area. We've been concerned about the hundred hospitals that have closed, rural hospitals. We're also concerned that 40 percent of rural hospitals are operating at a negative margin. This is why we've taken action with the wage index to increase reimbursement to hospitals in rural areas, and we're also working on something, a new model for rural communities to basically think about how they can redesign their system.

I think those decisions need to be made at the local level, can't be made in Washington, but it's an opportunity for them to rethink the structure and to move in more value-based care. So we're excited to continue our work and our commitment to rural communities across America.

Mr. GIANFORTE. Again, I want to thank you for your work at CMS and thank you for being here today. And with that, I yield back.

Ms. VERMA. Thank you.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the gentleman from Illinois, Mr. Rush, for 5 minutes.

Mr. RUSH. I want to thank you, Madam Chair. And welcome, Administrator Verma.

Administrator Verma, last month I sent you a letter asking, to me, a very important question: Why are there so many dialysis centers in black neighborhoods? In the poor part of my district, it seems that there is a dialysis center on each and every corner. And I want to thank you for responding to my letter, and I am cautiously optimistic regarding CMS's aggressive goals to reduce the disproportionate rates of kidney disease in lower-income and minority communities.

Madam Chair, I ask unanimous consent to offer my letter to CMS and to offer their response into the record.

Ms. DEGETTE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. RUSH. Administrator Verma, will you describe in detail how the goals you outline in your response to me will ensure minority communities in particular that they will have access to the care and education on treatment options that they may require if they are on dialysis?

Ms. VERMA. Well, thank you for your question. This is an important area. The President has actually put out an executive order around kidney disease, and the goal of that is multifaceted. First of all, we want to improve the quality of care. We want to make sure that people that are living with kidney disease have options about their care. The first thing that we want to do is make sure that the transplants, that the ability to have a transplant to cure their disease is available. And we know that there's a lot of regulations that get in the way of having more organs be available, and so the President has asked us to take action on that issue.

The second thing we want to do is make sure that we're paying doctors for the quality and the outcomes that they achieve. And one of the things that we want to focus on is giving people living with kidney disease more options so that they don't necessarily have to go into a dialysis treatment center and they can have more home-based dialysis.

Mr. RUSH. Ms. Verma, I want to know about the dialysis centers and those patients who are on dialysis, not those patients who are looking for organ transplants. And that is really good, but please center your answers on the issue of the dialysis center epidemic in lower and minority communities throughout the Nation, certainly in my district.

Ms. VERMA. Well, I think that's what this executive order focuses on. We want to improve the quality of care. We want to make sure that people have options. That they're not forced to just go to a dialysis center, that they can even receive that care at home.

Mr. RUSH. So you don't have an answer to my question?

Ms. VERMA. Well, I think our executive order, writ large, focuses on it, on kidney care.

Mr. RUSH. Well, let me ask you another question then.

I am concerned about hospitals closing in my district and in similarly situated districts across the Nation, all right. What do you have, any data on closures of hospitals in lower and minority income communities across the Nation?

Ms. VERMA. I'm sorry. The question is, you want to understand the impact on—

Mr. RUSH. I want to know, do you have any data on the number of hospitals that have been closed in my district and lower-income and minority districts across the Nation within the last 5 years?

Ms. VERMA. I don't have that data with me today, but I can commit to you that we can help your office and provide any data that we have available to your office.

Mr. RUSH. Do you know why there is an increase in the number of hospitals that are closing in lower and minority income communities?

Ms. VERMA. I have not studied that issue, but I'd be happy to work with my team and get you that information.

Mr. RUSH. Can you come up with any idea about how to prevent hospitals from closing in minority and low-income communities across the Nation if, in fact, the data reveals that we have such an epidemic?

Ms. VERMA. Well, we want to make sure that people all across the Nation have access. I think we've looked at the issue in rural areas—

Mr. RUSH. I yield back.

Ms. VERMA [continuing]. But happy to work with you on that.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes Mr. Carter from Georgia for 5 minutes.

Mr. CARTER. Thank you very much, Madam Chair. And, Administrator Verma, thank you for being here. We appreciate it very much. Is there anything you need to respond to before I get—you are OK? OK.

I want to thank you. I have been working with you now for close to 2½ years, and I appreciate your work. I think you understand what we are trying to do, and I think we are on board. I want to especially tell you how much I appreciate the proposed rule changes earlier this year concerning rebates with PBMs and especially with DIR fees. And whereas I know you have to temper your remarks, but I don't, I was devastated that they did not—that the administration blocked those rules and that we weren't able to get them through, and I hope that you will continue to work toward that.

I, for one, believe that we need to do away with PBMs, and I certainly believe we need to do away with DIR fees. Both of them need to be eliminated. But one thing that I don't think needs to be eliminated is the 340B program. I do think it serves a useful purpose. However, I do think it needs to be updated, and I think that we need to tighten up that program. There are flaws in that program, and it can be better than what it is now if we simply make some changes to it.

We did a study in the last Congress about the 340B program and made some recommendations, and one of the things that we cited was duplicate discounts. The discounts that are going to the recipient, the covered entity receives a rebate for the drug that is dispensed to the patient and the Medicaid agency, and it can be both the State Medicaid drug rebate plan or the Medicare managed care plan.

And I just wanted to ask you, whereas I know HRSA has primary jurisdiction over the 340B program, CMS has jurisdiction over the Medicaid program. What are we doing about that? Can you help me?

Ms. VERMA. Sure. And I also do want to address the DIR fees. What I will say is we're very concerned about small pharmacies and we want to make sure that our policies ensure a competitive marketplace, and I can tell you that the agency continues to work on that issue. We're particularly concerned about some of the quality metrics that may be impossible for some of these pharmacies to comply, so we're going to continue to do what we can under the law.

Mr. CARTER. And, of course, as you well know we are trying to address it legislatively as well, and I want to thank my colleagues on the other side of the aisle for assisting in that as well.

Ms. VERMA. Thank you. And then, in regards to the 340B program, as you know that is the subject of litigation, so I won't get into that, but we are concerned about the double discounts. At the end of the day, some of the proposals that we made would result in our seniors paying less, and we're concerned about that. I also would add that the President's budget in terms of the 340B project or our proposal would say that if we made any changes to the 340B program that any savings could be directed back to the safety net institutions.

And so, I would ask that you take a look at that because I think that would be helpful in reforming the program, ensuring that beneficiaries are paying less when they get their medications but also ensuring that we support safety net institutions.

Mr. CARTER. Absolutely. And I don't mean to be redundant, but again as I said earlier, I am not opposed to the program. It just needs—we need to upgrade the program, and we need to make it even better, and we can make it even better.

OK, and then let's shift over to your oversight of hospital accrediting organizations because I know that is your responsibility as well. And it is my understanding that you have a new pilot program out there that is dealing with the "increase the agency's oversight of organizations involved in accrediting and inspecting most hospitals"?

Ms. VERMA. I think, one—we do have, we had an RFI out on this. One of the things that we've had some concerns about is that organizations that are reviewing safety and quality at hospitals—we put out an RFI because we've also heard some concerns that these organizations are also receiving consulting dollars from those same entities, so we're taking a look at that. We want to make sure that the American public can count on the accreditation and that they have the information that they need about the hospital at their fingertips.

Mr. CARTER. Obviously that is a conflict of interest, if they are doing the consulting and the accrediting. Is the pilot program in place, or you just have an RFI for it?

Ms. VERMA. We—so there's two different issues. One is around the accreditation issue and conflicts of interest. The other issue that we have in place is just looking at, we have a pilot program to do joint review so that we can have our oversight of the accred-

iting organizations and that we basically do the review of the hospitals at the same time so that we're not duplicating that. We're going to see how that goes.

Mr. CARTER. Great. And again, I want to thank you for all your work and especially for your work on the DIR fees, because as you say, particularly for small pharmacies, which we need in this country, this is devastating for them. So thank you, and I yield back.

Ms. VERMA. Thank you.

Ms. DEGETTE. The gentleman yields back.

I want to thank our witness for her participation in today's hearing, and I want to remind Members that, pursuant to committee rules, they have 10 business days to submit additional questions for the record to be answered by the witness who has appeared before the subcommittee.

Administrator Verma, I would ask that you agree to respond promptly to any such questions should you receive them. And with that, the subcommittee is adjourned.

Ms. VERMA. Thank you.

[Whereupon, at 12:31 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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The Health 202: Obamacare is getting more affordable under the Trump administration

By [Paige Winfield Cunningham](#)

THE PROGNOSIS

Obamacare premiums will become more affordable next year – despite dire predictions by Democrats that the Trump administration would destroy the insurance marketplaces.

In a marked shift from previous years, average premiums for mid-level “silver” plans will decrease 4 percent for 2020, while the number of plans available on the Affordable Care Act marketplaces will swell 13 percent, according to figures released this morning by the Centers for Medicare and Medicaid Services. Nearly 7 in 10 people will have access to at least three marketplace plans, up from six in 10 last year (the figures don't include the 11 states running their own marketplaces instead of relying on Healthcare.gov.)

“President Trump – the president supposedly trying to sabotage this law – has been better at running it than the guy who wrote the law and that has remained the case this year,” Health and Human Services Secretary Alex Azar told reporters.

The improvements are striking, considering that Democrats have spent the last few years blasting the Trump administration for peeling away Obamacare regulations. Those actions include removing the law's penalty for lacking health coverage known as the individual mandate and allowing more insurance plans to cover fewer medical services than typically allowed under the 2010 health-care law.

It's also an irony for the president himself, who has repeatedly lambasted Obamacare as a "disaster" and tried fruitlessly through Congress to repeal and replace it. **But Trump now says because of his administration's actions, the ACA isn't so bad after all: "Once we got rid of the individual mandate it made it better but Obamacare doesn't work -- but it works at least adequately now. And we had that choice to make. And politically it's probably not a good thing that I did, but it's the right thing to do for a lot of people," he said in July.**

But Democrats disagree. "Working families are paying the price for Republicans' relentless effort to sabotage their health care and drive up insurance premiums," House Speaker Nancy Pelosi (D-Calif.) said last year.

Former vice president Joe Biden, who is seeking the Democratic presidential nomination:

For years, Democrats have been charging Trump is sabotaging the marketplaces. From Senate Minority Leader Chuck Schumer (D-N.Y.), two years ago:

If Trump's top health officials were trying to actively sabotage the Obamacare marketplaces, which will be open for enrollment from Nov. 1 through Dec. 15, they don't seem to be doing a very good job of it.

During the Obama administration and in the Trump administration's first year, the marketplaces suffered from double-digit premium increases, spikes in annual deductibles and insurer exits, leaving many customers frustrated by the lack of choice and affordability. Insurers hiked premiums [an average](#) of 32 percent from 2017 to 2018, driving away many customers who earned too much for financial assistance.

But average premiums [dropped](#) last year for the first time since Obamacare was enacted, by 1.5 percent. This year, the marketplaces look even more stable – and are even thriving in some areas. Some additional figures from HHS:

—Average premiums for “silver” plans are decreasing at least 10 percent in six states: Delaware, Montana, Nebraska, North Dakota, Oklahoma and Utah. They’re increasing at least 10 percent in three states: Indiana, Louisiana and New Jersey.

—Just 12 percent of customers will have access to a single insurance issuer, down from 20 percent last year. Sixty-eight percent will have access to three or more insurance issuers, up from 58 percent.

—Most Healthcare.gov customers are eligible for government subsidies. But prices can still be steep for those who are ineligible. For example, a 27-year-old without subsidies will pay an average premium of \$426 for a “gold” plan, \$374 for a “silver” plan and \$278 for a “bronze” plan.

Trump's health officials have often faced tricky political questions about why the administration is refusing to defend the ACA in a [high-profile lawsuit](#) in which a decision is expected any day.

But yesterday, they were clearly trying to take a victory lap, pushing back hard against criticisms from Democrats over how they've handled the ACA.

“Our results speak for themselves,” said CMS administrator Seema Verma. “It’s the proof this administration’s tireless work to mitigate the damage caused by Obamacare is paying off.”

That's been the line Azar and Verma have frequently adopted about the ACA: That they are trying to make the best of a flawed law. They told reporters they still want the law repealed – something Republicans in Congress tried and failed to do back in 2017 – but said they're “fixing” it in the meantime.

“The Trump administration’s actions have worked,” Verma said. “Without them, Obamacare would have continued to spiral out of control.”

Democrats were furious when HHS issued regulations last year opening the door wider to leaner but cheaper health plans people can buy outside the marketplaces.

Short-term plans can now be purchased for a year instead of just three months, and there's broader latitude for chambers of commerce and trade associations to come together to buy coverage through association health plans.

These plans, allowed to cover fewer medical services than typical Obamacare plans, were expected to attract healthy people out of the marketplaces, leaving sicker ones behind and driving up premiums overall. The Congressional Budget Office [projected](#) their expansion would drive up premiums – but just by 3 percent.

Then there was the 2017 tax overhaul, in which congressional Republicans repealed the ACA's penalty for lacking health coverage. That also fueled charges from Democrats that healthy people would abstain from buying coverage, therefore driving up marketplace premiums for everyone left behind.

Marketplace enrollment has [declined somewhat](#) – falling by 300,000 people this year – but getting rid of the penalty hasn't had the catastrophic event many had predicted. Some states, including California, New Jersey and Rhode Island, have implemented their own penalties in the absence of a federal one.

“I think people who predicted immediate meltdowns probably overstated the case,” said Joel Ario, who directed the HHS Office of Health Insurance Exchanges under Obama. “But over time, I think it will prove correct that states without mandates will have trouble keeping a stable pool.”

Even as Democrats’ predictions haven’t come true, the Trump administration may also be claiming more credit than it deserves. Marketplace insurers reached profitability after their massive rate increases in 2018, so it’s possible the rates would have leveled out with or without the administration’s new policies. The ACA limits how much money insurers can collect in premiums relative to their overhead costs, so more massive rate hikes would have required them to pay large rebates to customers.

Insurers are also pointing to the “reinsurance” programs the administration has approved in 12 states as another reason for why they’re lowering rates. Through these reinsurance programs, states can help cover the sickest, high-cost individuals, in order to keep premiums lower for everyone in the marketplaces.

“We really have seen this market stabilize over the years,” said Justine Handelman, senior vice president for the Blue Cross Blue Shield Association, told reporters recently.

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Congress of the United States
Washington, DC 20515

July 1, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

We encourage swift finalization of the proposed rule, titled “Patient Protection and Affordable Care Act; Exchange Program Integrity,” as it relates to compliance with the separate payment requirement in Section 1303 of the Patient Protection and Affordable Care Act (ACA). We support the rule and sincerely thank the Department of Health and Human Services (HHS) for proposing it. Finalization of this rule is critical and very time sensitive, as Open Enrollment for 2020 begins November 1, 2019.

Section 1303 of the ACA required qualified health plans (QHPs) that covered elective abortions to collect a separate payment—sometimes referred to as an abortion surcharge—of at least \$1 per enrollee per month and deposit it into an abortion account. By no means is this measure consistent with the principle of the long-standing Hyde Amendment; however, it is important that the administration comply with these minimal requirements with transparency. Section 1303 specifically requires:

- QHPs must “collect from each plan” a “separate payment” of not less than \$1 per month for any elective abortions covered.
- QHPs must deposit these separate elective abortion payments into “a separate account that consists solely of such payments and that is used exclusively to pay” for elective abortions.

Unfortunately, in an exercise of executive overreach, the Obama Administration undermined Section 1303 by interpreting “separate” to mean “together” in subsequent regulatory guidance. Blatantly disregarding congressional authority, the guidance stated that simply sending a single notice about the surcharge or itemizing the abortion surcharge on monthly bills would satisfy the requirement under Section 1303. This meant QHPs could collect the “separate” abortion surcharge payment “together” with the remaining premium in one check. This misinterpretation of the law created a hidden abortion surcharge in many health care plans on exchanges throughout the nation, requiring enrollees to—in some cases unknowingly—subsidize elective abortion.

The proposed rule is consistent with the clear meaning and congressional intent of Section 1303 and eliminates the hidden abortion surcharge in many ACA plans. While this requirement does

not change the fact that the ACA violates the precedent of the long-standing Hyde Amendment through its involvement of tax dollars in subsidies to abortion-covering plans, it is an important step in providing transparency and awareness for enrollees.

As stated in a letter sent to HHS in January, we are concerned that the proposed rule neglected to directly address the Obama Administration's deliberate misinterpretation of the law. We hope the final rule will clearly acknowledge the illegality and extent of this executive overreach in the prior regulation.

We were grateful to see an indication from the Office of Management and Budget that the rule may be finalized in August. We continue to urge swift action to finalize the rule in time for 2020 Open Enrollment. Failing to do so will result in another year of noncompliance with the requirements of Section 1303. It is time for the Obama-era regulation to be replaced.

Sincerely,



Cindy Hyde-Smith
United States Senator



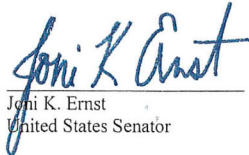
Michael Cloud
Member of Congress



Deb Fischer
United States Senator



Steve Scalise
Member of Congress



Joni K. Ernst
United States Senator



Vicky Hartzler
Member of Congress



Marsha Blackburn
United States Senator




Christopher H. Smith
Member of Congress



Jim Inhofe
United States Senator



Daniel W. Lipinski
Member of Congress

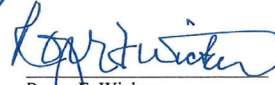

Pat Roberts
United States Senator



Michael B. Enzi
United States Senator


Mike Crapo
United States Senator

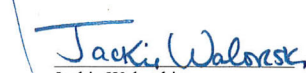

John Thune
United States Senator


John Barrasso
United States Senator

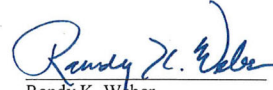

Roger F. Wicker
United States Senator


James E. Risch
United States Senator



Roy Blunt
United States Senator

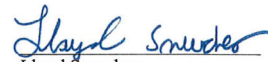

Jackie Walorski
Member of Congress



David P. Roe, M.D.
Member of Congress


Randy K. Weber
Member of Congress


Ted Budd
Member of Congress



Bradley Byrne
Member of Congress



Lloyd Smucker
Member of Congress



Gary Palmer
Member of Congress


Bruce Westerman
Member of Congress


John Hoeven
United States Senator


Marco Rubio
United States Senator

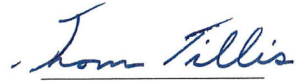

Mike Lee
United States Senator


Tim Scott
United States Senator



James Lankford
United States Senator



Steve Daines
United States Senator


M. Michael Rounds
United States Senator


Thom Tillis
United States Senator


Paul Mitchell
Member of Congress


John Ratcliffe
Member of Congress



Ross Spano
Member of Congress


Michael Guest
Member of Congress

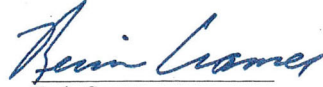

Roger W. Marshall
Member of Congress

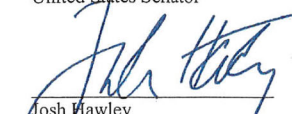

William R. Timmons, IV
Member of Congress

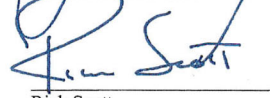

Tom Emmer
Member of Congress


Ralph Norman
Member of Congress


Todd Young
United States Senator


Kevin Cramer
United States Senator


Josh Hawley
United States Senator

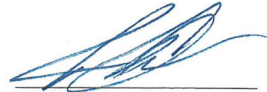

Rick Scott
United States Senator


Doug LaMalfa
Member of Congress



Jim Hagedorn
Member of Congress

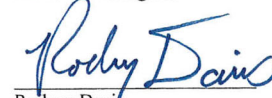

Jody B. Hice
Member of Congress

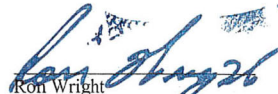

Jack Bergman
Member of Congress



Ralph Abraham, M.D.
Member of Congress



Mike Johnson
Member of Congress


Barry Loudermilk
Member of Congress


Rodney Davis
Member of Congress



Ron Wright
Member of Congress


W. Gregory Steube
Member of Congress


David Kustoff
Member of Congress

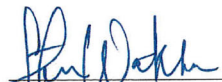

Mark E. Green, M.D.
Member of Congress



Kelly Armstrong
Member of Congress


Ben Cline
Member of Congress

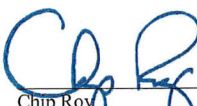

Kevin Hern
Member of Congress


Tim Burchett
Member of Congress

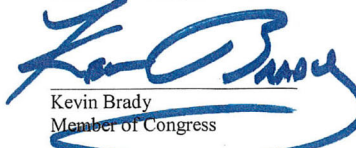

Steve Watkins
Member of Congress


Troy Balderson
Member of Congress


John Rose
Member of Congress


Chip Roy
Member of Congress

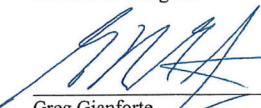

Trent Kelly
Member of Congress

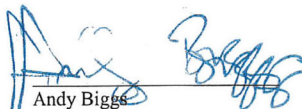

Kevin Brady
Member of Congress

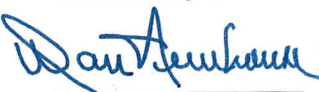

James Comer
Member of Congress


Robert B. Aderholt
Member of Congress


Daniel Webster
Member of Congress


Greg Gianforte
Member of Congress


Andy Biggs
Member of Congress


Dan Newhouse
Member of Congress



Glenn Grothman
Member of Congress



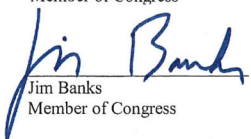
Dusty Johnson
Member of Congress



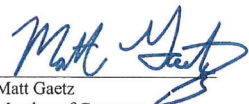
Ron Estes
Member of Congress



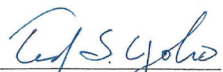
Mike Kelly
Member of Congress



Jim Banks
Member of Congress



Matt Gaetz
Member of Congress



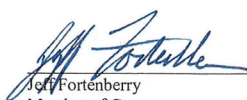
Ted S. Yoho, D.V.M.
Member of Congress



Paul Gosar, D.D.S.
Member of Congress



Joe Wilson
Member of Congress



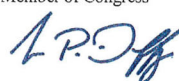
Jeff Fortenberry
Member of Congress



David Schweikert
Member of Congress



Roger Williams
Member of Congress



Sean Duffy
Member of Congress



Mark Walker
Member of Congress



Jim Jordan
Member of Congress



Tom Graves
Member of Congress



Pete Olson
Member of Congress



Mark Meadows
Member of Congress



Steve King
Member of Congress



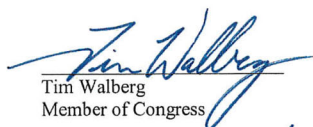
Bill Flores
Member of Congress



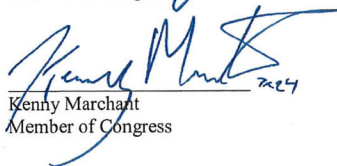
Blaine Luetkemeyer
Member of Congress



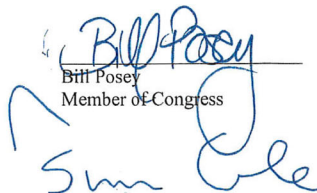
Brian Babin
Member of Congress



Tim Walberg
Member of Congress



Kenny Marchant
Member of Congress



Bill Posey
Member of Congress

Tom Cole
Member of Congress



Gus M. Bilirakis
Member of Congress



Jeff Duncan
Member of Congress



Bill Huizenga
Member of Congress



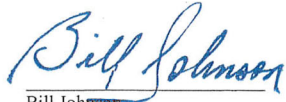
Chris Stewart
Member of Congress



Louie Gohmert
Member of Congress



Andy Harris, M.D.
Member of Congress



Bill Johnson
Member of Congress




Steven M. Palazzo
Member of Congress



Doug Lamborn
Member of Congress



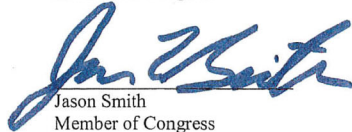
Debbie Lesko
Member of Congress



Rick W. Allen
Member of Congress



Steve Chabot
Member of Congress



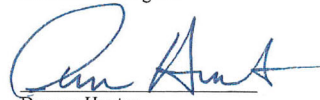
Jason Smith
Member of Congress



Brad Wenstrup
Member of Congress



Rick Crawford
Member of Congress



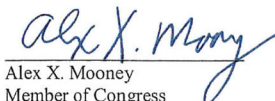
Duncan Hunter
Member of Congress



Earl L. "Buddy" Carter
Member of Congress



David Rouzer
Member of Congress



Alex X. Mooney
Member of Congress



Bob Gibbs
Member of Congress



Billy Long
Member of Congress

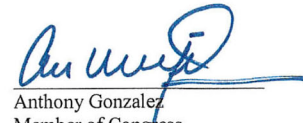


Robert E. Latta
Member of Congress


K. Michael Conaway
Member of Congress


Dan Crenshaw
Member of Congress


Clay Higgins
Member of Congress


Anthony Gonzalez
Member of Congress


Carol D. Miller
Member of Congress


Rob Wittman
Member of Congress

October 21, 2019

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Ave. SW
Washington, D.C. 20201

Dear Administrator Verma,

We are grateful for the ongoing efforts within the Trump administration and the Department of Health and Human Services to align health-related policies with pro-life principles, to protect women and their unborn babies, and to protect taxpayers from being unwilling participants in abortion funding. To continue this goal, we write to urge the finalization of the abortion separate payments rule.

Since 1976, the Hyde Amendment has prohibited federal funding through Health and Human Services to cover elective abortions or insurance plans that include elective abortion coverage. Research shows that by the end of 2018, over 2.3 million babies have been saved as a result of this amendment. This policy applies to Medicaid and other federal health care programs.

The sole deviation from the Hyde principle is Obamacare. Contrary to the Hyde principle, Section 1303 of the Affordable Care Act expressly allows abortion coverage in taxpayer-funded health insurance plans as long as the insurer collects a separate abortion surcharge of at least \$1 per enrollee per month.

The Obama administration went on to implement their own law with a gross misinterpretation of it, requiring “separate” to mean “together.” This gave insurance companies the ability not only to cover elective abortion, but to do so while creating hidden abortion surcharges, for enrollees who are unknowingly paying into plans that subsidize elective abortion.

We were very supportive of the November 2018 Department of Health and Human Services proposed rule, “Patient Protection and Affordable Care Act; Exchange Program Integrity,” which would bring federal regulations into compliance with the clear meaning of Section 1303. While including abortion at all in government subsidized health insurance plans runs afoul of the long-standing principle of the Hyde Amendment, requiring separate payments is an important first step in correcting this wrong and providing transparency.

As we near the one year anniversary of the proposal of this rule, we strongly urge its finalization and swift implementation.

Sincerely,

Marjorie Dannenfelser
President
Susan B. Anthony List

Carol Tobias
President
National Right to Life Committee

Tom McClusky
President
March for Life Action

Donna J. Harrison, M.D.
Executive Director
American Association of Pro-Life Obstetricians
and Gynecologists

Catherine Glenn Foster
President & CEO
Americans United for Life

Lila Rose
Founder and President
Live Action

Travis Weber
Vice President for Policy and Government
Affairs
Family Research Council

Kristan Hawkins
President
Students for Life

Fr. Frank Pavone
National Director
Priests for Life

Austin Ruse
President
C-Fam

Eunie Smith
President
Eagle Forum

Thomas A. Glessner, J.D.
President
National Institute of Family and Life Advocates

Alexandra Snyder, Esq.
Executive Director
Life Legal Defense Foundation

Janet Morana
Co-founder
Silent No More Awareness Campaign

Joe Langfeld
Executive Director
Human Life Alliance

Eric J. Scheidler
Executive Director
Pro-Life Action League

James Nolan
President
Crossroads Pro-Life

Fr. Shenan J. Bouquet
President
Human Life International

Brian Gibson
Executive Director
Pro-Life Action Ministries

Penny Young Nance
CEO & President
Concerned Women for America LAC

Russell Moore
President
Southern Baptist Ethics & Religious Liberty
Commission

Jessica Anderson
Vice President
Heritage Action for America

Ryan Bomberger
Chief Creative Officer
The Radiance Foundation

Roland C Warren
President & CEO
Care Net

Allan E. Parker Jr
President
The Justice Foundation

Cynthia Collins
Global Advisor
Operation Outcry

Cheryl Sullenger
Senior Vice President
Operation Rescue

Jordan Sekulow
Executive Director
American Center for Law and Justice

Jo Ann Gerling
Director
Coalition on Abortion Breast Cancer

Rabbi Pesach Lerner
President
Coalition for Jewish Values

Steven Ertelt
Editor
LifeNews.com

Terry Schilling
Executive Director
American Principles Project

Bev Cielnicky
President
Crusade for Life, Inc.

David Nammo
CEO & Executive Director
Christian Legal Society

Cathie Humbarger
Executive Director
Allen County Right to Life

John Helmberger
Chief Executive Officer
Minnesota Family Council

Elisa Martinez
Founder and Executive Director
New Mexico Alliance for Life

Lois Anderson
Executive Director
Oregon Right to Life

Brad Mattes
President
Life Issues Institute

Larry Cirignano
DC Representative
Children First Foundation

Cathi Herrod
President
Center for Arizona Policy

Melissa Clement
President
Nevada Right to Life

Tami Fitzgerald
Executive Director
NC Values Coalition

Julaine K. Appling
President
Wisconsin Family Action




SUBCOMMITTEE ON DIGITAL COMMERCE
AND CONSUMER PROTECTION
SUBCOMMITTEE ON ENERGY
SUBCOMMITTEE ON ENVIRONMENT
SUBCOMMITTEE ON HEALTH

Despite the positive results of CMS's multi-year study, Trump Administration ended all paid marketing efforts – citing cost-saving measures. In Peck's testimony, he referred to a Freedom of Information Act (FOIA) request from Democracy Forward, which showed that CMS Administrator Seema Verma's then-Chief of Staff, Brian Colas, received the results of the multi-year study, referenced in Peck's testimony, three weeks prior to slashing the marketing and outreach budget from \$100 million to \$10 million. When the decision was made, a CMS fact sheet stated that "no correlation has been seen between Obamacare advertising and either new enrollment or effectuated enrollment."⁵

According to emails obtained between CMS and Weber Shandwick, the public relations firm handling HealthCare.gov advertising, this cut to critical funding resulted in over 100,000 fewer people enrolling in coverage – a conservative estimate according to Weber Shandwick. In his testimony submitted to the House Committee on Appropriations, Peck estimated that a minimum of 2.3 million new enrollments have been lost due to the Administration's actions.

To provide greater transparency and visibility to the general public, please provide any and all documents including studies, presentations, fact sheets, underlying data sets in an anonymized way, or educational materials created from 2014 onward related to marketing and outreach efforts for the *Affordable Care Act*.

Sincerely,

		
Lisa Blunt Rochester Member of Congress	Frank Pallone Chairman	Anna G. Eshoo Chairwoman Subcommittee on Health

⁵ https://www.healthcare.gov/about/submit-our-obamacare-advertising-cut-us_50119f65e4b7466070b0a

Pam Soto

Kathy Costa

Billy L.

Jung M. = Mary

Paul D. Turo

John P. Luhn

Donis Matsui

Eliot L. Engel

Paula Gering

Diane DeBette

Debbie Dingsell

SK

Ann McFarlane Fuster

Peta Welch

Jan Schunry

Patricia Kelly

Monette Dany Bangari

Yvette W. Clarke

Tony Cardenas

A. Donald McEwen

James

Paul Luback

Mr. Dyl

Tom O'Hallen

Mark E. Hester

Ben R. Ly's

M. V. O.

James R. Ly's

CONGRESSWOMAN LISA BLUNT ROCHESTER

DELAWARE AT-LARGE

WASHINGTON OFFICE
1519 LONGWORTH HOB
WASHINGTON, D.C. 20515
(202) 225-4165WILMINGTON OFFICE
1105 N MARKET ST, STE. 400
WILMINGTON, DE 19801
(302) 830-2330GEORGETOWN OFFICE
28 THE CIRCLE, SUITE 2
GEORGETOWN, DE 19947
(302) 858-4773

Congress of the United States
House of Representatives
Washington, DC 20515

ASSISTANT WHIP

COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON DIGITAL COMMERCE
AND CONSUMER PROTECTION
SUBCOMMITTEE ON ENERGY
SUBCOMMITTEE ON ENVIRONMENT
SUBCOMMITTEE ON HEALTH

May 16, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

On March 27, 2019, I led a letter, signed by 30 members of the House Committee on Energy and Commerce, including Chairman Frank Pallone, formally requesting that the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) publicly disclose any and all documents, studies, and underlying data related to the effectiveness of marketing and outreach efforts for the *Affordable Care Act* (ACA).

To date, my office has not received a response to this request from HHS or CMS. Further, it does not appear that HHS or CMS has disclosed any of the requested documents either to the public or to the congressional committees of jurisdiction.

HHS and CMS have had over 50 days to respond to this request and provide these crucial documents to the public and/or Congress. The refusal to comply demonstrates an unwillingness to embrace the level of transparency the American people expect from their federal government. There are significant indicators to suggest that your agencies are withholding crucial information that could help Congress develop effective policy to reach our common goal of quality and affordable health insurance for all Americans. Worse, those same indicators suggest HHS and CMS are authorizing policy changes that are contradicted by third-party analyses launched by the agencies themselves.

While estimates vary, it is clear that marketing and outreach efforts created by the ACA could significantly improve the lives of tens of thousands of Americans. Many of these Americans are

simply unaware of the health insurance and financial assistance options available to them; HHS and CMS have the power and obligation to assist the public in understanding these options. Yet, both of these agencies abandoned that responsibility by cutting the funding for efforts to help Americans make better, informed decisions. Congress and the American people deserve an evidence-based rationale for decisions that have life-or-death consequences.

Consequently, I hereby request HHS and CMS to release the documents requested in my March 27, 2019, letter within 30 days of the date of this letter and without further delay.

Sincerely,



LISA BLUNT ROCHESTER
Member of Congress

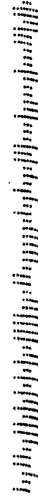
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Administrator
Centers for Medicare & Medicaid Services
Washington, DC 20201-0001

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE \$300



The Honorable Lisa Blunt Rochester
U. S. House of Representatives
Washington, DC 20515





DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JUN - 7 2019

Administrator
Washington, DC 20201

The Honorable Lisa Blunt Rochester
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blunt Rochester:

Thank you for your letters regarding the effectiveness of marketing and outreach efforts for the Patient Protection and Affordable Care Act (PPACA). The Secretary has asked that I respond to your letter on behalf of both the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). We appreciate hearing from you on this important matter.

Data from the Health Insurance Exchanges 2019 Open Enrollment Report shows that plan selections for Exchange plans in the 50 states and D.C. remained steady at 11.4 million, a small decrease from the same time last year. Additionally, demographic data provided in the report also demonstrate stability on the Exchanges. The percentage of young adults between the ages of 18 and 34 who selected a plan through HealthCare.gov remained unchanged from the prior year, at 26 percent.

While the overall number of plan selections decreased slightly from the previous year, this represents remarkably steady enrollment at a time when a strengthening economy and job market may be reducing the need and demand for subsidized health coverage. There are several factors that may have contributed to this year's lower enrollment. At the time Open Enrollment began, there had been more than two million jobs added to the economy compared to the prior year, which resulted in the lowest unemployment rate in nearly fifty years. More people in jobs means more people with access to job-based health coverage, which should reduce demand for subsidized coverage. In addition, because of the expansion of Virginia's Medicaid population, CMS believes that a substantial number of enrollees in the Exchange during 2018 would be eligible for expanded Medicaid.

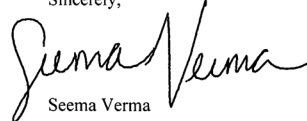
As was the case last year, CMS remained committed to our primary goal of providing a seamless enrollment experience for HealthCare.gov consumers, and data show that we achieved this goal. Consistent with last year, the consumer satisfaction rate at the call center remained at an all-time high—averaging 90 percent—throughout the entire Open Enrollment Period and, for the second year in a row, CMS did not need to deploy an online waiting room during the final days of Open Enrollment. As a result, HealthCare.gov consumers were able to shop and pick a plan with minimal interruption throughout the entire enrollment period.

consumers, as well as 3.2 million outreach emails to help Navigators, agents and brokers assist consumers. In addition, senior Administration officials, including the Secretary and myself, encouraged people to enroll through television and radio interviews broadcast to more than 195 stations across the country.

One of this Administration's priorities is to deliver affordable coverage options to the men and women left behind by the PPACA. I believe it is important that all Americans have access to high quality, affordable health coverage that meets their needs and the needs of their families. Unfortunately, the PPACA is not working for far too many Americans, particularly those middle-class Americans who cannot receive subsidies and are shut out from access to affordable coverage options.

Thank you again for your letter and interest in this issue. We are focused on improving our nation's health care system by working to expand access to affordable and high quality coverage options, and we look forward to working with you to achieve these goals. Should you have additional questions, please contact the CMS Office of Legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "Seema Verma", with a stylized flourish at the end.

Seema Verma

Congress of the United States
Washington, DC 20515

September 3, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201-0004

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20201-0004

Dear Secretary Azar and Administrator Verma:

Given the Executive Order signed by President Donald Trump on July 10, 2019 to launch the *Advancing American Kidney Health* initiative, we are writing to respectfully request that the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) consider the impact of both current and future policies on vulnerable populations receiving dialysis treatment. As the Administration works to decrease the number of patients with end-stage renal disease (ESRD), we must discuss the factors affecting those receiving dialysis treatments in clinics and the barriers that prevent individuals from receiving kidney transplants.

Specifically, we want to ensure the effective and transparent use of dialysis services, particularly with regard to low-income individuals, as well as to increase preventive and alternative treatments when and where possible. Dialysis is an essential treatment for those with ESRD.

Medicare spends nearly \$35 billion per year on dialysis treatments alone, representing fully seven percent of total Medicare costs.¹ Since the federal government pays 80 percent of all dialysis costs for most patients and at a time when there are few other options and patients are fighting for their lives, we must ensure that all patients, working with their doctors and clinicians, receive the most effective and appropriate care possible.²

Disproportionate Share of Dialysis Treatments

At this time, it is unknown why more individuals have kidney disease in low-income neighborhoods. Researchers have pointed to access to health care, environmental toxin exposures more commonly found in higher poverty areas, and individual lifestyle factors as possible contributing factors.³ Since more patients in low-income areas have kidney disease, it comes as

¹ https://www.usrds.org/2017/view/v2_09.aspx

² <https://www.kidney.org/atoz/content/dialysisinfo>

³ <https://www.sciencedaily.com/releases/2015/06/150615162902.htm>

no surprise that they receive more dialysis treatment, but the numbers of low-income and minority individuals receiving dialysis treatment for ESRD are still striking.

The percentage of adults beginning dialysis for ESRD who live in zip codes with high poverty rates continues to increase. According to a study completed by the Loyola University Chicago Stritch School of Medicine, this percentage rose from 27.4 percent to 34 percent between 1995 and 2010 (an increase of 6.6 percentage points).⁴ At the same time, the general population saw an increase from 11 percent to 12.5 percent (an increase of 1.5 percentage points).⁵

Additionally, Medicaid expansion under the Affordable Care Act has had a beneficial impact on those with ESRD. Between 2014 and 2017, the number of patients with ESRD who died within the first year of dialysis treatment decreased in states that expanded Medicaid, while it remained the same or worsened in non-expansion states. According to a recent research study, this was due not just to increased adherence to dialysis treatments (due to reduced cost), but was also the result of improved access to pre-dialysis care for kidney disease. More patients received an arteriovenous fistula or graft before beginning dialysis, which are methods to improve access to the bloodstream during treatment and reduce the likelihood of infection. In Medicaid expansion states, there was an increase of 2.3 percentage points in the number of patients receiving a fistula or graft.⁶

The Relationship Between Income and Dialysis Options

Recent research from the University of Michigan's Kidney Epidemiology and Cost Center examined the employment status of 496,989 patients who initiated maintenance hemodialysis (HD) from 2006 to 2015. The study found that "patients who maintained employment 6 months prior to initiating dialysis had a lower risk for death and a higher likelihood of receiving a kidney transplant than those who left their jobs, according to a new study. Likewise, not-for-profit dialysis centers offered patients the best chance of maintaining employment through their dialysis treatments."⁷ The causes of this finding may be directly related to the pre-dialysis care that many low-income patients are unable to afford.

The benefits of pre-dialysis kidney care are similar to other preventive care for those with pre-existing conditions. Unfortunately, as many as 40 percent of U.S. patients with ESRD do not see a nephrologist before its onset.⁸ Individuals who do not receive good preventive care early and consistently from their condition's onset are more likely to require dialysis treatment during or after a health crisis. These events, often referred to as "crashing" into dialysis, leave little, if any, time for a patient's physicians to explain treatment options. Studies have shown that over time, patients who crash into in-center dialysis become less likely to consider other options. This means

⁴ <https://www.sciencedaily.com/releases/2015/06/150615162902.htm>

⁵ <https://consumer.healthday.com/diseases-and-conditions-information-37/misc-kidney-problem-news-432/u-s-dialysis-patients-increasingly-live-in-poor-areas-700497.html>

⁶ <https://www.brown.edu/news/2018-10-26/dialysis>

⁷ <https://www.healio.com/nephrology/kidney-care-community/news/online/%7Ba21d3b78-f101-4a18-ac91-265ea77cd898%7D/patients-employed-6-months-before-dialysis-have-lower-mortality-more-transplants>

⁸ <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-252>

is allowing more low-income patients to reach the point of ESRD and is forcing more patients into an expensive and often endless cycle of treatments.

The relationship between those receiving dialysis and their zip code remains alarming. As such, we are concerned about predatory practices targeting the most vulnerable in our communities and by the rapid explosion of dialysis centers in poorer, largely minority, areas. We respectfully request that HHS and CMS consider the following questions as you implement the Executive Order:

- 1) Why is the dialysis rate so much higher for adults in low-income zip codes compared to the general population and is there any evidence of systematic steering of low-income patients into dialysis treatment, leading to the increased number of dialysis centers in low-income areas?
- 2) Because low-income patients are less likely to engage in preventative care and regular doctor visits, what measures could be implemented to reduce the rates of low-income individuals reaching ESRD and requiring dialysis treatment?
- 3) Are individuals given the full range of options when discussing dialysis with their doctors, and how soon are patients being given these options? Is there any pressure unduly exerted on patients to sign up for dialysis at dialysis centers?
- 4) Are patients, especially low-income patients, being encouraged to receive dialysis treatments in centers rather than in the home setting? What is the cost difference between Medicare, Medicaid, and private insurance for both clinic-based dialysis treatments and in-home care? What is the difference in reimbursement to providers of each of these options? Are the current Medicare and Medicaid payment rates sufficient to cover the cost of care and provide a strong foundation for expansion of care as needed in low-income and minority communities?
- 5) While the majority of dialysis recipients require dialysis treatments for the rest of their lives unless they receive a kidney transplant, are there patients who are placed on dialysis temporarily? If so, how many? Are these individuals given a plan to stop their dialysis treatment and when is this plan generally formulated?

We appreciate your diligent and timely consideration of these questions and concerns and look forward to your response on how the *Advancing American Kidney Health* initiative will address these issues. We hope to receive a response prior to the release of any such proposed rule.

Sincerely,





Bobby L. Rush
Member of Congress




Katie Porter
Member of Congress



 Rosa L. DeLauro
 Member of Congress

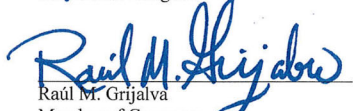

 Danny K. Davis
 Member of Congress

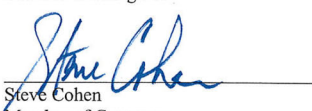

 Barbara Lee
 Member of Congress



 Grace F. Napolitano
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 Member of Congress


 TJ Cox
 Member of Congress



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 21 2019

 Administrator
 Washington, DC 20201

The Honorable Bobby L. Rush
 U.S. House of Representatives
 Washington, DC 20515

Dear Representative Rush:

Thank you for your letter expressing interest in Medicare beneficiaries with kidney disease. The Trump Administration shares your concern about beneficiaries with kidney disease, and I have made it a priority for the Department of Health and Human Services (HHS) to address this important issue. As you noted, on July 10, 2019, President Trump signed an Executive Order to launch Advancing American Kidney Health (AAKH), an initiative focused on dealing with the challenges people living with kidney disease face throughout the stages of disease, with the key goals of reducing the risk of kidney failure, improving access to and the quality of person-centered treatment options, and increasing access to kidney transplants. We believe that the AAKH initiative will help to improve the lives of patients, their caregivers, and family members, and we look forward to working with you on this important effort.

Per the United States Renal Data System, the prevalence of end-stage renal disease (ESRD) more than doubled between 1990 and 2015, and the number of prevalent ESRD cases has continued to rise by approximately 20,000 cases per year, reaching 726,331 prevalent cases by 2016, with the prevalence of ESRD ratings higher among racial minorities. Compared to Whites, ESRD prevalence in 2016 was approximately 9.5 times greater in Native Hawaiians and Pacific Islanders, 3.7 times greater in African Americans, 1.5 times greater in American Indians and Alaska Natives, and 1.3 times greater in Asians. Major risk factors for ESRD include diabetes and high blood pressure, in addition to having a family history of kidney failure. Additionally, the rate of beneficiaries with acute kidney injury who may need temporary dialysis has grown. In 2016, 4.4 percent of Medicare fee-for-service beneficiaries experienced a hospitalization complicated by acute kidney injury, which is double the proportion of 2.2 percent in 2006.

The first goal of the AAKH initiative is centered on reducing the number of Americans developing ESRD by 25 percent by 2030. In order to help accomplish this goal, the Trump Administration is committed to advancing public health surveillance capabilities and research to improve identification of at risk populations and those in early stages of chronic kidney disease (CKD). In addition, we also are committed to encouraging adoption of evidence-based interventions to delay or stop progression to kidney failure. This includes support for existing efforts such as the national CKD surveillance system from the Centers for Disease Control and Prevention and the National Institutes of Health-funded Chronic Renal Insufficiency Cohort Study to examine risk factors for CKD progression. Additionally, consistent with the Executive Order, the Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare and Medicaid Innovation, released the optional Kidney Care First (KCF) Model to test

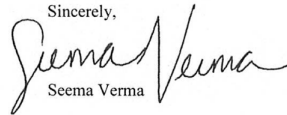
alternative payment arrangements designed to promote preventative kidney care and kidney transplants. The KCF Model includes strong incentives for nephrology practices and coordinated care entities to better identify and manage the prevention or delay of the onset of dialysis.

The second goal of the AAKH initiative is to improve access to and the quality of person-centered treatment options by aiming to have 80 percent of new American ESRD patients in 2025 to receive a transplant or receive dialysis in the home. In order for ESRD patients to receive the most appropriate treatment for their specific set of medical and environmental conditions, and in order to prevent perverse incentives for patients steering to higher paying modalities, Medicare payment is the same whether dialysis is received in-center or at home. However, too many Medicare beneficiaries are not being given a true choice, and are being opted into in-center dialysis when other approaches may be more beneficial. In order to help encourage a greater focus on beneficiary choices, CMS issued a proposed rule to implement the mandatory ESRD Treatment Choices Model (84 FR 34484). This model would test the effectiveness of adjusting certain Medicare payments to ESRD facilities and managing clinicians selected to participate in the model in order to: 1) encourage greater utilization of home dialysis and kidney/kidney-pancreas transplants; 2) support beneficiary modality choice; 3) reduce Medicare expenditures; and 4) preserve or enhance the quality of care. As part of the model, we are proposing a number of beneficiary protections, including prohibiting model participants and downstream participants from taking any action to avoid treating beneficiaries based on their income levels or based on factors that would render a beneficiary an "at-risk beneficiary."

The third major goal of the AAKH initiative is to increase access to transplantation, with the goal of doubling the number of kidneys available for transplant by 2030. Transplantation is the best treatment for most beneficiaries with ESRD, but often many beneficiaries do not receive the proper education about the transplant process or do not have access to an available kidney. HHS is proposing a series of efforts to increase the utilization of available organs from deceased donors by: 1) increasing organ recovery and reducing the organ discard rate; and 2) increasing the number of living donors by removing disincentives to donation and ensuring appropriate financial support.

We appreciate your concern on this important issue, and look forward to working with you to help ensure quality care for beneficiaries with CKD and ESRD. An identical copy of this response will be shared with the co-signers of your letter.

Sincerely,


Seema Verma