

MEMBER DAY HEARING

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

FIRST SESSION

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MEMBER DAY HEARING

THURSDAY, JULY 25, 2019

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
WASHINGTON, DC.

The committee met, pursuant to call, at 10:00 a.m., in the John D. Dingell Room 2123 Rayburn House Office Building, Hon. Frank Pallone, Jr., (chairman of the committee) presiding.

Members present: Representatives, Pallone, Rush, Eshoo, Engel, DeGette, Doyle, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, McNerney, Welch, Luján, Tonko, Clarke, Loeb sack, Schrader, Kennedy, Cardenas, Ruiz, Peters, Dingell, Veasey, Kuster, Kelly, Barragán, McEachin, Blunt Rochester, Soto, O'Halleran, Walden (ranking member), Upton, Shimkus, Burgess, Scalise, Latta, Rodgers, Guthrie, Olson, McKinley, Kinzinger, Griffith, Bilirakis, Johnson, Long, Bucshon, Flores, Brooks, Mullin, Hudson, Walberg, Carter, Duncan, and Gianforte.

Staff present: Mohammad Aslami, Counsel; Kevin Barstow, Chief Oversight Counsel; Billy Benjamin, Systems Administrator; Jacquelyn Bolen, Professional Staff; Jesseca Boyer, Professional Staff Member; A. J. Brown, Counsel; Jeffrey C. Carroll, Staff Director; Jacqueline Cohen, Chief Environment Counsel; Sharon Davis, Chief Clerk; Luis Domingues, Health Fellow; Jennifer Epperson, FCC Detailee; Elizabeth Ertel, Office Manager; Adam Fischer, Policy Analyst; Jean Fruci, Energy and Environment Policy Advisor; Evan Gilbert, Press Assistant; Lisa Goldman, Counsel; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Caitlin Haberman, Professional Staff Member; Alex Hoehn-Saric, Chief Counsel, Communications and Technology; Megan Howard, FDA Detailee; Zach Kahan, Outreach and Member Service Coordinator; Rick Kessler, Senior Advisor and Staff Director, Energy and Environment; Saha Khaterzai, Professional Staff Member; Chris Knauer, Oversight Staff Director; Brendan Larkin, Policy Coordinator; Una Lee, Senior Health Counsel; Jerry Leverich, Counsel; Jourdan Lewis, Policy Analyst; Perry Lusk, GAO Detailee; Dustin Maghamfar, Air and Climate Counsel; John Marshall, Policy Coordinator; Kevin McAloon, Professional Staff Member; Dan Miller, Policy Analyst; Jon Monger, Counsel; Elysa Montfort, Press Secretary; Phil Murphy, Policy Coordinator; Lisa Olson, FERC Detailee; Joe Orlando, Staff Assistant; Kaitlyn Peel, Digital Director; Mel Peffers, Environment Fellow; Alivia Roberts, Press Assistant; Tim Robinson, Chief Counsel; Chloe Rodriguez, Policy Analyst; Nikki Roy, Policy Coordinator; Samantha Satchell, Professional Staff Member; Andrew Souvall, Director of Communications, Out-

reach and Member Services; Sydney Terry, Policy Coordinator; Kimberlee Trzeciak, Senior Health Policy Advisor; Rick Van Buren, Health Counsel; Eddie Walker, Technology Director; Teresa Williams, Energy Fellow; Tuley Wright, Energy and Environment Policy Advisor; C. J. Young, Press Secretary; Jennifer Barblan, Minority Chief Counsel, Oversight and Investigations; Mike Bloomquist, Minority Staff Director; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel, Health; Robin Colwell, Minority Chief Counsel, Communications and Technology; Jerry Couri, Minority Deputy Chief Counsel, Environment and Climate Change; Jordan Davis, Minority Senior Advisor; Kristine Fargotstein, Minority Detailee, Communications and Technology; Margaret Tucker Fogarty, Minority Staff Assistant; Melissa Froelich, Minority Chief Counsel, Consumer Protection and Commerce; Theresa Gambo, Minority Human Resources/Office Administrator; Caleb Graff, Minority Professional Staff Member, Health; Brittany Havens, Minority Professional Staff, Oversight and Investigations; Peter Kielty, Minority General Counsel; Bijan Koohmaraie, Minority Counsel, Consumer Protection and Commerce; Tim Kurth, Minority Deputy Chief Counsel, Communications and Technology; Ryan Long, Minority Deputy Staff Director; Mary Martin, Minority Chief Counsel, Energy and Environment and Climate Change; Sarah Matthews, Minority Press Secretary; Brandon Mooney, Minority Deputy Chief Counsel, Energy; James Paluskiewicz, Minority Chief Counsel, Health; Brannon Rains, Minority Staff Assistant; Zach Roday, Minority Communications Director; Kristen Shatynski, Minority Professional Staff Member, Health; Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations; Peter Spencer, Minority Senior Professional Staff Member, Environment and Climate Change; Natalie Sohn, Minority Counsel, Oversight and Investigations; Danielle Steele, Minority Counsel, Health; Everett Winnick, Minority Director of Information Technology; and Greg Zerzan, Minority Counsel, Consumer Protection and Commerce.

Mr. PALLONE. I call the committee to order.

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

Today, we are going to hear from our colleagues about the issues of importance to them within our committee's jurisdiction.

This hearing fulfils a new requirement that was approved as part of the House rules package for the 116th Congress and I think it's a good idea.

The Energy and Commerce Committee is working hard to build a stronger economy, create more good-paying jobs, combat climate change, and protect consumers from skyrocketing costs that make it increasingly difficult to make ends meet.

We are putting consumers first and I am proud that a lot of our work in this area has been done in a strong bipartisan fashion.

Just yesterday, the House overwhelmingly approved a bipartisan bill that will put consumers back in control of their phones by targeting annoying and illegal robocalls, and just last week the Energy and Commerce Committee advanced a bill that will protect patients and families from surprise medical bills.

This bipartisan cooperation is nothing new. This committee has a proud tradition of working together to meet the needs of the American people. We also have a proud tradition of listening to the ideas of members not on this committee and incorporating their ideas or advancing their proposals as we work to develop the best legislation possible.

So we look forward to continuing to listen to the ideas of all Members and this hearing today will help with that in the coming months.

So today we are going to break up the testimony. Well, let me say, we have asked members to tell us if they are coming and so we have kind of—we have created time slots, essentially, and we are going to try to stick to that.

But if somebody does show up who is not—doesn't have a time slot we are still going to hear from them. But we are trying to do it that way. And we also broke it up by the jurisdiction of our five legislative subcommittees.

The subcommittee chair—I have asked the subcommittee chair of that particular jurisdiction to be here when we concentrate on that issue. So, for example, right now, Mr. Doyle is here. He is the chairman of the Communications and Technology Subcommittee. And so the people that we scheduled for this time spot in the next hour or so will primarily focus on that.

But you don't have to. You know, if you want to talk about other things, that is fine. But we try to do it that way. So we begin with the issues within the jurisdiction of our Communications and Technology Subcommittee, followed by Consumer Protection and Commerce, then Energy, then Environment and Climate Change, and then we are going to end with our Health Subcommittee.

We have about 50 members who said they are going to testify before us. I don't know if they will all show up, but we will see.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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Today we will break up the testimony by the jurisdictions of our five legislative subcommittees. We will begin with testimony on issues within the jurisdiction of our Communications and Technology Subcommittee, followed by Consumer Protection and Commerce, Energy, Environment and Climate Change, and then we will end with our Health Subcommittee.

We have about 50 members who plan to testify before us today, and I look forward to hearing their ideas.

Mr. PALLONE. And everybody is asked to speak for 5 minutes. So now I will turn it over to our ranking member from Oregon, and, you know, again, he and I have been very—tried as much as possible to work in a bipartisan fashion and I appreciate that, Greg.

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

Mr. WALDEN. It is mutual. Thank you, Mr. Chairman, and welcome to our members who are here today. I think this is really an important improvement in how the committee operates.

We have had Member Day before. They haven't been as wide ranging as this. But I think this is a good addition.

As you may recall, Mr. Chairman, we did this for the opioid's legislation package last time and we ended up with 60 individual pieces of legislation, all of which were bipartisan, that moved across the House floor and eventually became one bill called the SUPPORT Act—H.R. 6.

But members come here to make a difference and offer up their ideas, not just here in this committee but also across the entire scope of the House, and for those that aren't members of the Energy and Commerce Committee we welcome you.

We look forward to your ideas and concepts. My only regret is we didn't do this in January or February but at least we are doing it before the August break and so I think that is important, as I say, a good addition and we have got a lot of work to do in this committee and we wanted to hear from you.

So with that, Mr. Chairman, I will yield back and we can get on about our business.

Mr. PALLONE. I thank our ranking member, and I should also mention that the—Mr. Latta from Ohio, who is the ranking member of the Telecommunications—I mean, the Communications and Technology Subcommittee is here as well.

So what is our order?

All right. So just so you know, Mr. Brindisi is first. I think, Mr. Takano, they have you a little later. But since you showed up early, we are going to put you second—recording you second. And we are not doing this, you know, D versus R. We are just, you know, based on the list that we put together.

So we will start with the gentleman from New York. Thanks for being here.

OPENING STATEMENT OF HON. ANTHONY BRINDISI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. BRINDISI. Good morning, Chairman Pallone, Ranking Member Walden, Subcommittee Chairman Doyle, and Ranking Member Latta.

Thank you for the opportunity to testify at today's Energy and Commerce Committee Member Day. I appreciate your strong leadership on several of these issues.

So my largely rural district in upstate New York stretches from Lake Ontario in the north all the way down to the Pennsylvania border in the south.

So when I hear cable executives talk about 5G access and 10-gigabit connections, I am left shaking my head. For many families in my area, basic internet access remains out of reach.

Worst of all, I have heard from countless constituents who have seen their cable bills go up every month as the service just gets worse and worse. I have heard stories from families who see their connections grind to a halt at home when they try to get online, and when they contact their cable company, they get no help, only excuses.

As I see it, there are three areas where Congress can do the most good when it comes to delivering high-speed internet access to rural America.

First, we need better data. Even the FCC agrees that the data they use to map homes with high-speed internet is woefully inadequate. We need better information from companies so we know exactly where federal investments are needed most.

I want to thank the committee for making this issue a top priority.

Second, we need to continue to expand programs which build out broadband access in rural areas. This includes maintaining the FCC Universal Service Fund programs and ensuring that each unique program receives the funding it requires.

And as we continue to invest in these vital programs, we need strong oversight at the FCC to make sure internet service providers are fulfilling their obligations.

And that brings me to my third point—accountability. These cable behemoths often operate as monopolies, leaving customers no choice but to overpay for subpar service.

In New York, one cable company in particular failed to live up to the terms of their corporate merger agreement and had to be fined and threatened with expulsion from the state by our Public Service Commission.

The first bill I introduced in Congress—the Transparency for Cable Consumers Act—would force companies like this to disclose information about their business practices to bring transparency and accountability to the market.

By doing so, we can curb the worst monopoly practices and perhaps help introduce real competition into the market. I have been fortunate to work with many members of this committee, Republicans and Democrats, on these priorities this year.

Expanding access to high-speed internet remains a task as large as rural electrification 100 years ago, and I look forward to continuing to work with this committee to ensure every home in rural America is connected.

I want to thank you for your time and I am happy to answer any questions and yield back my time.

Thank you.

[The prepared statement of Mr. Brindisi follows:]

PREPARED STATEMENT OF HON. ANTHONY BRINDISI

Chairman Pallone, Ranking Member Walden, Subcommittee Chairman Doyle and Ranking Member Latta, thank you for the opportunity to testify at today's Energy and Commerce Committee Member Day. I appreciate your strong leadership on these issues.

My largely rural district in Upstate New York stretches from Lake Ontario in the north all the way down to the Pennsylvania border in the south. So when I hear cable executives talk about "5G access" and "10-gigabit connections," I am left shaking my head. For many families in my area, basic internet access remains out of reach. Worst of all, I have heard from countless constituents who have seen their cable bills go up month after month as the service just gets worse and worse. I have heard stories from families who see their connections grind to a halt at home when they try to get online. And when they contact their cable company, they get no help—only excuses.

As I see it, there are three areas where Congress can do the most good when it comes to delivering high-speed internet access to rural America.

First, we need better data. Even the FCC agrees that the data they use to map homes with high-speed internet is woefully inadequate. We need better information from companies so we know exactly where federal investments are needed most. I want to thank the committee for making this issue a top priority.

Second, we need to continue to expand programs which build out broadband access in rural areas. This includes maintaining the FCC Universal Service Fund programs and ensuring that each unique program receives the funding it requires. And as we continue to invest in these vital programs, we need strong oversight at the FCC to make sure internet service providers are fulfilling their obligations.

And that brings me to my third point: Accountability. These cable companies often operate as monopolies, leaving customers no choice but to overpay for subpar service. In New York, one cable company in particular failed to live up to the terms of its corporate merger agreement and had to be fined and threatened with expulsion from the state by our Public Service Commission. The first bill I introduced in Congress, the Transparency for Cable Consumers Act, would force companies like this to disclose information about their businesses to bring transparency and accountability to the market. By doing so, we can curb the worst monopoly practices and perhaps even help introduce real competition into the market.

I have been fortunate to work with many members of this committee—Republicans and Democrats—on these priorities this year. Expanding access to high-speed internet remains a task as large as rural electrification 100 years ago, and I look forward to continuing to work with this committee to ensure every home in rural America is connected.

Thank you for your time, and I am happy to answer any questions you may have.

Mr. PALLONE. I thank the gentleman.

Now, again, I mean, nobody has to ask questions but I think you should feel free to do so, or comments, and we would do—oh, there's no questions at all? Oh, we are just listening?

All right. Well, I didn't know that.

Mr. DOYLE. Mr. Pallone?

Mr. PALLONE. Yes.

Mr. DOYLE. Are we allowed to make a comment? I am not going to ask a question but—

Mr. PALLONE. I am shocked that you didn't like the idea of not asking questions.

[Laughter.]

Mr. PALLONE. But yes, feel free to make a comment.

Mr. DOYLE. Actually, I do like that idea.

Mr. PALLONE. OK.

Mr. DOYLE. No, I was—just a couple comments. Anthony, there isn't anyone on this committee that doesn't agree that the mapping issue is a complete disaster and needs to be improved. That is something we have talked about on the committee for a long time.

I just want to say with regards to getting broadband deployed into rural America, there is not a valid business case for that so we need money to do that, and every time we talk about expanding broadband to rural America, it is, like, how do we pay for it.

Well, we have an opportunity to pay for it with C-band. There is going to be an auction. That hasn't been determined how that auction is going to take place.

But I think it would be almost unimaginable that we would allow a private auction and for foreign satellite companies to keep the money. I am hopeful that is not going to happen.

But we have an opportunity here on the committee to work on the C-band plan that will allow us to start deploying that mid-range band, which is important for 5G and get it paid for—and to get some money into the Treasury which could help us deploy broadband in rural America.

It is a way to close the digital divide and there is money to pay for it. So I am hoping that members on this committee on both our side and our friends on the Republican side can come together and do something legislatively to see that made a reality.

Thanks, Mr. Chairman.

Mr. PALLONE. Look, I understand we weren't supposed to ask questions or comments. But, you know, you are here for a few hours, members of the committee.

So if you want to briefly make a comment or ask a question I am not going to forbid it and I am going to be bad myself and say that I did want you to know—you may already know—that we had a bill called the LIFT America Act, which every member—well, every Democratic member, at least, on the subcommittee—I mean, on the committee has signed, which has about \$40 billion for broadband in underserved areas. So we are very not—we are very conscious of that.

Thank you so much.

I am going to go to Mark Takano next, the chairman of the Veterans Committee.

OPENING STATEMENT OF HON. MARK TAKANO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. TAKANO. Thank you, Chairman Pallone and Ranking Member Walden, and members of the committee. I appreciate the opportunity to testify today.

I want to start off with a brief quotation from a constituent. My office obtained a consumer complaint to the FTC from a constituent, and this complaint—this excerpt—clearly demonstrates why many—what so many customers experience as online shoppers.

I quote: “When you place an order, you are automatically enrolled in a monthly membership which incurs an automatic charge each month to your account and credit card of \$40 without permission. This is not clear at all when ordering. I never agreed to it,” end quote.

Amazingly, the reason why my constituent and so many other online shoppers are getting swindled is really not in dispute. It is obvious. These deals rely on a murky sales tactic known as nega-

tive option billing, which reverses the structure of a typical consumer purchase.

Many of us have been there. You are shopping online. You sign up for an enticing so-called risk-free trial offer, only to get hammered later with hidden fees and unexpected costs.

I see nodding heads from the chairman and ranking member. Often, you know, we could feel foolish for having fallen for something, but actually it is very deceptive marketing and the specific tools of online sellers that I think are bilking consumers unfairly.

Now, these transactions—these online deals have duped consumers out of more than a billion dollars during the last decade. Related complaints to the Federal Trade Commission more than doubled between the years 2015 and 2017.

These transactions allow a business to interpret a customer's lack of action to reject an offer as an approval to be charged for goods and services. Expensive obligations can go misunderstood or unnoticed for months while the costs pile up.

Making matters worse, customers seeking to terminate their purchase or enrollment are often met with cumbersome and confusing cancellation and return policies. These outcomes I think we would regard as unacceptable.

That is why I encourage the committee to consider legislation that I have introduced which addresses this important topic.

My bill, which is titled the Unsubscribe Act, will give shoppers the protections needed in today's online marketplace and ensure negative option deals cannot be used unfairly to deceive consumers.

And this bill—my bill—would achieve this in three ways.

First, require a straightforward cancellation process. Businesses are required on my bill to provide a cancellation mechanism that mirrors the enrollment process, ensuring consumers can escape an unwanted deal as easily as they were lured into it.

It is common sense. If you sign up online you should be able to cancel online, not have to go and wait on a telephone line for 20 minutes before you talk to somebody who can say, OK, and explain to them. There should be an easy way for you to opt out again.

Secondly, consumers—we need to protect consumers from getting stuck in an expensive unwanted deal. We will require sellers to obtain additional affirmative consent to bind consumers at the end of free-trial periods.

This way consumers are protected from accidentally enrolling in a pricey membership plan if they only intended on making a single purchase.

Thirdly, we would ensure that consumers remain fully and fairly informed. Online shoppers are required to receive periodic notification of any and all obligations or changes to their contracts, proactively reminding buyers of recurring charges, reenrollment details, and agreement changes that will help decrypt the complex nature of negative option agreements.

Now, members of this committee, I am sure, understand how critically important it is for consumers to receive protections that keep pace with today's gigantic online marketplace.

In the first quarter of 2019 alone, U.S. online retailers raked in over \$135 billion, and during the last—in the past decade, the pro-

portion of online sales to our entire retail market jumped from about four percent to over ten percent.

At a time when more and more Americans use their phone or computer to shop, Congress must step up to ensure no consumer is left unfairly vulnerable to misleading and abusive online deals.

Thank you, I yield back my time.

[The prepared statement of Mr. Takano follows:]

PREPARED STATEMENT OF HON. MARK TAKANO

Chairman Pallone, Ranking Member Walden, and members of the committee, thank you for the opportunity to testify today.

We've all been there. You are shopping online and sign-up for an enticing "risk-free trial offer" only to get hammered later with hidden fees and unexpected costs. You're not alone. Online deals like these have duped consumers out of more than a billion dollars during the last decade. Related complaints to the Federal Trade Commission more than doubled between 2015 and 2017. My office obtained a consumer complaint to the FTC from a constituent in my district demonstrating what so many customers experience:

"When you place an order, you are automatically enrolled in a monthly "membership" which incurs an automatic charge each month to your account and credit card of \$40 without permission! This is not clear at all when ordering. I never agreed to it!"

Amazingly, the reason why my constituent and so many online shoppers are getting swindled isn't in dispute—it's obvious. These deals rely on a murky sales tactic known as "negative option billing" which reverses the structure of a typical consumer purchase. These transactions allow a business to interpret a customer's lack of action to reject an offer as approval to be charged for goods or services. Expensive obligations can go misunderstood or unnoticed for months while costs pile up. Making matters worse, customers seeking to terminate their purchase or enrollment are often met with cumbersome and confusing cancellation and return policies. These outcomes are unacceptable.

That's why I encourage the committee to consider legislation that I have introduced which addresses this important topic. My bill, the Unsubscribe Act, will hold companies accountable for deceptive marketing and ensure that buyers are less vulnerable to the confusing nature of online negative option agreements. The bill achieves this in three ways:

- One—require a straightforward cancellation process.
 - Businesses are required to provide a cancellation mechanism that mirrors customers' method of enrollment. A simple "click-to-cancel" option allows buyers to escape an unwanted deal as easily as they were lured into it.
- Two—protect consumers from getting stuck in an expensive, unwanted deal.
 - Sellers are required to obtain additional affirmative consent to bind consumers at the end of free-trial periods. This way consumers are protected from accidentally enrolling in a pricey "membership" plan if they only intended on making a single purchase.

And lastly, three—ensure consumers remain fully and fairly informed.

- The bill also ensures shoppers receive periodic notification of any and all obligations or changes to their contracts. Proactively reminding buyers of recurring charges, reenrollment details, and agreement changes will help decrypt the complex nature of negative option agreements.

Members of this committee understand how critically important it is for consumers to receive protections that keep pace with today's gigantic online marketplace. During the first quarter of 2019 alone, U.S. online retailers raked in over \$135 billion dollars, and the proportion of online sales in the retail market jumped from under four percent to over ten percent during the past decade. At a time when more and more Americans use their phone or computer to shop, Congress must step up to ensure no consumer is left unfairly vulnerable to misleading and abusive online deals.

Thank you, I yield back.

Mr. PALLONE. Thanks so much.

Mr. Doyle?

Mr. DOYLE. It sounds like an issue for the Federal Trade Commission, probably Congresswoman Schakowsky's subcommittee.

Mr. PALLONE. Absolutely.

Mr. DOYLE. This would be more germane there. But, Mark, I think it is a great piece of legislation.

Mr. TAKANO. Thank you.

Mr. PALLONE. And, Mark, we really have been trying to put a lot of focus on consumerism, if you will, and Jan Schakowsky, who chairs the Consumer Protection Subcommittee I am sure would be very interested in this.

So thanks a lot. Thanks for coming.

Mr. WALDEN. Mr. Chairman, could I say something as well?

I appreciate it as well. I remember when we were in business, we would find these little charges on our phone bill. When we'd go to chase them out, they were things we had never agreed to. It was only a buck or two a month—

Mr. TAKANO. Yes.

Mr. WALDEN [continuing]. And then you fought with the phone company and they said, oh, we are just the biller—it is a third party. You will have to take it up with them. Things you never agreed to, and you would be months fighting this.

And I just always wondered with bazillions of phone lines out there how much of this was going on where people didn't know they were getting an extra dollar or two a month.

Just a little different than your shopping deal but it's the same thing.

Mr. TAKANO. Yes, and sometimes—

Mr. WALDEN. Consumers getting ripped off.

Mr. TAKANO. Sometimes you have to take a couple of steps to figure out because the description—

Mr. WALDEN. Yes.

Mr. TAKANO [continuing]. On the bill is not all that clear and then it is not straightforward about how to find out. As you say, who do you go to?

Mr. WALDEN. Yes, and somebody is making—the people doing the billing are making money and putting it on your bill.

Mr. TAKANO. That is right. A little—everyone is taking a piece of it.

Mr. WALDEN. Everybody is getting their piece out of our hide, and so I am interested in this as well.

Mr. TAKANO. Thank you. Thank you, ranking member. I appreciate it. Thanks.

Mr. PALLONE. Thank you, Mr. Takano.

Mr. TAKANO. Am I excused?

Mr. PALLONE. You're excused, yes.

[Laughter.]

Mr. PALLONE. All right. So next we are going to go to the gentleman from Hawaii.

Mr. Case, good to see you.

OPENING STATEMENT OF HON. ED CASE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF HAWAII

Mr. CASE. Moving right across the country, Chair Pallone, Ranking Member Walden and members, thank you so much for allowing me to share my thoughts on some issues of concern to Hawaii and to our country, I believe.

I would like to focus today on what I believe are needed changes to the 1996 Communications Decency Act that are unintentionally preventing my state and its counties as well as many others throughout our country from enforcing our planning and zoning laws and implementing overall public policy in affordable housing, community safety, and other critical areas.

The Internet has brought much progress to our world and Section 230 of the Communications Decency Act, which provides internet platforms with some broad immunity from liability for third-party content posted on their sites, has been a part of that.

But today's massive internet platforms that offer services cannot be allowed to knowingly facilitate lawbreaking in our states and localities by hiding behind CDA 230 immunity.

Congress first saw and addressed the modern misuse of CDA 230 last year when we passed the Allow States and Victims to Fight Online Sex Trafficking Act—FOSTA—legislation which imposed accountability for internet platforms that were profiting from human trafficking.

In a parallel situation, though, this issue is also especially acute with respect to platforms that advertise and sell illegal short-term vacation rentals, like Airbnb, TripAdvisor, Homeaway, VRBO, or Flipkey.

In this area, the online host platforms claim that CDA 230 prohibits states and counties from prohibiting and regulating such rentals and from penalizing platforms that knowingly sell them illegally.

By one account, my own State of Hawaii alone hosts approximately 23,000 short-term vacation rental units, and that was 2017, meaning one out of every 24 of our housing units was a short-term rental.

That was widely considered to be low then and has only grown since, driven largely by the ease of advertising and reserving these units online.

The vast majority of these units are illegal since we know that legal permitted short-term vacation rentals are in the low thousands. The negative consequences of this unregulated disruption of our housing market impact all segments of our society.

First, anytime we knowingly and practice widespread lawbreaking that has its own broader consequences. Second, these units operate as the functional equivalent of hotels and yet do not pay hotel-required taxes and fees and do not comply with labor, workplace safety, or consumer laws.

Third, these units turn residential neighborhoods into the functional equivalent of hotel zones with the loss of those neighborhoods and the community sense.

And fourth, and possibly most important, from my perspective, they completely distort our already sky-high housing market, which in Hawaii is one of the highest in the country, but this happens in any jurisdiction where this issue is prevalent.

And because these residential dwellings are effectively converted to hotel rooms, the available owner and renter markets are compressed, leading to substantially higher rents and home prices that crowd out still more local residents in what is already one of the highest rent and lowest home ownership areas of our country.

There should be a way to compel short-term rental platforms to remove these illegal units from their inventory, and yet CDA 230 serves as a roadblock to that effort.

In particular, the platforms have frequently asserted that CDA 230 does not allow full implementation and enforcement of these initiatives. They have sued cities such as San Francisco, Boston, Santa Monica, New York, and Miami Beach, and possibly others, claiming that CDA 230 preempts local regulatory efforts to take down illegal listings.

Although the U.S. Court of Appeals for the Ninth Circuit upheld a lower court ruling in the Santa Monica case recently that found that the short-term rental companies did not have a valid claim under 230, the assertion still chills the remedy.

This pattern has repeated itself throughout our country, as states and counties have continued to pursue a number of initiatives to prevent illegal rentals while attempting to withstand legal challenges from the online platforms.

The state of Hawaii, for example, passed legislation in 2016 which would require operators posting on rental platforms to list their legal tax identification number and platforms not to host advertising which does not contain such numbers.

The city and county have followed suit in trying to regulate these illegal rentals recently and in that new ordinance, which was just enacted about two weeks ago, was a prohibition on the platforms facilitating short-term rentals for units that are not properly registered, permitted, or otherwise allowed.

I strongly disagree that CDA 230, either in language or in intent, can be used as a legal shield against these types of common-sense regulations and I cannot accept that in any event that federal law does not allow states and cities to adopt and implement reasonable planning and zoning laws and instead to accept the broad negative social consequences of nonenforcement of the illegal rentals, especially when those platforms know full well that their business model relies largely on knowing breaches of the law by their operators and advertisers.

My request to this committee is to formally examine this and other abuses of CDA 230. We can follow the FOSTA legislation which gives us a roadmap and I hope to work closely with you on this undertaking.

Thank you very much.

[The prepared statement of Mr. Case follows:]

PREPARED STATEMENT OF HON. ED CASE

Thank you for allowing me to share my thoughts with the committee on issues of importance to my constituents and the state and county governments in Hawai'i. Today I would like to focus on needed changes to the Communications Decency Act that are unintentionally preventing my state and its counties as well as many others throughout our country from enforcing our planning and zoning laws and implementing overall public policy in affordable housing, community safety and other critical areas.

The Internet has brought the world much progress and section 230 of the CDA, which provides internet platforms with broad immunity from liability for third-party content posted on their sites, has been a part of that. When the statute was passed in 1996 it had an important role to play in fostering the internet's growth. But today's massive internet platforms that offer services cannot be allowed to knowingly

facilitate law breaking in our states and localities by hiding behind CDA 230 immunity.

Congress first saw and addressed the modern misuse of CDA 230 last year when it passed the Allow States and Victims to Fight Online Sex Trafficking Act (“FOSTA”) legislation and imposed accountability for internet platforms that were profiting from human trafficking. In a parallel situation, this issue is also especially acute with respect to platforms that advertise and sell illegal short-term vacation rentals, like Airbnb, TripAdvisor, Homeaway, VRBO or Flipkey. In this area the online host platforms claim that CDA 230 prohibits states and counties from prohibiting and regulating such rentals and from penalizing platforms that knowingly sell them illegally.

By one account my State of Hawaii alone hosted approximately 23,000 short-term vacation rental units in 2017, meaning one out of every 24 of our housing units was a short-term rental. This number is widely considered to have been low then, and has only grown since, driven largely by the ease of advertising and reserving these units online.

The vast majority of these rental units are illegal since legal, permitted short-term vacation rentals are known and number in the low thousands. The negative consequences of this unregulated disruption of our housing market impact all segments of our society.

First, commonly known and practiced widespread derogation of any law has its own broader consequences. Second, these units operate as the functional equivalent of hotels and yet do not pay hotel-required taxes and fees and do not comply with labor, workplace safety or consumer laws. Third, these units turn residential neighborhoods into the functional equivalent of hotel zones with loss of neighborhoods and communities.

Fourth, they completely distort our already sky-high housing market. Because residential dwellings are effectively converted to hotel rooms, the available owner and renter markets are compressed, leading to substantially higher rents and home prices that crowd out still more local residents in what is already one of the highest rent, lowest home ownership areas of our country.

There should be a way to compel short-term rental platforms to remove these illegal units from their inventory, and yet CDA 230 serves as a roadblock in that effort. The platforms have frequently asserted that CDA 230 does not allow full implementation and enforcement of these initiatives. They have sued the cities of San Francisco, Boston, Santa Monica, New York, and Miami Beach—and possibly others—claiming CDA 230 preempts local regulatory efforts to take down illegal listings. Notably, the U.S. Court of Appeals for the Ninth Circuit upheld a lower court ruling in the Santa Monica case that found the short-term rental companies didn’t have a valid claim under Section 230 or the First Amendment.

This pattern has repeated itself throughout our country, and states and counties have continued to pursue a number of initiatives to prevent illegal rentals while attempting to withstand legal challenges from the online platforms. The State of Hawaii, for example, passed legislation in 2016 which would require operators posting on rental platforms to list their legal tax identification number and platforms not to host advertising which does not contain such numbers. The City and County of Honolulu just passed an ordinance for stricter enforcement of our local laws that limit short-term rental units on the island of O’ahu. Included in the new ordinance was a prohibition on platforms facilitating short term rentals for units that are not properly registered, permitted or otherwise allowed.

I strongly disagree that CDA 230—either in language or in intent—can be used as a legal shield against these types of common-sense regulations. I cannot accept in any event that federal law does not allow states and cities to adopt and implement reasonable planning and zoning laws and instead to accept the broad negative social consequences of non-enforcement, especially given that the platforms know full well that their business model relies largely on knowing breaches of the law by their operators and advertisers.

I respectfully ask that the committee formally examine this and other abuses of CDA 230. We have a valuable template in the FOSTA legislation that passed the House by a vote of 388–25 and was signed into law last year, which could be replicated to cover other illegal online sales. I hope to work closely with you on moving such legislation forward and supporting our communities.

Last, I would like to call to the Committee’s attention the fact that a version of CDA 230 appears in the digital goods chapter (Article 19) of the draft United States-Mexico-Canada Agreement currently under consideration. While I understand that trade is not in this Committee’s jurisdiction, to the extent you agree that CDA 230 needs Congressional review, we should carefully consider whether embedding a version of the statute in our international trade agreements is wise.

Thank you very much for your consideration.

Mr. PALLONE. Thank you, and we will certainly look into it. You know, I represent the Jersey Shore, so, you know, when you talk about rentals and tourism and economy.

And I guess it is an opportunity for me to say right now that I know the members are here today for this Member Hearing. But, you know, don't hesitate personally with me or the rest of us or with your staff to contact us as a follow up today. It's not like, you know, you're just here and we disappear. All right. We want you to understand that.

Mr. CASE. Appreciate that very much. We will be taking you up on that kind offer.

Mr. PALLONE. All right. Thanks a lot. Thanks, Ed.

And next I think is my colleague from New Jersey. Have you—have you recovered from Prom Night or dare I ask that question?

You have not? OK. Well, if you'll proceed, I appreciate it, my friend.

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

Mr. PASCRELL. Mr. Chairman Pallone and Ranking Member Walden, it is good to see you both this morning. I thank you for the opportunity to highlight the need for transparency and regulation in the badly corrupted primary and secondary live-events ticket marketplace.

Been in the press a lot lately. We tried nine years ago unsuccessfully and I think it's time again that we look here. So one of my favorite groups is Metallica where a lot of the young people today like to go to their concerts and spend—I think they have to give a point of blood, too, in order to get in there because the tickets are so expensive.

I followed this marketplace for over a decade. "Wherever I May Roam" is one of Metallica's songs. Wherever I go across the country, Canada, I hear complaints from my constituents on their frantic Ticketmaster—frantic experience with ticket sales, and you can't believe the mail that we get on this subject. It is the furthest thing on all of our minds when we come to work in the morning but I am telling you a fact of life here.

The combined behemoth dominates a \$9 billion per year industry and holds over 80 percent of market share. They have sway over everything, including the peanuts you buy there.

The record sales, licensing, the talent—the talent management, venue ownership, ticket sales, the concessions, down to selling hot dogs and pretzels—you name it, it is there. If there ever was a monopoly, this is it. Sorry, Mr. Holden, you blew it. You know what I am talking about. He permitted the merger of it.

The GAO study of the live tickets industry that Chairman Pallone and I requested notes questionable industry practices, a surprise to no one who has tried to buy tickets.

It is important to emphasize the marketplace has been governed by zero federal regulation. Live Nation operates with impunity. Another Metallica song, "Nothing Else Matter" to them but profits.

It is time for Congress to turn the page, pass legislation to add regulation, impose some order, and stop bad actors who make a living by ripping off regular folks daily.

The Better Oversight of Secondary Sales and Accountability of Concert Tickets, better known as the BOSS Act—I wonder why we named it that—is endorsed by all the consumer groups and attacks problems of both the primary and secondary ticket marketplace.

The BOSS Act makes an easy fix, bans the last second fees, requires every seller advertising all fees up front, which most—none of them do.

GAO estimated that primary and secondary ticketing companies charge fees averaging 27 and 31 percent of the ticket price. In my neighborhood in Paterson, New Jersey, that is called thievery.

At the FTC's Ticket Forum last month, nearly every stakeholder agreed that they could accept such a law, and for fans all-in pricing would allow for easier comparison, stopping to find the best deal.

The BOSS Act lets ticket buyers know how many tickets are going on sale, how many are going to be held back, and where those tickets are coming from. It will also prevent those with connections to venues and artists from knowingly reselling tickets at a jacked-up price. For the secondary marketplace, the BOSS Act addresses speculative ticket sales and so-called white label sites that trick consumers.

I first introduced the bill 12 years ago when there was a major issue with Bruce Springsteen tour, and these problems are not going away. Just last week, Billboard Magazine uncovered the latest scam.

Unbeknownst to fans, apparently Ticketmaster and Live Nation was working with the bands' management to hold back 88,000 tickets and posted them directly on resale sites. That is sad but it is true. Ticketmaster has denied past participation in such schemes.

In the case of Whiplash, Live Nation admitted to the scheme last week in about a dozen artists between 2016 and 2017. They could still be doing the same. This is wrong.

I think we need a commitment to toll the bell for an end of the unregulated ticket marketplace by passing the BOSS Act, and I am open for any questions and I duly appreciate your time and your efforts on all the issues that you deal with.

[The prepared statement of Mr. Pascrell follows:]

PREPARED STATEMENT OF HON. BILL PASCRELL, JR.

Chairman Pallone/Chairwoman Schakowsky, thank you for this opportunity highlight the need for transparency and regulation in the badly corrupted primary and second live events ticket marketplace. I have followed this marketplace for over a decade. Wherever I may roam across our country, and Canada too, I hear complaints from my constituents on their frantic experiences with ticket sales.

And much of this can be traced to the Live Nation-Ticketmaster merger. The combined behemoth dominates a \$9 billion per year industry and holds over 80% market share. They have sway over everything. The record sales, licensing, talent management, venue ownership, ticket sales, and concessions down to selling hot dogs and pretzels. The GAO study of the live tickets industry that Chairman Pallone and I requested notes questionable industry practices that surprise no one who has tried to buy tickets.

It's important to emphasize the marketplace has been governed by zero federal regulation. Live Nation operates with impunity. Nothing else matters to them than profits.

It's time for Congress to turn the page and pass legislation to add regulation, impose some order, and stop bad actors who make a living by ripping regular people off. The Better Oversight of Secondary Sales and Accountability in Concert Ticketing or BOSS ACT (H.R. 3248) is endorsed by all the consumers groups and attacks problems in both the primary and secondary ticket marketplace. The BOSS ACT makes one easy fix makes: bans last second fees and requires every seller advertise all fees up front. GAO estimated that primary and secondary ticketing companies charge fees averaging 27 and 31 percent of ticket prices.

At the FTC's ticket forum last month, nearly every stakeholder agreed that they could accept such a law. And, for fans, all-in pricing would allow for easier comparison shopping to find the best deals. The BOSS ACT lets ticket buyers know how many tickets are going on sale, how many are being held back, and where those tickets are coming from. It also prevents those with connections to venues and artists from knowingly reselling tickets at a jacked-up price.

For the secondary marketplace, the BOSS Act addresses speculative ticket sales and so-called white label sites that can trick consumers.

I first introduced this bill 12 years ago when there was a major issue with a Bruce Springsteen tour on sale. And these problems are not going away. Just last week, Billboard Magazine uncovered the latest scam perpetrated upon consumers. Unbeknownst to fans, apparently Live Nation was working with the band's management to hold back 88,000 tickets and post them directly on resale sites. Sad but true!

Ticketmaster has denied past participation in such schemes. But, in a case of whiplash, Live Nation admitted to the scheme last week and "about a dozen artists" between 2016 and 2017. And could still be doing this today. This is wrong. And we should investigate these deceptive practices.

Be the hero of the day help me support consumer transparency and give fans have a fairer chance to purchase live event tickets. John Donne, Earnest Hemingway, and James Hetfield have each asked for whom the bell tolls?

I ask this committee to toll the bell for the end of an unregulated ticket marketplace by passing the BOSS ACT.

Also, I wish to highlight the bipartisan Laboratory Access for Beneficiaries (LAB) Act (H.R. 3584) I helped Representative Scott Peters introduce. The ongoing cuts to clinical labs hurt patient access and erect further barriers to care. I encourage the committee to consider H.R. 3584 to ensure payment rates under the Clinical Lab Fee Schedule will reflect market prices and that data collection will be representative of the whole laboratory community. Clinical laboratory services account for less than two percent of Medicare fee-for-service spending, but the results of laboratory tests help guide critical decisions for diagnosis, treatment, and prevention for millions of patients. We must tear down any barriers to this critical resource so that we are improving healthcare for patients every day.

Mr. PALLONE. Well, I want to thank you. I know that you have been out front on this in trying to tackle this problem and we do consider it a priority and, you know, we will take it up in the fall, hopefully. You and I can talk more about it.

And, of course, I appreciate you reminding me about the Boss and Bruce Springsteen because I am looking forward to being back to the Jersey Shore and the Asbury Park and all the venues, you know, that he hangs out in.

Mr. PASCRELL. The Stone Pony.

Mr. PALLONE. Yes, Stone Pony as well.

The gentleman—

Mr. WALDEN. Just a quick question.

Mr. Pascrell, thank you for bringing this to our attention, and on a side note can you tell us how many Metallica song titles were in your testimony?

Twelve.

[Laughter.]

Mr. WALDEN. I got 11 of them. All right.

Turn on your mic. We want to hear this.

Mr. PASCRELL. They are advertising for—you know, they are coming out to New York City area. But that is the only reason why that I—and I happen to like the group myself.

Mr. WALDEN. There is just—you know, you learn a lot at Member Day and knowing that Mr. Pascrell is a fan of Metallic is something I learned today. So this is——

Mr. PASCRELL. Yes.

Mr. PALLONE. Well——

Mr. WALDEN. Thank you.

Mr. PASCRELL. I have to search for my talents. I don't have—I have so few.

[Laughter.]

Mr. PASCRELL. But that interesting, and I close out my statement, Mr. Walden, on "For Whom the Bells Toll." It is one of my favorite old movies and books.

They have a song—Metallica—"For Whom the Bells Toll," and I hope it tolls for Ticket Master. It was the worst thing that happened, allowing them to join—they own the market. They own 85 percent of the entire—I mean, we go after airlines sometimes and this and that.

Monopolies have become, you know, part of us now. That's not good. You know why? Our kids—well, my kids are grown—want to go to a concern. You know, you need a wheelbarrow full of money, literally, or else they can't go. Baseball games—you are getting—and, you know, nobody watches over this. It is entertainment. They say, well, if you don't want to spend the money don't go. Well, that is very true.

Mr. PALLONE. We promise to look into it, and although I have to say that I think I would have preferred the band that you had last night to Metallica myself. But, you know, all right. Thanks a lot, Bill. Appreciate it.

Mr. PASCRELL. My honor. Thank you.

Mr. PALLONE. Next, we are going to go to the gentleman from Georgia, Mr. Bishop.

OPENING STATEMENT OF HON. SANFORD D. BISHOP, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. BISHOP. Thank you very much, Mr. Chairman.

I would like to thank you, Chairman Pallone, and Ranking Member Walden, and the members of the House Energy and Commerce Subcommittee on Health for giving me the opportunity to testify this morning on an issue of great importance to the delivery of healthcare, especially in rural communities across the nation.

The issue is non-emergency medical transportation, or NEMT, which currently provides Medicaid beneficiaries with rides to medical appointments every year.

This benefit, which has been in place since Medicaid's inception in 1966, has come under attack recently by the Centers for Medicare and Medicaid Services, which has sought to roll it back by making it optional at the state level.

Such a change would have wreaked havoc on millions of Americans' ability to get to and from their medical appointments quickly and, most importantly, safely.

Individuals who bear the highest burden of chronic conditions, including cancer, HIV, substance abuse disorder, and end-stage renal disease, would not have been able to access vital medical services like chemotherapy, physical therapy, and dialysis.

They also would not have been able to travel to pharmacies to obtain their drug prescriptions or their medical supplies.

In Georgia alone, non-emergency medical transportation provided patients transportation nearly 60,000 times last year to pharmacies to pick up prescriptions that are important for their adherence to a plan of care.

Ending Medicaid coverage for non-emergency medical transportation would literally have been a matter of life and death for many of these individuals.

Earlier this year, I sent a letter to Representative Rosa DeLauro, who chairs the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, as well as to Ranking Member Tom Cole opposing this change.

Our letter requested legislative language in the appropriations bill blocking funding for the implementation of that rule change. It was signed by the entire Congressional Black Caucus in the House and received important bipartisan support from a number of my Republican colleagues in the House.

I would like to ask unanimous consent that the letter be included in the record with my testimony.

Mr. PALLONE. Without objection, so ordered.

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

Mr. BISHOP. Fifty-six non-emergency medical transportation stakeholders including groups representing Medicaid beneficiaries with substance user disorder, behavioral disorders, and end-stage renal disease also sent a letter opposing the rule change.

I would like to ask unanimous consent that the list of those people be included in the record also.

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

Mr. BISHOP. I am pleased to report that the language was successfully added to the fiscal year 2020 Labor-HHS Appropriations bill in an amendment that was offered as a manager's amendment by Chairwoman DeLauro.

Following its inclusion in the bill, we heard word from CMS that they won't try to promulgate the rule until after the 2020 elections.

Although this is welcome news, we still have to be vigilant and ensure that this important benefit remains available to our most vulnerable citizens.

Yesterday, I joined my colleagues Tony Cárdenas, Tom Graves, and Buddy Carter in introducing bipartisan legislation that would codify the Title XIX of the Social Security Act, the Medicaid transportation benefit.

The bill, H.R. 3935, would simply preserve the status quo. It would add non-emergency medical transportation services for individuals without other means of transportation to the list of mandatory benefits that every state Medicaid program is required to provide by law.

According to CBO, the bill would have no cost provided that we act before CMS publishes the proposed rule. I am hopeful that the

legislation will be considered quickly by this subcommittee for inclusion in the extenders package by the end of the year.

In the coming weeks, we plan on introducing legislation on the Medicare front as well. The legislation will provide coverage for non-emergency medical transportation for patients who qualify for Medicare based on their end-stage renal disease.

The measure is being finalized as we speak and the details are still being worked out. I was inspired to work on this issue by a staff member in my Albany, Georgia office whose daughter had end-stage renal disease and subsequently had a successful kidney transplant in 2015.

I look forward to working with all of you in the days, weeks, and months ahead to ensure that these important transportation services are protected now and into the future.

So I thank you for allowing me to appear before you this morning.

[The prepared statement of Mr. Bishop follows:]

PREPARED STATEMENT OF HON. SANFORD D. BISHOP

I would like to thank Chairman Pallone, Ranking Member Walden, and members of the House Energy and Commerce Subcommittee on Health for giving me the opportunity to testify this morning on an issue of great importance to the delivery of healthcare, especially in rural communities across the nation.

The issue is Non-Emergency Medical Transportation, or NEMT, which currently provides Medicaid beneficiaries with rides to medical appointments each year. This benefit, which has been in place since Medicaid's inception in 1966, has come under attack recently by the Centers for Medicare and Medicaid Services, which has sought to roll it back by making it optional at the state level.

Such a change would have wreaked havoc on millions of Americans' ability to get to and from their doctor quickly and, most importantly, safely.

Individuals who bear the highest burden of chronic conditions including cancer, HIV, substance abuse disorder, and end stage renal disease would not have been able to access vital medical services like chemotherapy, physical therapy, and dialysis.

They also would not have been able to travel to pharmacists to obtain drug prescriptions or medical supplies. In Georgia alone, non-emergency medical transportation transported patients nearly 60,000 times last year to the pharmacy to pick up prescriptions that are important to their adherence to a plan of care.

Ending Medicaid coverage for non-emergency medical transportation would literally have been a matter of life and death for many of these individuals.

Earlier this year, I sent a letter to Representative Rosa DeLauro, the Chair of the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, and Ranking Member Tom Cole opposing this change. The letter requested legislative language in the appropriations bill blocking funding for the implementation of the rule change. It was signed by the entire House Congressional Black Caucus and received important bipartisan support from a number of my Republican colleagues in the United States House of Representatives. I ask unanimous consent that the letter be included in the record.

Sixty NEMT stakeholders including groups representing Medicaid beneficiaries with substance user disorder, behavioral disorders and end stage renal disease also sent a letter opposing the rule change.

I am pleased to report that the language was successfully added to the Fiscal Year 2020 Labor-HHS Appropriations bill in an amendment offered by Chairwoman DeLauro.

Following its inclusion in the bill, we heard word from CMS that they will not try to promulgate the rule until after the 2020 elections. Although this news is welcome, we still have to be vigilant and ensure that this important benefit remains available to our most vulnerable citizens.

Yesterday, I joined my colleagues Tony Cárdenas, Tom Graves, and Buddy Carter in introducing bipartisan legislation that would codify, in Title XIX of the Social Security Act, the Medicaid transportation benefit.

The bill would simply preserve the status quo. It would add Non-Emergency Medical Transportation services for individuals without other means of transportation to the list of mandatory benefits that every state Medicaid program is required to provide by law.

According to CBO, the bill would have no cost provided we act before CMS publishes the proposed rule. I am hopeful that the legislation will be considered quickly by this subcommittee for inclusion in an extenders package by the end of this year.

In the coming weeks, I also plan on introducing legislation on the Medicare front as well. The legislation provide coverage for non-emergency medical transportation for patients who qualify for Medicare based on their end-stage renal disease. The measure is being finalized as we speak and the details are still being worked out.

I was inspired to work on this issue by a staff member in my Albany office whose daughter had end stage renal disease and subsequently had a successful kidney transplant in 2015.

I look forward to working with all of you in the days, weeks, and months ahead to ensure that these important transportation services are protected now and into the future.

Mr. PALLONE. I thank the gentleman.

So you want us to look into a permanent fix, basically?

Mr. BISHOP. Yes.

Mr. PALLONE. All right. We will certainly look into it. Thanks a lot. Thanks.

And now we go to Mr. Westerman.

OPENING STATEMENT OF HON. BRUCE WESTERMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. WESTERMAN. Chairman Pallone, Ranking Member Walden, thank you for hosting today's Member Hearing. I appreciate the time that you are giving to members like me who are not on this committee, but who share your concerns and wish to be involved in reforming issues related to the Energy and Commerce Committee.

As a bit of background, I represent a very large and rural district in the Fourth District of Arkansas. My constituents are hard-working men and women who love our country and are busy raising families and trying to make ends meet.

Our current system of healthcare is failing them. As Members of Congress with the ability to address this broken system, we are failing them every day we do not take action.

Health insurance premiums are spiraling out of control, patients can barely afford essential medications that keep them alive, and costs to obtain care are outrageously unaffordable.

Furthermore, access is limited. Individuals in my district must often drive hours just to get basic medical care because local providers are out of network or because telemedicine is not an option.

Our healthcare policy and delivery system affects everyone. Most people don't give a lot of thought to healthcare when they don't need it. But when they do, it is all they think about.

In the United States of America, we can do much better in healthcare. We can cover more people. We can cover preexisting conditions. We can lower cost and we can provide Americans with more options, transparency, and the best care on the planet.

We are all quick to point out the problems. But I am here today, hopefully, to provide solutions. I am not a doctor. I am not a pharmacist or insurance actuary, though friends of mine who are ex-

perts in those fields do serve in Congress and bring much to the table.

I am an engineer. I was educated to approach problems logically, methodically, and with common sense and reason. When the American Health Care Act and its Senate counterparts proved unsuccessful to address our nation's healthcare crisis, I thought, why leave the heavy lifting to the traditional healthcare policymakers? Might a fresh set of eyes make a difference? Might a different approach be something that we need?

With that mind set, I set out to develop a bipartisan healthcare bill that would provide the people of this nation with some relief and I spent a year and a half doing a deep dive into the policy.

The Fair Care Act, which I introduced earlier this year, can be the bipartisan framework to our nation's healthcare crisis.

In it, I address public and private payers, drug prices, provider competition, and healthcare innovation. My legislation would increase access to insurance provided on the ACA exchanges, create competition between providers and drug makers, and ensure long-term solvency of the Medicaid program without abandoning those who are currently covered.

It would continue to cover patients with pre-existing conditions and states would have increased opportunities to design healthcare programs that meet the unique needs of their population.

And please, before you assume that a Republican from the South couldn't possibly introduce legislation with provisions from both parties, familiarize yourself with its content.

For example, the bill limits the exclusivity period for certain drugs and biologic products. I see that Representative Schakowsky is here today. She and I have already introduced a bipartisan bill to address that particular issue.

It reforms payment structures for Medicare Parts B and D for wealthy individuals. It creates fair access and reduces income cliffs so more individuals can afford to enroll in insurance plans. It reestablishes anti-trust laws that apply to health and dental insurers.

It holds Pharmacy Benefit Managers accountable for their actions, discourages hospital consolidation, and increases transparency throughout the system, plus it does a whole lot more.

I have developed this legislation from my personal convictions as well as evidence-based research about what is best for the greatest number of Americans, without the influence of interest groups, lobbyists, or enterprises.

We have a choice as lawmakers, as representatives sworn to serve our constituents. I have found that the healthcare problems are not unsolvable.

We can either fight and bicker about trivial political matters or we can work together to make progress and actually address the healthcare crisis. Waiting until the next election cycle doesn't help the American people.

Waiting for the system to collapse doesn't help the American people. Working together on real solutions does.

I bring this legislation to you today in the hopes that it will serve as a starting point for objective discussions and legitimate negotiations on these issues.

I am willing to meet with any of you to discuss working together, and I sincerely hope that we do. Healthcare cannot and should not be a political issue if we truly hope to help all Americans.

Again, I thank you again for this opportunity today and I would welcome any questions you may have.

[The prepared statement of Mr. Westerman follows:]

PREPARED STATEMENT OF HON. BRUCE WESTERMAN

Chairman Pallone, Ranking Member Walden—Thank you for hosting today's Member Hearing.

I appreciate the time you are giving to members like me who are not on this committee, but who share your concerns and wish to be involved in reforming issues related to Energy and Commerce.

As a bit of background, I represent a very large and rural district, the Fourth District of Arkansas.

My constituents are hard-working men and woman often just trying to make ends meet.

Our current system of healthcare is failing them. And as Members of Congress with the ability to address this broken system, we are failing them every day we do not take action.

Health insurance premiums are spiraling out of control, patients can barely afford essential medications that keep them alive, and costs to obtain care are outrageously unaffordable.

Furthermore, access is limited.

Individuals in my district must often drive hours just to get basic medical care because local providers are out of network or because telemedicine is not an option.

It's simple—no one gives a lot of thought to healthcare when they don't need it, but when they do, it's all they think about.

There is no reason for this to be the case in the United States of America.

But I'm not here to simply to discuss the problems. I'm here to promote solutions.

I am not a doctor, pharmacist, or insurance actuary—though friends of mine who are experts in those fields do serve in Congress.

I am an engineer, trained to approach problems logically and methodically.

When the American Health Care Act and its Senate counterparts proved unsuccessful in attempts to address our nation's healthcare crisis, I thought, why leave the heavy lifting to the traditional healthcare policymakers?

Might fresh eyes be useful?

With that mindset, I set out to develop a bipartisan healthcare bill that would provide the people of this nation with some relief.

The Fair Care Act, which I introduced earlier this year, is my answer to our nation's healthcare crisis.

In it, I address public and private payers, drug prices, provider competition, and healthcare innovation.

My legislation would increase access to insurance provided on the ACA exchanges, create competition between providers and drug makers, and ensure long-term solvency of the Medicaid program without abandoning those who are currently covered.

It would continue to cover patients with pre-existing conditions.

And states would have increased opportunities to design healthcare programs that meet the unique needs of their population.

And please, before you assume that a Republican from the South couldn't possibly introduce legislation with provisions from both parties, familiarize yourself with its content.

For example, the bill limits the exclusivity period for certain drugs and biologic products, eliminates Medicare Parts B and D for wealthy individuals, funds subsidies for more individuals to enroll in insurance plans, reestablishes anti-trust laws that apply to health and dental insurers, holds Pharmacy Benefit Managers accountable for their actions, discourages hospital consolidation, and increases transparency throughout the system.

I've developed this legislation from my personal convictions as well as evidence-based research about what is best for the greatest number of Americans, without the influence of interest groups, lobbyists, or enterprises.

We have a choice as lawmakers, as Representatives sworn to serve our constituents.

We can either fight and bicker about trivial political matters for the next sixteen months, or we can work together to make progress and actually address this healthcare crisis.

Waiting until the next election cycle doesn't help the American people.

Waiting for the system to collapse doesn't help the American people.

Working together on real solutions does.

I bring this legislation to you today in the hopes that it will serve as a starting point for objective discussions and legitimate negotiations on these issues.

I'm willing to meet with any of you to discuss working together, and I sincerely hope that we do.

Healthcare cannot, and should not, be a political issue if we truly hope to help all Americans.

I thank you again for welcoming me today, and I look forward to working with you, my colleagues, to solve this problem once and for all.

Mr. PALLONE. All right. I want to thank you and I assure you that we will look into your bill. And I do want to say it really drives me crazy, and members have heard me say it many times in this committee, that we have these disparities between rural America and the rest of the country.

I mean, it just should not be that, you know, if you are in a rural area that you can't get—and I understand it is not always true but that you often can't get access or quality healthcare or resources, and I have had a chance over the last couple years because my son was in Japan in a rural area teaching English.

And I was amazed how it didn't really matter whether you went there in this small town a thousand miles from Tokyo or you were in Tokyo. You basically had access to the same level of care. And it is just not true here and we have got to do something about it.

Did you want to—

Mr. WALDEN. No, I just want to thank the gentleman from Arkansas and also concur with you, Mr. Chairman, on the disparity in access to care.

I got three countries with no hospitals and no doctors because they are so remote. One person for every nine miles of power lines. I mean, these are wide open spaces and yet if a heart attack or a stroke occurs, that golden hour is the same length of time as it is in an urban setting.

So expansion of telehealth is essential in these basic services. But I know Mr. Westerman has worked really hard and put a lot of thought into this plan and I hope if there is an opportunity we can dig into it a little further because he has really worked on this for a couple of years now. So I appreciate it.

Mr. WESTERMAN. I appreciate that, and I believe it's a policy that works for rural America and urban America.

Mr. PALLONE. Ms. Schakowsky?

Ms. SCHAKOWSKY. Yes, I just wanted to thank the gentleman. I am so happy that we are co-sponsoring a bill to lower the price of prescription drugs and it is an honor to be working with you on that.

Thank you.

Mr. WESTERMAN. Thank you.

Mr. PALLONE. Thanks again. Appreciate it.

Mr. WESTERMAN. Thank you.

Mr. PALLONE. The gentleman from California, Mr. Lieu. Thank you for being here.

OPENING STATEMENT OF HON. TED W. LIEU, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. LIEU. Thank you, Chairman Pallone, Ranking Member Walden, Chairwoman Schakowsky, and Ranking Member McMorris Rodgers, for allowing me to testify.

Today, I am here to urge you to consider my legislation H.R. 3570, the Therapeutic Fraud Prevention Act, which aims to prevent for-profit conversion therapy.

This legislation has been co-sponsored by 89 of our colleagues including 14 members of the Energy and Commerce Committee, and six members of the Consumer Protection and Commerce Subcommittee.

It is supported by a wide range of organizations including the American Academy of Pediatrics, the American Psychoanalytic Association, and the Human Rights Campaign.

When I was in the California State Senate, I authored the first law in the nation to ban gay conversion therapy. Since then, 18 states have banned this practice and this is a bipartisan issue. In seven of those states Republican governors signed the legislation and in a number of those states the state bill had bipartisan support.

Now, conversion therapy has three main problems.

Number one, it doesn't work. It is fraudulent. Number two, not only does it not work and in some cases, it could severely harm the patients who undergo it, and number three, it could be very costly.

According to the Williams Institute, nearly 700,000 folks in the United States have been subjected to conversion therapy, and one group known as JONAH, was charging about \$100 for weekly individual sessions. A lawsuit filed by former victims of JONAH represented by the Southern Poverty Law Center, revealed that individuals could spend more than \$10,000 per year on conversion therapy.

JONAH was ordered to shut down in 2015 for violating New Jersey's Consumer Fraud Act. So in addition to being costly and being fraudulent, we know that the entire medical community is arrayed against this.

The American Psychiatric Association has said that no credible evidence exists that any mental health intervention can reliably and safely change sexual orientation nor from a mental health perspective does sexual orientation need to be changed.

There is simply no disease known as being gay. It's simply being human. That was removed out of the DSM-IV manual decades ago. So when a for-profit mental health professional comes and says, I am going to charge you money to get rid of a disease that does not exist, that is called fraud.

In addition, studies have shown that patients can undergo severe harm from this. Patients have committed suicide or thought about committing suicide.

When I did this legislation in the California State Senate, we had witnesses come up to talk about going through this practice and then wanting to commit suicide later.

So this can also greatly harm people.

I also want to note that this legislation that I introduce here only applies to for-profit conversion therapists. So if you are a priest and

you want to talk about this with members of your church, that is fine. It doesn't apply to you. It applies to these groups that are scamming consumers with this fraudulent practice.

I note that this bill will protect individuals from being defrauded by conversion therapists and falls clearly within the subcommittee's mission to protect consumers.

So I respectfully request that either the subcommittee or the entire committee consider this bill, and thank you for the opportunity to testify and happy to answer any questions that you may have.

[The prepared statement of Mr. Lieu follows:]

PREPARED STATEMENT OF HON. TED W. LIEU

Chairman Pallone, Ranking Member Walden, Chairwoman Schakowsky, and Ranking Member McMorris Rodgers, thank you for allowing me to testify.

Today, I am here to urge you to consider my legislation H.R. 3570, the Therapeutic Fraud Prevention Act, which aims to prevent for-profit conversion therapy. This legislation has been cosponsored by 89 of our colleagues in the House of Representatives, including 14 members of the Energy and Commerce Committee, and six members of the Consumer Protection and Commerce Subcommittee. It is supported by a wide range of organizations including the American Academy of Pediatrics, the American Psychoanalytic Association, the Southern Poverty Law Center, and the Human Rights Campaign.

About Conversion Therapy

Conversion therapy, also known as reparative therapy or sexual orientation change efforts, refers to the practice of attempting to change an individual's sexual orientation or gender identity. According to the Williams Institute at the University of California Los Angeles, nearly 700,000 adults in the United States have been subjected to conversion therapy. Not only is conversion therapy common, but it also costs. One conversion therapy organization, People Can Change, charges \$650 to \$850 for weekend conversion therapy retreats in the woods. Another, Jews Offering New Alternatives to Healing (JONAH), charged about \$100 for weekly individual sessions and \$60 for group therapy sessions. A lawsuit filed by former victims of JONAH revealed that individuals could spend more than \$10,000 per year on conversion therapy. JONAH was ordered to shut down in 2015 for violating New Jersey's Consumer Fraud Act.

Inefficacy, Harms of Conversion Therapy

The national community of professionals in education, social work, health, mental health, and counseling has recognized universally that conversion therapy is a wholly useless and risky pseudoscience. In reality, it is not possible to change an individual's sexual orientation or gender identity, nor should we seek such change. Moreover, administering conversion therapy causes serious harms to its victims including depression, self-harm, and suicide. In 2013, the American Psychiatric Association released the following statement:

"The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed."¹

So-called conversion therapists should not be able to sell their services by claiming that they are effective and harmless, especially when forced upon minors. As legislators, I believe that we have a responsibility to protect our constituents from being swindled by these individuals and organizations.

About the Therapeutic Fraud Prevention Act

In June, I re-introduced H.R. 3570, the Therapeutic Fraud Prevention Act. This legislation makes it unlawful for any person to provide for-profit conversion therapy or to advertise for the provision of conversion therapy. It allows the Federal Trade

¹ APA Reiterates Strong Opposition to Conversion Therapy. November 15, 2018. Accessed July 22, 2019. <https://www.psychiatry.org/newsroom/news-releases/apa-reiterates-strong-opposition-to-conversion-therapy>.

Commission to enforce the prohibition under the Federal Trade Commission Act and provides additional enforcement authority to the Department of Justice and state attorneys general.

Because this legislation targets only those who charge for conversion therapy, it does not infringe on First Amendment rights. At the same time it is an incredibly effective way to ensure that for-profit practitioners are not allowed to engage in this fraudulent behavior.

State Progress

Across the nation, we are seeing growing support for laws preventing conversion therapy. In 2012, California enacted the first law in the nation to protect minors from conversion therapy. Since that time, seventeen states—including Illinois and Washington—the District of Columbia, and several more municipalities have passed similar laws. Seven of these state laws were signed by Republican governors and several received bipartisan support in their respective state legislatures.

These bans are working. The aforementioned Williams Institute study found that 10,000 LGBT youth living in states that ban conversion therapy have been protected from the harm. Still, the report also showed that 16,000 LGBT youth living in states without such bans will receive conversion therapy from a licensed professional before they turn 18. Clearly, we need federal action.

Conclusion

The Therapeutic Fraud Prevention Act will protect individuals from being defrauded by conversion therapists and falls clearly within the subcommittee's mission to protect consumers. I respectfully request that the subcommittee consider this important piece of legislation and thank you for the opportunity to testify before you.

Mr. PALLONE. I thank the gentleman. Again, we will take a look and we certainly are always concerned about anything that relates to consumer fraud and trying to prevent consumer fraud.

So unless anyone else, I thank you again for being here and we will follow up.

Mr. LIEU. Thank you.

Mr. PALLONE. Thanks.

And next we go to the gentleman from Wisconsin is next. Thank you.

Mr. GROTHMAN. I voted for one of your nice amendments yesterday.

OPENING STATEMENT OF HON. GLENN GROTHMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

I am here to talk about H.R. 380. It deals with requiring—well, right now when it comes to dams, environmental agencies frequently feel that we need fish passageways so the fish can swim upstream.

We have a major dam in the state of Wisconsin, which is actually in Congressman Pocan's district but it's kind of very close to my district, and right now that dam is the only thing that prevents Asian carp, a huge invasive species, from swimming upstream in the Wisconsin River.

It is a very important thing to the state of Wisconsin. Asian carp have gone all the way from the Gulf of Mexico into Wisconsin River, which is the most important river in the state of Wisconsin.

Wisconsin River is not only important in its own right but as you work your way up the river you wind up in many, many lakes in northern Wisconsin.

The only thing that has prevented these massive Asian carp from doing so much to destroy the upper Wisconsin River and lakes in northern Wisconsin is a dam on the southern Wisconsin River.

Right now, the secretary of interior is doing a study to see whether they can put a fish passageway up there. I can understand why in most circumstances you want a fish passageway. I can think of other examples in other parts of my district where they work well.

However, in this era of invasive species, some of these dams are so valuable in protecting our rivers and lakes and for that reason, myself, with the assistance of Mr. Pocan, we drafted a bill requiring the Department of Interior to look at it, and I think if we do we can rest easy in knowing that not only the upper Wisconsin River but all the lakes in northern Wisconsin could be protected from the Asian carp. I am sure there are other places around the country where this must be a problem as well.

Do you have any questions for me?

[The prepared statement of Mr. Grothman follows:]

PREPARED STATEMENT OF HON. GLENN GROTHMAN

Mr. Chairman Rush, Ranking Member Upton, and members of the committee, thank you for giving me the chance to speak in favor of amending the Federal Power Act to require the Secretary of Commerce or the Secretary of Interior to consider the threats posed by invasive species before mandating a new fish passageway be built through a dam.

- My bill is bipartisan and enjoys the support of Congressman Mark Pocan also of Wisconsin.

- Our home state currently faces an invasive species threat that may affect the entire Great Lakes Region.

- Invasive species are not just a problem in Wisconsin but are causing serious large-scale environmental and economic problems across the country. According to the Department of the Interior, the prevalence of invasive species is estimated to cost the U.S. economy over \$100 billion annually, including impacts to business and industry, recreation, and public health.

- A hydroelectric dam in Prairie du Sac, Wisconsin, offers a case in point.

- The United States Fish and Wildlife Service has ordered the installation of a fish passageway located at the hydroelectric plant in Prairie du Sac dam. Asian Carp, which is an invasive species that can grow nearly three feet in length, have been found at the base of this dam.

- Fish passageways can serve an important role of preserving and enhancing the populations of desirable, native fish by allowing them a way to travel safely, timely, and effectively around dams.

- However, invasive species use these same fish passageways to invade rivers and lakes and devastate native species and their habitats.

- Installing a fish passageway at the Prairie du Sac dam could allow the Asian Carp to migrate upstream to the Wisconsin River, Lake Wisconsin and eventually the Great Lakes.

- Currently, the dam acts as a physical barrier to upstream movement of Asian Carp and other invasive species. None of the invasive species established in the Mississippi River Basin are currently known to exist upstream of the dam.

- In fact, Asian Carp have been captured by Wisconsin Officials below the dam as recently as 2014.

- The presence of these invasive species in the lower Wisconsin River raises concerns that these fish could penetrate past the protective wall of the dam and travel upstream if a fish passage is installed.

- If they do indeed move upstream through the Wisconsin waterways, and eventually into the Great Lakes, there would be significant adverse effects to the environment, native fish populations, and the recreation industry of Wisconsin.

- This bill would simply ensure that federal officials have to consider this threat before prescribing and finalizing fishway conditions like the one in Prairie du Sac.

- We believe that there are viable non-fishway alternative approaches which can both support the maintenance of native fish populations, while also eliminating the risk of spreading invasive species into protected waterways.

- Allowing for greater flexibility and discretion from Department of Interior, with respect to considering non-fishway alternatives will protect watersheds and local

economies in the Great Lakes region from the detrimental effects of invasive species.

•I would like to thank the Committee again for holding this hearing and am happy to answer any questions you may have.

Mr. PALLONE. Well, I just want—you know that we worked with you and Mr. Pocan on this in the last Congress and we will continue to work on it. I just want you to know that.

Yes, Mr. Upton?

Mr. UPTON. Well, thank you for being here today, and I know that as a member of the Great Lakes Caucus—I think you are too—that fighting the Asian carp from getting further north is a tremendous priority for all of us.

And we had a bipartisan group from Michigan go down to Illinois during the 4th of July break to look at one of the locks down there just literally about an hour south of Midway Airport.

The Corps of Engineers, as you know, has come up with a study that I think we need to implement that would block that carp then from going north and infiltrating, causing irreversible damage to the Great Lakes Region, and it appears as though it is going to be a bipartisan effort.

The Corps assured us that they were on board to try and do this, but I appreciate your commitment and your work and your interest, and there is a lot of people that are on your side.

Mr. GROTHMAN. Yes. I should point out that not only is this important for the Wisconsin River but it is important for all the Great Lakes because near where this dam is the tributaries that flow into Lake Michigan go there as well. I mean, it is right on the Continental Divide and a lot of people feel that if the carp got north it wouldn't only affect the lakes in Wisconsin but it would work its way to Lake Michigan.

Mr. UPTON. Thank you.

Mr. PALLONE. I thank the gentleman and we will work on it again. Thanks.

Mr. GROTHMAN. Thanks much.

Mr. PALLONE. And now the gentlewoman from New Mexico. Thanks for being here.

OPENING STATEMENT OF HON. XOCHITI TORRES SMALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. TORRES SMALL. Thank you, Chairman Pallone, thank you, Congressman Upton, and members of the Energy and Commerce Committee.

It is an honor to get to speak with you today about the issues relevant to New Mexico's 2nd Congressional District.

I first want to applaud the Energy and Commerce Committee's work to lift up rural and underserved communities. Our rural communities are important threads to the fabric of our nation. They provide the food we put on our tables and the energy that powers our day-to-day lives. More importantly, they represent the American values and traditions that are at the heart of who we are.

I love our values and way of life, but our rural communities are facing increased hardships like never before. Since I was sworn in, I have visited all 19 counties in New Mexico's 2nd Congressional

District and in each place, I visited, residents voiced the same message. They want the same economic opportunities and healthcare access that cities and suburbs have.

These are the issues I came to Congress to tackle, and it is why I am here today speaking before the committee with broad and far-reaching jurisdiction to address these problems.

When meeting with my constituents, access to basic healthcare leads nearly every conversation, because in southern New Mexico it's not just about healthcare affordability; it is also about healthcare accessibility.

I have met expecting mothers who have to drive for hours for every single prenatal appointment. I have met veterans who have to get on a bus in the middle of the night to get to a doctor's appointment in Albuquerque the next day.

I have met with teenagers in the midst of a crisis who face a long waiting list for a much-needed mental health appointment, and I have visited rural and community hospitals on the verge of closing.

These are daily challenges for the six million Americans living in rural communities. I am by no means an expert, but I think it is clear that one way to increase healthcare access in rural areas is increasing the number of doctors serving in them.

In March, along with a bipartisan group of colleagues, I helped introduce the Resident Physician Shortage Reduction Act of 2019, H.R. 1763.

This bipartisan legislation takes critical steps towards reducing nationwide physician shortages, with an emphasis in rural areas, by increasing the number of Medicare-supported residency positions by 15,000 positions.

H.R. 1763 already has 139 co-sponsors, including 16 members of this committee. I strongly encourage the committee to support this bill.

Similar in mission, I also helped introduce the Training the Next Generation of Primary Care Doctors Act alongside Representative Ruiz in May.

H.R. 2815 reauthorizes and expands the Teaching Health Center Graduate Medical Education Program.

The program has helped address physician shortages in low-income regions of the country such as the district I serve, because many medical students go on to serve the communities where their residency program was located.

In the 2018–19 academic year, the THCGME Program supported the training of 728 residents in 56 primary care residency programs across 23 states.

These graduates are almost three times more likely to remain in primary care practice than traditional GME graduates, almost two times more likely to practice in underserved communities, which is most of New Mexico, and more than two times more likely to serve in rural America.

The THCGME program's success thus far helps meet this mission and I will continue to advocate for its expansion. Other issues that impact New Mexico include transportation. We have transportation programs that help rural residents get to their medical appointments and we have seen that that helps everyone's health.

We have also seen the devastating impact that high drug prices have and we have an obligation to address them. Let us keep building on the momentum of the legislation passed in June and continue putting forth measures to protect our constituents suffering from inflated and unregulated drug prices.

Members of this committee, even with the hardships rural communities face, we are often the first to be forgotten when legislators and healthcare experts discuss healthcare quality, access, and affordability.

Thank you again, Chairman Pallone and Ranking Member Walden, for holding this hearing and for your work delivering better healthcare to all our constituents.

[The prepared statement of Ms. Torres Small follows:]

PREPARED STATEMENT OF HON. XOCHITI TORRES SMALL

Chairman Pallone, Ranking Member Walden, and members of the committee, thank you for the opportunity to speak about the pressing issues facing New Mexico's Second Congressional district.

I first want to applaud the Energy and Commerce Committee's work to lift up rural and underserved communities.

Our rural communities are important threads in the fabric of our nation. They provide the food we put on our tables and the energy that powers our day-to-day lives.

More importantly, they represent the American values and traditions that are at the heart of who we are.

I love our values and way of life, but our rural communities are facing increased hardships like never before.

Since I was sworn-in, I've visited all 19 counties in New Mexico's Second Congressional District.

And in each place I visited, residents voiced the same message. They want the same economic opportunities and healthcare access that the bustling cities and growing suburbs have.

These are the issues I came to Congress to tackle, and it is also why I am here today speaking before the committee with broad and far-reaching jurisdiction to address these problems.

When meeting with my constituents, access to basic healthcare leads nearly every conversation, because in southern New Mexico, it's not just about healthcare affordability, it's also about healthcare accessibility.

I have met expecting mothers who have to drive for hours, often across state lines, for prenatal appointments.

I have met veterans who have to get on a bus in the middle of the night to get to a doctor's appointment in Albuquerque the next day.

I have met teenagers in crisis who face a long waiting list for a much-needed mental health appointment.

And I have visited rural and community hospitals on the verge of closing.

These are daily challenges for the 60 million Americans living in rural communities.

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This bipartisan legislation takes critical steps toward reducing nationwide physician shortages, with an emphasis in rural areas, by increasing the number of Medicare-supported residency positions by 15,000 positions.

If passed, H.R. 1763 will significantly increase training programs for rural physicians and take the first steps towards expanding rural healthcare access and incentivizing medical students to serve our rural communities.

H.R. 1763 already has 139 cosponsors, including 16 members of this committee. I strongly encourage the committee to support this bill.

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In the 2018–19 academic year, the THCGME Program supported the training of 728 residents in 56 primary care residency programs across 23 states. Of these graduates,

- 1A82 percent remain in primary care practice, compared to 23 percent of traditional GME graduates;
- 1A55 percent of practice in underserved communities, compared to 26 percent of traditional GME graduates; and
- 1A20 percent practice in rural America, compared to eight percent of traditional GME graduates.

Training the next generation of rural healthcare providers means investing in the programs that have proven to keep them in areas with the highest need.

The THCGME program's success thus far helps meet this mission and I will continue to advocate for its expansion.

In the coming weeks, I plan to introduce legislation to address the maternal morbidity crisis faced in rural communities.

The bill will likely be directed to this committee and I look forward to working with each of you to move this critical legislation for a full floor vote.

Additionally, it is essential that we help those in rural communities get to their healthcare providers, even if they live several towns or counties away. When lack of transportation prevents people from attending routine or preventative care appointments, it increases healthcare costs and leads to worse health outcomes.

Currently, there are several federal programs that help patients in rural communities reach their medical providers with non-emergency medical transportation. Studies have proven that programs like these not only increase access to healthcare but also pay for themselves through healthcare savings.

However, these programs can't meet the immense need. We need to do more to expand federal patient transportation programs to ensure that no American is prevented from seeing their doctor due to issues with transportation.

Last, I can attest that across my diverse district, Republicans, Democrats, and independents all agree drug prices are too high and that Congress has an obligation to lower them.

Let's keep building on the momentum of the legislation passed in June and continue putting forth measures to protect our constituents suffering from inflated and unregulated drug prices.

Members of this committee, even with the hardships rural communities face, we are often the first to be forgotten when legislators and healthcare experts discuss healthcare quality, access, and affordability.

By working to solve these issues, this committee can be on the forefront of advancing healthcare, no matter where a person lives.

Thank you again, Chairman Pallone and Ranking Member Walden for holding this hearing, and for your work delivering better healthcare to all our constituents.

Mr. PALLONE. I want to thank the gentlewoman.

You know, what you said about training people and then they are staying in the community is so true and, you know, I have seen that. You know, one of the things that we did when we did the—I think it was in the ACA—that we said that you could get additional slots for—you know, for residency programs if you did it—if you set it up at a community health center, and because they were outside of the regular system.

And I saw that—I can't remember what tribe it was but we were—we were on the Puget Sound, I guess, in Washington State—one of the tribes, and they had actually done that with their Indian Health Service where they had set up a residency program and they just got the additional slots without having to transfer or buy them anywhere.

And they said in every—in almost every case the doctors that were trained there stayed, you know, with the community health center or with the tribe in that area, and that is—it is true.

I mean, if you have those training programs in those underserved areas, people tend to stay there. It's just a reality.

So the other thing that the gentleman from Arkansas mentioned is trying to be innovative with technology too in telemedicine, which is important.

So we will definitely look into it. Thanks again.

Thanks.

And next is the gentleman from Minnesota, Mr. Phillips.

OPENING STATEMENT OF HON. DEAN PHILLIPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. PHILLIPS. Thank you, Chairman Pallone, Mr. Upton, and members of the committee for the invitation to speak today about some important issues facing my community.

Minnesota is fortunate to be home to many pristine waters and natural treasures, including the Mississippi River, our infamous 10,000 lakes—and those are just ones with names—and the Boundary Waters.

The Boundary Waters is the most visited wilderness in our country and a special place for Minnesotans and many throughout our nation. People from across the world also visit to canoe, hike and to fish.

In May, the Department of the Interior decided to renew two mining leases for a proposed copper sulfide mine right on the edge of the Boundary Waters, despite scientific evidence, economic data, ongoing litigation, and a public record of opposition dating back over 50 years.

This unilateral action from the Trump administration to move forward on the copper sulfide Twin Metals mine is irresponsible and unacceptable. We must continue to protect our public lands and waters and ensure that Minnesota's and the nation's wilderness areas can be enjoyed by future generations.

Minnesota's 3rd District is home to one of the most visited lakes in our state, Lake Minnetonka, made famous by Prince's movie, "Purple Rain." I am sure that is the first time that has been uttered in this room.

Right now, Lake Minnetonka and the rest of our state's waters face the grave threat of aquatic invasive species, something to which my colleague from Wisconsin referred to just moments ago.

Aquatic invasive species including Asian carp, spiny water fleas, and zebra mussels—none of them native to Minnesota and all of which cause major harm to our waters' ecosystems.

These species have been moving throughout Minnesota, clogging our lakes and rivers, and killing off native animals and plants. Life in our district revolves around these lakes, so this problem is of grave concern to our community.

In June, I convened a roundtable of local experts to discuss the threat posed by these invasive species and the consensus was very clear. Congress must invest resources and support state and local governments to prevent the further spread of invasive species in our lakes and our rivers.

And unfortunately, the problem of aquatic invasive species is exacerbated by our changing climate. Invasive species can now live

in waterways that were uninhabitable just a few decades ago, while native species are struggling to adapt fast enough to compete with them.

Climate change is right in our backyards and it is time to act. I hear it from my constituents every day. Middle and high school students in particular who contact my office to express their distress that our federal government has refused to take bold steps or any meaningful action to solve this issue.

These young people are motivated to organize and contact their representatives because they feel it is their only option; their life and future depends on it.

And I also hear from their parents and their grandparents, worried about the world they will leave behind for their families. Climate change is complex and requires a multi-pronged approach. We need to consider solutions and policies like federal support for research and development of renewable energy, extending and supporting new tax credits for renewables, supporting consumer purchase of electric vehicles, and other thoughtful proposals.

Another policy we need to explore is placing a price on carbon, like the Energy Innovation and Carbon Dividend Act.

This legislation places a fee on fossil fuels at the source, beginning at \$15 per metric ton of CO₂ equivalent emissions, and steadily increases annually by \$10 per metric ton.

The fees would be deposited into a carbon dividend trust fund and allocated as dividend payments to all U.S. citizens and lawful residents. Thus, the bill would use market forces to provide incentives for the reduction of carbon emissions.

This is an achievable solution that both parties can support and should, and I urge all who are present to consider doing so.

The American people have sent a clear message to Congress: please take action on climate change, and I hope you'll join me in doing all we can to keep our planet safe and prosperous for generations to come.

Thank you, Mr. Chair.

[The prepared statement of Mr. Phillips follows:]

PREPARED STATEMENT OF HON. DEAN PHILLIPS

Thank you, Chairman Tonko, Ranking Member Shimkus, and members of the committee for the invitation to speak today about these important issues facing my community.

Minnesota is fortunate to be home to many pristine waters and natural treasures, including the Mississippi River, our infamous 10,000 lakes, and the Boundary Waters.

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In May, the Department of the Interior decided to renew two mining leases for a possible copper sulfide mine on the edge of the Boundary Waters in Minnesota, despite scientific evidence, economic data, ongoing litigation and a public record of opposition dating back 50 years.

This unilateral action from the Trump Administration to move forward on the copper sulfide Twin Metals mine is irresponsible and unacceptable. We must continue to protect our public lands and waters and ensure that Minnesota's wilderness can be enjoyed by future generations.

Minnesota's third district is home to one of the most visited lakes in our state, Lake Minnetonka—made famous by Prince's film *Purple Rain*.

Right now, Lake Minnetonka and the rest of our state's waters face the grave threat of Aquatic Invasive Species.

Aquatic Invasive Species including Asian carp, spiny waterfleas and zebra mussels, are not native to Minnesota and cause major harm to our waters' ecosystems. These species have been moving throughout Minnesota, clogging our lakes and rivers, and killing off native animals and plants. Life in our district revolves around lakes, so this problem is of high concern to our community.

In June I convened a roundtable of local experts to discuss the threat posed by these invasive species and the consensus was clear. Congress must invest resources and support state and local governments to prevent the further spread of invasive species in our lakes and rivers.

And unfortunately, the problem of Aquatic Invasive Species is exacerbated by our changing climate. Invasive species can now live in waterways that were uninhabitable a few decades ago, while native species are struggling to adapt fast enough to compete with them.

Climate change is right in our backyard and we must act.

I hear it from my constituents every day. Middle and High School students contact my office regularly to express their distress that our federal government has not taken bold steps to solve this issue. These young people are motivated to organize and contact their representative because they feel it is their only option—their life and future depends on it. I also hear from parents and grandparents worried about the world they will leave behind for their families.

Climate change is complex and will require a multi-pronged approach. We need to consider solutions and policies like federal support for research and development into renewable energy, extending and supporting new tax credits for renewables, supporting consumer purchase of electric vehicles, and other proposals. Another policy we need to explore is placing a price on carbon—like in the Energy Innovation and Carbon Dividend Act.

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Thus, the bill would use market forces to provide incentives for the reduction of carbon emissions. This is an achievable solution that both parties could support, and I urge all who are present to do just that.

The American people have sent a message to Congress: take action on climate change. I hope you'll join me in doing all we can to keep our planet safe for generations to come.

Thank you.

Mr. PALLONE. Thank you, and I did want to mention that just this week myself, Mr. Tonko, and Mr. Rush, we had—we made an announcement earlier this week that we were going to try to achieve a goal of 100 percent, I guess I will say carbon neutral by 2050 and that we were going to begin a series of hearings, which actually started yesterday, and Mr. Tonko of the Environment and Climate Change Subcommittee, to see what legislative proposals that we have before the committee or others with the idea that by the end of the year, if not sooner, we would come up with legislation—you know, sort of a climate action plan, if you will, that we will then try to sell to the rest of not only Democrats but Republicans as well.

So we certainly want to look at your proposal in the context of that, and we will.

Mr. PHILLIPS. Thank you. And Mr. Chair, if I might say, you know, we are in this together and to the extent that we can identify best practices as practiced by other countries in many cases ahead of us on this issue I would encourage—

Mr. PALLONE. Right. And it is true. We mentioned that, you know, the scientific community basically says that by 2050 if we don't—you know, if we don't take action now to get to carbon neutral by 2050 we are going to have a catastrophe, and several coun-

tries have used that date—you know, France, Germany, Japan, and others.

Did you want to say—

Mr. UPTON. I just want to say thank you, Mr. Phillips, for being here. I know that Minnesota is known as the land of 10,000 lakes. Michigan has more.

Mr. PHILLIPS. I knew that was coming.

[Laughter.]

Mr. UPTON. Yes. Yes.

But last year I went down the Paw Paw River which is—merges into Lake Michigan, and when you take the jigs and jogs you go about 35 miles inland from Lake Michigan and you actually get 100 miles upriver, because it goes like this.

And we were working on identifying lamprey eel larva and eggs, and that is how far we went up to look at the lampricide that then forced the younglings of the lamprey eels to surface and then we were able to collect and, of course, that has been an issue that we have had at the Great Lakes for many decades, and that is why it is so important as we look at Asian carp and other invasive species that came in maybe with ballast water, I think, with those eels—lamprey eels. But it is a tremendous impact on the fisheries and tourism and everything else, and when you look at zebra mussels as well as a huge issue for all of us.

Mr. PHILLIPS. Thank you.

Mr. PALLONE. Thank you. Thanks again. Appreciate your being here.

And we now go to the gentlewoman from Ohio, the chairwoman of the Energy and Water Appropriation Subcommittee who we have worked with on quite a few issues because of the overlap between your Appropriations Subcommittee and this committee. Thank you for being here.

**OPENING STATEMENT OF HON. MARCY KAPTUR, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. KAPTUR. Thank you, Mr. Chairman and members of the committee, and I want to thank you for your openness to working across committees to even do greater things for our country, Chairman Pallone.

It is a real honor to be before you today, and I want to thank Ranking Member Walden and all members of the committee for the opportunity to address you this afternoon. I see my great friend, Fred Upton, from our sister Wolverine state up there and it is wonderful to have you there as well.

As chair of the Energy and Water Appropriations Subcommittee, I deeply value the collaborative relationship and consultation between our two subcommittees and I believe we can accomplish so much more working together.

In addition to my verbal testimony, I also have highlighted several priorities that relate to the Health Subcommittee in my longer written testimony that I will submit. But I want to concentrate on three areas this morning. I know you were really busy last week in several areas of overlapping jurisdiction.

But the three I want to talk about this morning are workforce development, weatherization, and energy efficiency at our drinking water and wastewater treatment plants across this country.

The Energy and Commerce Committee was extremely active last week in several areas of overlapping jurisdiction.

I want to applaud first on workforce development Chairman Rush and the full committee for your attention to the workforce development and pipeline issues at the Department of Energy.

Last week, you approved H.R. 1315, the Blue Collar to Green Collar Jobs Development Act of 2019, and in March of this year, our Appropriations Subcommittee on Energy and Water also held a workforce development hearing.

We have a lot of work to do together on this one. As you know, our nation has a serious pipeline and workforce development crisis in the energy and nuclear security industries, both at the Department of Energy as well as in the private sector.

According to the Energy and Employment Report for 2018, roughly, 12 percent of today's energy workforce is eligible to retire—we are talking about hundreds of thousands of people—and 70 percent—70 percent—of industry employers in energy report hiring difficulty.

I hear this over and over and over again, whether it is electrical engineers, whether it is nuclear, staff for our nuclear power plants. In STEM fields, our nation is not meeting demand.

The Department of Energy must be more proactive about recruiting and training a new generation of innovators because our country needs to compete in a new world economic order in which our nation is skills short.

I believe that we need to be as aggressive as Members of Congress in exploring how to create this more aggressive recruitment opportunity in the same way as we do when we select individuals from our district working with our service academies to move young Americans into fields and into places that perhaps they hadn't imagined when they were much younger.

But I don't think we are going to meet the demand based on current trends and I would be more than willing to work with this excellent committee on the workforce development issue, engaging—fully engaging the Department of Energy in that effort.

Number two, I want to focus on weatherization and I can't thank your committee and subcommittees enough for recently approving H.R. 2041, Representative Tonko's Weatherization Enhancement and Local Energy Efficiency Investment and Accountability Act.

The Department of Energy's Weatherization program has a direct positive impact on the lives of everyday Americans, and it is a great training ground for people going into the various specialty sectors in the building trades as well, particularly drawing in low-income Americans, spanning all 50 states, our territories and our Native American tribes.

H.R. 2041 expands flexibility for the program and creates new opportunities to innovate, and I hope to work with your committee to ensure we can get a floor vote on the weatherization reauthorization.

In addition, I hope that we can work together to add language to encourage initiatives that encompass neighborhood scale weath-

erization. I think we have to tiptoe our way into that one, but the innovation fund encourages innovative roofing, energy efficiency, and new outreach and assistance programs, and I would like to provide slightly more clarity to the Department of Energy on this front.

This is an older program that operates well. The states are fully engaged and I think we can give them a hand up by augmenting that particular language in the bill. Specifically, the legislation I believe should include within innovative outreach, a neighborhood scale weatherization.

At the ground level, the community action agencies work seamlessly between various federal programs and I am on a mission to ensure that other federal agencies, including HUD, the Department of Health and Human Services, and the Veterans Department collaborate with the Department of Energy to ensure that these programs work together more seamlessly for maximum impact at the neighborhood level.

And finally, on energy efficiency at drinking water and waste water treatment plants, the largest segment of most cities' and large regions' electric bills—power bills come from their having to provide their drinking water and wastewater treatment facilities with the—with the regular power.

We have important work to do in making our wastewater and drinking water facilities more energy efficient. In many cities as much as 30 to 40 percent of their entire power bill attends to operating those facilities.

On behalf of ratepayers, consumers, and the general public, we have an opportunity to help our country immensely by reducing energy usage at these facilities.

Both EPA Green Project Reserve and DOE's Office of Energy Efficiency and Renewable Energy have a major role to play. We need to focus that a bit.

I am glad to see the Energy and Commerce Committee is continuing to take decisive action to improve the lives of the American people across our nation and I want to thank you for the opportunity to highlight some of these issues of concern to our committee and want to thank again the chairman and ranking member for the opportunity to testify.

[The prepared statement of Ms. Kaptur follows:]

PREPARED STATEMENT OF HON. MARCY KAPTUR

Colleagues, thank you for the opportunity to address you this afternoon. As chair of the Energy and Water Appropriations Subcommittee, I deeply value the collaborative relationship between our two subcommittees. We can accomplish so much together. In addition, I will highlight several priorities that relate to the Health Subcommittee.

The Energy and Commerce Committee was extremely active last week in several areas of overlapping jurisdiction.

A. Workforce Development

I applaud Chairman Rush and the committee for your attention to the workforce development and pipeline issues at DOE. Last week, you approved H.R. 1315, the Blue Collar to Green Collar Jobs Development Act of 2019. In March, my committee also held a workforce development hearing.

As you know, we have a pipeline and workforce development crisis in the energy and nuclear security industries, both at the Department of Energy and in the private sector. According to the Energy and Employment Report for 2018, roughly 12

percent of today's energy workforce is eligible to retire and 70 percent of energy industry employers reported hiring difficulty.

DOE must be more proactive about recruiting and training a new generation of innovators because our country needs to compete in a new world economic order.

B. Weatherization

This committee recently approved H.R. 2041, Rep. Tonko's Weatherization Enhancement and Local Energy Efficiency Investment and Accountability Act.

DOE's Weatherization program has a direct, positive impact on the lives of every day Americans, particularly low-income Americans, spanning all 50 states, U.S. territories, and Native American Tribes.

H.R. 2041 expands flexibility for the program and creates new opportunities to innovate. I hope to work with you to ensure we can get a floor vote on the weatherization reauthorization. In addition, I hope that we can work together to add a tweak to add what I call "neighborhood scale" weatherization. The innovation fund encourages innovative roofing, energy efficiency, and new outreach and assistance programs and I would like to provide slightly more clarity to DOE on this front.

Specifically, the legislation should include within innovative outreach, "neighborhood scale" weatherization. At the ground, the community action agencies work seamlessly between federal programs. I am on a mission to ensure that other federal agencies, including HUD, HHS, and the VA collaborate to ensure that these programs work together.

But, DOE can also be a focal point for innovation. We must think about weatherization eligible individuals as part of a larger pool of people, and take a neighborhood scale approach to ensure mobile homes, multi-family units, or neighborhoods participate in the weatherization program. These communities are yearning to participate in the weatherization program but just need a small lift from DOE and the community partners.

The needs of our nation are evolving, and with neighborhood scale weatherization, we can connect multiple units with integrated solar, geothermal, community scale wind, and achieve efficiency of scale by ensuring groups of individuals are enrolled in the weatherization program together.

C. Energy Efficiency at Drinking and Wastewater Treatment Facilities

We also have important work to do in making our waste and drinking water facilities more energy efficient. Drinking and Wastewater facilities are one of the largest industrial users of electricity. On behalf of ratepayers, consumers, and the general public, we have an opportunity to help our country by reducing energy usage at these facilities. Both EPA and DOE have role to play.

The State Revolving Loan Fund can and must do better. The Green Project Reserve (GPR) sets aside 10% of the SRF to energy efficiency and green infrastructure. But the states have not been given adequate direction about how to utilize the set aside. The Green Project Reserve is misunderstood, undersubscribed and does not serve its purpose. I am working on a legislative solution and hope to work together with the environment subcommittee with jurisdiction over the Safe Drinking Water Act.

DOE provides technical assistance to drinking and wastewater facility operators to help them determine what types of energy efficiency measures would work best in specific plants and provides them a path to realize those savings. DOE's research and development programs, such as those within the Office of Energy Efficiency and Renewable Energy, help develop the next generation of efficiency technologies.

Congress must examine the SRF and chart out a path to ensure that federal dollars put aside for green projects are being used for their intended purpose.

D. Drug Pricing

I've discussed some of my energy priorities, and it is also important to recognize the value of energy and its role in keeping the American public healthy—especially after the blazing summer heat last weekend. I would like to address a couple of my priorities within the Health Subcommittee's jurisdiction as well.

The current state of play in drug pricing involves the corporate consolidation of Big Pharma and company monopolies which have created a closed market—where not even capitalism can breathe. Fundamental to capitalism is competition in the marketplace. From patent thicketing to the stalling and prevention of generics from entering the market for consumers, the unfair business practices of Big Pharma have allowed greed to overtake innovation.

I appreciate the Energy and Commerce Committee's work on pay for delay, which takes an important first step—but there's more work to be done. The legislative framework Big Pharma has enjoyed for too long must be reformed. Finding cures

for diseases should not involve various entities being rewarded by inflated prices at the expense of patients inability to afford lifesaving medicine.

I come before you today as an advocate for thousands of my constituents in Ohio's 9th congressional district who are struggling to afford their prescription medicine. In recent months I have been hearing alarming concerns from seniors, patients and families in my district who are rationing their prescription drugs and making life-altering decisions because the cost of their medicine continues to rise. I am glad the committee has held public hearings on the matter and is taking steps to address this crisis.

Recent data has shown that the price of pharmaceuticals continues to rise. Politico reported in the first six months of 2019, prescription drug prices for over 3,400 drugs rose by an average of 10.5 percent—outpacing the rate of inflation four times. Congressional rhetoric alone will not force companies to engage in moral business standards, which is why we must enact stronger backstops into law to protect patients from industry's predatory practices. The American public is relying on us to bring down the costs of pharmaceuticals, and the time to act is now. I appreciate many of the ideas Reps. Doggett and Schakowsky have proposed, and encourage action on H.R. 1046 the Medicare Negotiation and Competitive Licensing Act of 2019. We must continue to urge fair market competition to lower healthcare costs, and allow Medicare to negotiate prescription drug prices in a similar manner as the Veterans Administration.

E. Opioids

Not only are we witnessing pharmaceutical companies price gouge consumers, Big Pharma has fueled and exacerbated our nation's deadly opioid epidemic. According to the Ohio Health Department, from 2000 to 2017, Ohio's death rate due to unintentional drug poisonings increased by over 1,000 percent. This is absolutely devastating, and just last week, federal prosecutors in our state filed criminal charges against an opioid distributor and two of their former executives. These bad actors must be held accountable.

Additional data released by the Washington Post last week has shed more light into the destruction unleashed on our communities. Between 2006 and 2012, the nation's top pharmaceutical companies distributed 76 billion oxycodone and hydrocodone pills, according to evidence from the largest civil action in U.S. history—and with six distributors dispersed 75 percent of the opioids, we know pharmacies also share some blame in worsening the crisis.

The opioid epidemic has ravaged too many families and neighborhoods, and the Energy and Commerce Committee has crucial jurisdiction in reigning this in. In addition to the Health Subcommittee, the Oversight and Investigations Subcommittee also has a key role in ensuring drug companies are held accountable.

May our federal courts too, in Cleveland, bring justice for the victims and cities who have been devastated by opioids, and may we work to find ways to break up corporate consolidation in healthcare.

I can see the Energy and Commerce Committee is continuing its tradition as a legislative powerhouse. I do not pretend to have all the answers but I hope to work with you to help find solutions together. I want to again thank the committee for the opportunity to testify and I hope my colleagues will consider the issues I have discussed with you today before both the Energy and Health Subcommittees. Thank you for your time.

Mr. PALLONE. I want to thank the gentlewoman, you know, for continuing to work with us on common issues between your subcommittee and our committee.

The energy weatherization package that we did pass out of committee, we expect to bring that up fairly quickly on the floor, you know, when we come back in September.

I know we are running out of time, but you had mentioned to me about an initiative that was similar to the service academies but you didn't get into it.

What was that idea again?

Ms. KAPTUR. Well, I'll tell you, I am getting frustrated in going around to our national labs and—

Mr. PALLONE. Oh, it was on the labs. Right.

Ms. KAPTUR [continuing]. And looking at the—also the private sector that comes into the labs, and listening to what they are say-

ing to me about the lack of talent from our country that is available to hire.

You know that in many—in most of our labs we must hire American citizens to do work and——

Mr. PALLONE. So you wanted to do something like the service academies with the labs, right?

Ms. KAPTUR. I have been thinking about a model, and, again, I don't have it all thought out. But I know how much our office is involved as I am sure yours are.

Every year we select a certain number of individuals and we nominate them for West Point, Annapolis, the Air Force, the Coast Guard, the Merchant Marines, and we work with the Department of Defense on that.

And we have—I am on the Defense Subcommittee—we every year have the heads of these academies come before us and we have a very aggressive recruitment, and I believe we need to do the same in terms of the STEM fields for these jobs.

We simply do not have enough people coming in to the nuclear power industry, for example, and I was with—I went to one of the lab showcases here on the Hill yesterday. We are talking about thousands of jobs that are unfilled that must be filled by American citizens. And I don't have the magic answer. I am not the authorizing——

Mr. PALLONE. Well, get back to us. Yes.

Ms. KAPTUR. I am not the authorizing committee. But I would love to explore with you a better model——

Mr. PALLONE. Please.

Ms. KAPTUR [continuing]. To the Department of Energy into more aggressive recruitment. Maybe we work with the labs. Maybe my subcommittee has to provide money that would provide for the education of these individuals.

Many who go into electrical engineering by the time they get to the junior year they go, yes, I can make more money in business; why should I be going into debt, you know, to go into electrical engineering. I represent——

Mr. PALLONE. Well, get to back to us and we will work on an initiative, all right?

Mrs. KAPTUR. Thank you, Mr. Chairman. Thank you very much for your openness to that.

Mr. PALLONE. Mr. Upton?

Mr. UPTON. I just want to say thanks for being here. As you know, these bills that you reference—workforce development, particularly, on weatherization—they were strongly bipartisan.

I will tell you in advance that we did raise the authorization levels higher than they have been before. So you are now in a perfect position to fit that within your subcommittee along with nuclear waste.

So I look forward to working with you on that as you come back to us in September on the floor.

I yield back.

Ms. KAPTUR. Thank you, Ranking Member Upton. Thank you so much.

Mr. PALLONE. All right. Thanks a lot.

Ms. KAPTUR. Just for the record, this year we were able in the House with bipartisan support to move the appropriated level for the weatherization program from about \$254 million to \$290 million, and I don't know what the Senate is going to do, obviously, but we are serious about aggressively modernizing this program.

It has a terrific track record in the states and we can do so much more, and if I could just move on a side road just a second here.

Yesterday, again, in going to a weatherization display here yesterday from many, many communities, it became clear that the workforce development pathway from these various weatherization programs so people can get training and go into the various trades is not so streamlined, and I am very interested in how to use these weatherization programs to identify talented people around the country who can be skilled up to do jobs that are needed in every single trade, craft, around this country, and I think this can be one of the feeder programs if we are more focused on it.

Mr. PALLONE. All right. Thanks a lot.

You should know that she—Mr. Rush, she started out by praising you, just so you know.

Mr. RUSH. Well, thank you so very much for praise. I have to give someone the credit for all that she said to her and she is my neighbor in terms of where our offices are located. She has been my co-collaborator for a number of years on many policy issues.

She has been my co-conspirator. We have been conspiring in the interests of leadership on many occasions. She has really been a spiritual ally of mine on so many, many occasions and she has come into my—seeing my district on many occasions because, you know, in Chicago the largest community of Polish American citizens are located in Chicago. So she has been such an eminent friend of mine and been such a wonderful, wonderful, and true friend.

So I really want to welcome her here before us. I want to also say that in regard to weatherization, one of the amendments that we passed in the bills that we just marked up and passed out of the full committee amends weatherization programs to allow for training of community residents that—in the local areas that weatherization dollars are being spent and they are mandated to hire—to train and hire community-based residents for those programs. So it is line with the spirit of what you have been discussing.

And you mentioned the workforce development area, and we, thanks to—in a bipartisan way, thanks to our eminent ranking member on the Energy Committee, Mr. Upton, we have and under the leadership of Chairman Pallone and the ranking member, we have been able to come up with some significant legislation as it relates to workforce development.

We call it the green jobs and—blue and green jobs, and this would impact those out-of-work coal miners, minorities, women and veterans. It is a real, real world comprehensive bill that would try to amp up our workforce in the energy sector.

And so I am just excited to work with you and with the others as we embark on this space of using National Labs and others, the Department of Energy and other programs to really create opportunities for Americans who need work, quality work, fulfilling work,

and need to have a living wage while they are working and be able to take care of their families.

So but your spirit permeates a lot of what we do, and so I am just so pleased to have you with us. I am pleased to be your friend. I recall some years ago when you and I created a conference—Jobs Now conference—you know, the Jobs Now conference, which was way out in front of all of these things that we are discussing.

So, again, thank you for your stellar work and for your involvement.

Mr. PALLONE. Thank you. Thanks, Bobby.

I saw that you got—I knew when you mention anything about nuclear that Mr. Shimkus was going to get all energized here. So I will recognize the gentleman from Indiana.

Mr. SHIMKUS. Thank you, Mr. Chairman. I will be brief. I appreciate all my colleagues being here and as the Chairman Kaptur knows, I attended her Member Day and she knows, as I know, that there are 39 states, 121 locations.

We have a law—an authorization law on the book that the appropriators failed to fund. Bipartisan failure to fund. As we talk about the Green New Deal or the chairman's zero in 2050, nuclear has to be part of that portfolio.

It is only going to be around here longer and we have to address the waste. So I would just respectfully plead with the chairman to help us do this because we need to comply with the law and we need to finalize this so for the 39 states and the 121 locations at—in places.

Like I know John from Chicago Land. I know Levin's in the back row. We have got these places on major waterways, lakes, streams and in environmental sensitive areas—that I am just pleading with the appropriators to help us do the right thing and follow the law.

With that, Mr. Chairman, I will yield back.

Mr. PALLONE. Thank you.

As you can see, Marcy, you created a lot of interest here, needless to say. So——

[Laughter.]

Ms. KAPTUR. Well, Mr. Chairman, if I could just say to, first, Mr. Shimkus, believe me, we have heard you. We have heard you. I represent a state that has several power plants that have waste on site.

So I—and Ohio just passed special legislation to allow those plants to continue in operation. Other states have chosen other options. We have a serious challenge in the nuclear industry in this country.

I honestly believe it should not have been bucked to the states. I think there should have been a federal financing solution. It was not done by this administration and shame on them, and so the states have had to struggle.

So I share your concern about nuclear. I understand what you are saying about the waste. I hope to be someone that contributes to a real solution here that is both practically—practical from an engineering stand but also politically realizable, and I think we have to keep pushing. No one has been a stronger advocate than you have and we welcome you any time before our subcommittee as we struggle with this very, very important issue.

So you have been heard and I admire your work. I want to say to Congressman Rush also you are my Great Lakes buddy. You are my great, great friend and advisor from the city of Chicago, which needs our attention, but also across the country where the needs of those whose voices here are limited, and I reciprocate the admiration.

Mr. PALLONE. Thank you.

Ms. KAPTUR. Thank you, and Congressman Tonko I also complimented before your arrival today and mentioned the bill that you worked so very hard on along with Congressman Rush, and I thank you for your leadership in moving this forward.

And thank you, Mr. Chairman—

Mr. PALLONE. Thank you. Thank you, Chairwoman. Appreciate your being here and all that you said.

Now I have to say we are half an hour late and I don't want to keep holding everybody up. So what we may do is go back to what we were supposed to do and not even ask questions or make any comments at all.

So I may just go through the next five or six and ask everybody not to even comment on what you say, which I hate to do, but otherwise we are never going to get through it.

So next is the gentleman from Illinois, Mr. Casten. Although I do have to say he is a Middlebury graduate.

[Laughter.]

OPENING STATEMENT OF HON. SEAN CASTEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. CASTEN. Thank you, Chairman. I will do my best to be very boring.

Chairman Pallone, Chairman Tonko, the members of the committee, I want to, you know, first really thank you for giving us an opportunity today to share the thoughts on—as you think about your priorities this Congress.

Chairman Tonko, your subcommittee, I would submit to you, is the most important subcommittee in Congress right now. The work that we do in this Congress is going to be pivotal to determining whether or not we survive as a species. I do not say that lightly.

The climate crisis is existential. I greatly appreciate your leadership, Chairman Pallone's leadership, in addressing this crisis head on. I have been encouraged by your work to hold this administration and the EPA accountable for upholding existing climate policies, including CAFE standards.

I thank Chairman Tonko for his work developing the climate principles this past week, which is an integral first step towards finding consensus within our own caucus and across the chamber, and I believe the document lays out many important ideas currently missing from our conversations regarding climate policy.

If we are going to address the climate crisis, we have to acknowledge a couple facts that may be politically difficult, but that doesn't mean we can duck them.

First is that the climate crisis is urgent. We do not have time to debate settled science any more than we have time to debate gravity. It is real. It is now.

Every day that we fail to act the consequences of our inaction become more costly and more dire. History is going to judge us not by how we message to our political base but how we rose to this challenge.

However, that does not mean that the necessary changes in our energy and environmental policy are going to be simple. Our standard of living, our economy, our social safety nets, and our government itself depends on energy access.

It is the height of naivete to assume that the changes we have to make are going to have simple little fixes. We can't allow ourselves to be deluded into thinking that just because the problem is urgent any problem will—any solution will suffice.

If we ignore the urgency it is suicide. If we ignore the complexity it is irresponsible. So we have to account for both. We can't just issue edicts from on high. We also can't shy away from expertise.

We cannot act with the purpose of scoring easy political points. That may feel good, but we do at our own peril. The urgency of the crisis demands we act with serious determination and in a measured and deliberative manner that is not inconsistent with urgency.

So if I can only persuade you to do one thing today, please unleash the nerds. Those nerd-driven solutions may not be exciting. They may not be sexy. They may not have a great little sound bit around them.

They may not make prime time news headlines and many of the solutions are in fact already known. A lot of them are low-hanging fruit we could enact tomorrow.

That is a good thing. It is a great opportunity. Some of the solutions would build on policies that are already working. CAFE standards have helped increase the average fuel economy of our light-duty vehicle fleet.

I hope this committee could encourage policies like a feebates program that could build on this success by rewarding consumers who buy more efficient, cleaner vehicles.

The committee should also consider complementary policies to help get less efficient vehicles off the road. Many, many years ago when I did some work for California, we found that the single most cost effective they could do was just pay everybody with an old Dodge Dart \$10,000.

[Laughter.]

Mr. CASTEN. We can get those clunkers off the road and make a big difference.

Other climate policies have broad bipartisan support. I think members of both parties have agreed that we should prioritize the deployment and development of grid-scale energy storage technologies. Those technologies will not only lower electricity costs for consumers but make our grid more resilient and efficient while lowering greenhouse gas emissions.

That is why I was proud to sponsor H.R. 2909, the bipartisan and bicameral Promoting Grid Storage Act, alongside many members of the Energy and Commerce Committee, and I'd urge this committee to take up and pass the measure.

There are other solutions that require that we look back at existing laws with renewed scrutiny for how they worked in practice.

The Federal Power Act, for instance, makes it clear that FERC should ensure that electricity rates are just and reasonable, and yet rates across the country fail to account for the cost of carbon pollution.

FERC has been hesitant to address that massive externality because some there believe they do not have the authority. I disagree. I don't think it's what Congress intended.

I think the deregulation of energy markets did not mean that we still don't have social obligations to set prices that account for externalities and we need to say so and we need to say so loudly.

Now, to be clear, economy wide measures need to be taken to address the full scope of the issue and these policies should be technology neutral.

They need to put the goal of reducing CO2 above the path of how we get there and they need to embrace climate action as a once in a generation investment opportunity.

I have spent 20 years in the clean energy space. I have built over 80 projects in 30 different states. Every single project that I built lowered CO2 emissions and saved money. With one exception, none of my clients ever did those projects because they were as passionate about climate change as I was. They were greedy.

In Washington, to invest—I have invested about \$300 million. If we view that from the lens of Washington that is a cost we have to score and figure out how to pay for.

Outside of Washington, that is an investment opportunity. Let us embrace it as that investment opportunity.

Let us use this to goad the economy, and to be sure, not all these solutions are within the jurisdiction of your subcommittee or even the broader committee.

But each illustrates the kind of task we need to be willing to take on if we are going to address the climate crisis. The task is urgent. The task is complicated and I hope the committee will consider some of the proposals I have mentioned here today along with about 3,000 others that I am working on.

And I look forward to working with any and all of you in any way I can to help combat this crisis. Thank you again for having me today and thank you so much for your leadership.

[The prepared statement of Mr. Casten follows:]

PREPARED STATEMENT OF HON. SEAN CASTEN

Chairman Tonko, Chairman Pallone, members of the committee, thank you for providing members the opportunity to share our thoughts on the work of this subcommittee as you consider your priorities this Congress. This subcommittee has perhaps a more important role than almost any other. The work this Subcommittee does this Congress will be pivotal in addressing the greatest existential threat to life on Earth, the climate crisis.

I appreciate your leadership and dedication in addressing this crisis head-on. I have been encouraged by the Committee's work to hold this administration and the EPA accountable for upholding existing climate policies, including the CAFE Standards. I also thank Chairman Tonko for his work developing his climate principles—an integral first step toward finding consensus within our caucus and across this chamber and I believe the document lays out many important ideas currently missing from conversations regarding climate policy.

If we are going to address the climate crisis, we must acknowledge certain facts that are politically difficult, but that must guide the course of action we take.

The first is that the climate crisis is an urgent one. Regardless of what many of my colleagues may think, we do not have time to debate settled science, and we can-

not avoid this issue. The climate crisis is here. The climate crisis is now. And every day we fail to act, the consequences of our inaction become more costly and more dire. Future generations of Americans, and those from across the globe, will remember how each of us responded now. It is up to us to put aside partisan disagreements and act as quickly as this body can possibly act.

But that does not mean that the problem at hand is not a complex one. It is. And it requires a complex solution. Any actions we take to address the climate crisis that is not predicated on this fact, will not be successful in the long run. We cannot allow ourselves to become deluded into thinking that because the problem is urgent, any action will solve the problem.

We cannot simply issue edicts from on high. We cannot shy away from expertise. And we cannot act with the purpose of scoring easy political points. These things may make us feel good but do so at our own peril. The urgency of this crisis demands we act with seriousness, determination, and in a measured and deliberative manner. In essence, to best address the climate crisis, I'd urge this committee to unleash the nerds.

This also means that the solutions to the climate crisis may not be exciting, sexy, or ready-made for primetime news headlines. Many of the solutions are already known. And many solutions are low-hanging fruit that we could enact tomorrow. But that's a good thing and a great opportunity.

Some of these solutions build upon policies that are already working. For example, while CAFE Standards have helped increase the average fuel economy of our light-duty vehicle fleet, this committee should consider other policies like a feebates program that could build upon this success by rewarding consumers who buy more efficient, cleaner vehicles. The committee should also consider complementary policies to help get less efficient vehicles off the road—such as a cash for clunkers program.

Other climate policies have broad bipartisan support. For instance, members of both parties have agreed that we should prioritize the deployment and development of grid-scale energy storage technologies. These technologies will not only lower electricity costs for consumers but will make our grid more resilient and efficient, all while lowering greenhouse gas emissions. That is why I was proud to introduce H.R. 2909, the bipartisan and bicameral Promoting Grid Storage Act, alongside many members of the Energy and Commerce Committee. I'd urge the committee to take up and pass this measure.

Other solutions require we look back at existing laws with renewed scrutiny for how they have worked in practice. The Federal Power Act, for instance, makes clear that FERC should ensure that electricity rates are just and reasonable—and yet rates across the country fail to account for the devastating impacts and high costs of carbon pollution. While FERC has been hesitant to act to address this massive externality because some there believe they do not have the authority. This cannot be what Congress intended. And we should say so. Loudly.

Of course, economy-wide measures should be undertaken to address the full scope of this issue. Preferably, these policies will embrace the principle of technology-neutrality and will resist the well-intentioned but misplaced dual urges to either craft a plan that pleases all but does little or the urge to reject any good plan in search of perfection. We cannot wait for perfect. We cannot please everyone. We need climate action. We need it now.

Not all of the solutions I have mentioned today fall solely within the jurisdiction of this subcommittee or even the Energy and Commerce Committee as a whole. Yet, each illustrates the kinds of tasks we must be willing to take on if we are going to address the climate crisis. This task is urgent. This task is complex.

I hope the committee will consider some of the proposals I have mentioned here today. And I look forward to working with any of you in any way I can to combat this crisis. Chairman Tonko, thank you again for having me here today and thank you all for your leadership.

Mr. PALLONE. Thank you, Mr. Casten.

It's hard for me not to ask you questions because you raised a lot of points but I've got to move on. So thanks again. Appreciate it.

Now, the way that—the way this is set up Ms. Slotkin should be next. But I am told, Mr. Levin, you have a markup that is occurring right now?

Mr. LEVIN OF CALIFORNIA. Yes, sir.

Mr. PALLONE. Would you mind, Ms. Slotkin, if we let him go back to his markup and then we will go to you? It's OK? All right. Go ahead, Mr. Levin.

OPENING STATEMENT OF HON. MIKE LEVIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. MIKE LEVIN. Thank you, Mr. Chairman. I very much appreciate the opportunity to be here. Thank you to all my colleagues and friends who are on this committee. Some of the top priorities that I hear about from my constituents in southern California are issues that come before this committee so I am grateful for the opportunity to raise their voices here today.

One of those priorities that I hear about from my constituents is the need to move the spent nuclear fuel in our district at the San Onofre Nuclear Generating Station to a site that is not surrounded by millions of people, threatened by sea level rise, and located near active earthquake faults.

It's critical that the Federal Government establish a consolidated interim storage, or CIS, facility for this waste and other spent nuclear fuel across the country.

I strongly endorse Congresswoman Matsui's Store Nuclear Fuel Act, which would authorize the Department of Energy to take title to spent nuclear fuel in order to store it at a CIS facility.

I have also introduced common sense legislation that would prioritize sites like San Onofre that are in locations with high population density and high seismic risk.

My constituents are concerned for their safety and it is long past time that we start moving this waste to a safer location. I urge the committee to prioritize this pressing issue and I thank my colleagues who are equally concerned.

Another issue that I hear about from my constituents is the climate crisis and we need to take aggressive action that is commensurate with the scale of the challenge we face.

The science is clear. Climate change will have increasingly devastating effects on our planet if we do not make significant changes to the way we live.

I am grateful to Chairman Pallone and my friend, Chairman Tonko, for your continued leadership on this issue and I look forward to working with you for a long time to come.

I am also proud to have introduced legislation that presents an ambitious plan for transitioning auto sales in the United States to zero emissions.

We have got to position the United States to lead the world in clean energy and that includes clean vehicles. I encourage all of my colleagues to support the Zero Emission Vehicles Act of 2019.

I stand ready to work with anyone on either side of the aisle who is serious about combating the climate crisis and I look forward to supporting climate legislation that comes from this committee and I am very grateful for all the work that you are doing.

Lastly, I hear from constituents often about the need to lower healthcare costs and expand access to affordable care that covers people with preexisting conditions.

Nobody I talk to supports this administration's efforts in the courts to destroy the Affordable Care Act and rip insurance from millions of families.

Thank you to Chairs Pallone and Eshoo for working to defend the Affordable Care Act and lower drug prices. I believe that as we defend the ACA we must also work together to improve our healthcare system to achieve universal coverage.

We must also do more to address the substance abuse crisis plaguing our country and that must include measures to address problems with the addiction, treatment, and recovery system.

Many facilities do amazing work but there are outliers that do not. It's abhorrent that some treatment centers and recovery housing operators engage in bad practices at the expense of vulnerable patients and residents.

This includes deceptive marketing techniques, depriving individuals of needed medication, failing to monitor those who are suicidal or in withdrawal, and evicting vulnerable residents out on the street.

I hope this committee will join me in closely monitoring the development of recovery housing guidelines at the Substance Abuse and Mental Health Administration to ensure a robust framework.

Additionally, as the committee considers legislation regarding substance abuse disorder, I hope that you will consider ways that we can assist states in their enforcement efforts with an eye towards stronger oversight and accountability so that those in need actually receive the help they deserve and are not taken advantage of.

I appreciate the amazing work of this committee in tackling a wide range of issues—the widest range of any committee—and I thank all of my colleagues for their dedication to address the challenges that I've highlighted today.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Mike Levin of California follows:]

PREPARED STATEMENT OF HON. MIKE LEVIN

Thank you, Chairman Pallone, for the opportunity to testify today. Some of the top priorities that I hear about from my constituents in Southern California are issues that come before this committee, so I am grateful for the opportunity to raise their voices here today.

One of those priorities that I hear about from my constituents is the need to move the spent nuclear fuel at the San Onofre Nuclear Generating Station to a site that is not surrounded by millions of people, threatened by sea level rise, and located near active earthquake faults. It is critical that the Federal Government establish consolidated interim storage, or CIS, facilities for this waste and other spent nuclear fuel across the country. I strongly endorse Congresswoman Matsui's STORE Nuclear Fuel Act, which would authorize the Department of Energy to take title to spent nuclear fuel in order to store it at a CIS facility. I have also introduced common sense legislation that would prioritize sites like San Onofre that are in locations with high population density and high seismic risk. My constituents are concerned for their safety, and it is long past time that we start moving this waste to a safer location. I urge the committee to prioritize this pressing issue.

Another issue that I hear about from my constituents is the climate crisis, and our need to take aggressive action that is commensurate with the scale of the challenge we face. The science is clear: climate change will have increasingly devastating effects on our planet if we do not make significant changes to the way we live. I am grateful to Chairman Pallone and Congressman Tonko for your leadership on this crisis, and I look forward to working with you on this issue. I am proud to have introduced legislation that presents an ambitious plan for transitioning auto

sales in the United States to zero-emission vehicles. We must position the United States to lead the world in clean vehicle innovation. I urge all of my colleagues to support the Zero-Emission Vehicles Act of 2019. I stand ready to work with anyone who is serious about combating the climate crisis on either side of the aisle, and I look forward to supporting climate legislation that this committee considers.

Lastly, I hear from constituents often about the need to lower healthcare costs and expand access to affordable care that covers people with pre-existing conditions. Nobody I talk to supports this Administration's efforts in the courts to destroy the Affordable Care Act and rip insurance from millions of families. Thank you to Chairs Pallone and Eshoo for working to defend the Affordable Care Act and lower drug prices. I believe that as we defend the ACA, we must also work together to improve our healthcare system to achieve universal coverage.

We must also do more to address the substance abuse crisis plaguing our country, and that must include measures to address problems with the addiction treatment and recovery system. Many facilities do amazing work, but there are outliers that do not. It is abhorrent that some treatment centers and recovery housing operators engage in bad practices at the expense of vulnerable patients and residents. This includes deceptive marketing techniques, depriving individuals of needed medication, failing to monitor those who are suicidal or in withdrawal, and evicting vulnerable residents out on the street. I hope this committee will join me in closely monitoring the development of recovery housing guidelines at the Substance Abuse and Mental Health Administration to ensure a robust framework. Additionally, as the committee considers legislation regarding substance abuse disorder, I hope that it will consider ways we can assist states in their enforcement efforts with an eye towards stronger oversight and accountability so that those in need actually receive the help they deserve and are not taken advantage of.

I appreciate the amazing work of this committee in tackling a wide range of issues, and I thank all of my colleagues for their dedication to addressing the challenges I've highlighted today.

Mr. PALLONE. Thank you. And, again, I would like to ask you some questions but we are running out of time. So thanks for coming.

Thank you, Ms. Slotkin, for bearing with us.

Mr. BURGESS. Mr. Chairman?

Mr. Chairman, may I just say something on the—on the recovery centers? Because it is important and we spent some time on that, as you know, in the last Congress in developing the SUPPORT Act.

And I do think that is important and, of course, we had really an oversight but it was a hearing on the implementation of CURES because we had a large mental health title in the CURES initiative and we had SAMHSA here. Unfortunately, that hearing kind of got sidetracked on some other issues.

But I would just agree that that is an important topic and we should be in the lead on that and asking SAMHSA what is the—what is the current state of—in the Oversight and Investigations Subcommittee we heard some really tough stories about some of the things that were happening in the recovery centers.

We need to be on top of that. We are pumping a lot of money into that. A lot of grants are being made available. We need to make sure we are not hurting people in the process.

Mr. PALLONE. Thank you. Thank you, Dr. Burgess, and thank you, Mike.

Ms. Slotkin?

OPENING STATEMENT OF HON. ELISSA SLOTKIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Ms. SLOTKIN. Thank you, Chairman Pallone and Ranking Member, for the opportunity to testify today on something that is a scourge. I know we are all dealing with it—robocalls.

If you are like me and like most Michiganders, you hate these calls and whether you're a Democrat, a Republican, and Independent, I think they drive everybody equally crazy.

Everyone has a story about robocalls. I have two. They both relate to the same time period right after I got elected. I went in to meet one of the mayors of our towns, Rochester, Michigan—a wonderful guy named Rob Ray—and it was our first in call and I thought—I wasn't even sworn in—I thought he was going to tell me about all the grants he needs and all the information he wanted and I was ready for a bunch of asks.

And I said, you know, if I could do one thing when I go to Congress what would it be, and he said stop the dang robocalls. And then I came to Congress and I was given a cell phone, right. We are all given phones when we become Members of Congress.

I cannot answer that phone because I am constantly getting robocalls. So I'll see a number. I am sure, like most people here, you'll see a number. It's pretty similar to your number. You think is that someone calling with something important—congressional business. I cannot answer my phone. Let it all go to Voicemail because of the robocalls.

So I am particularly energized on this issue. Let me just give you some specifics. Michigan last year alone we had 1.2 billion robocalls made to us. Maybe because we are a swing state it's even worse. We are estimating that already this year 784 million robocalls have been made. It is getting worse.

A year ago we were—we were at a certain terrible number. We are now up 143 percent in one year, and it's important to note that it isn't just an annoyance that we all share.

Most of these calls are calling with some sort of scam, right. They are looking for your money. They are looking to lure you into something. Americans lost about \$10.5 billion due to robocall scams last year. They prey on the most vulnerable, particularly the elderly.

We know that they use the number spoofing so it looks really close to your number. You think it's someone calling from your neighborhood, someone calling who knows you. But it does cause serious problems in our communities and many people are like me. They don't—actually don't answer the calls anymore.

So if something came in—a hospital, some emergency happened—how many of us would let that call go to voicemail? And I just—I think it's—it is pesky but it also is important.

So the good news is I co-sponsored the Stopping Bad Robocalls Act. It was a bill that was introduced in this committee and I co-sponsored it. It passed the House yesterday. I am thrilled about that.

It is a really important first step to stemming the scourge of robocalls. I am really hoping the Senate takes it up but I would

urge your help in making sure that in this day and age some of these things that are very bipartisan actually get through.

Please keep your foot on the gas on this. And I know there is a number of pending pieces of legislation you're also looking at around these issues. I urge you to take them up.

This is something that affects all of our constituents in their daily lives. In an era when sometimes people feel like government can't get anything done, I think this would be a huge positive step that we are actually still working up here. So thank you very much, Mr. Chairman.

[The prepared statement of Ms. Slotkin follows:]

PREPARED STATEMENT OF HON. ELISSA SLOTKIN

Thank you Mr. Pallone for the opportunity to testify before you today.

Mr. Pallone, if you're like me, and if you're like most Michiganders, you hate getting robocalls.

Certainly in Michigan, whether you're a Democrat or Republican, this is an issue that unites us all in shared frustration.

In fact, shortly after I was elected, I had a meeting with a local, Republican mayor in our district, and asked him what was one thing I should be sure to work on in Congress.

I expected him to talk about a particular grant, or maybe roads or water—but he said, “robocalls,” and we spent a long time that day talking about just how pervasive this issue is in our community, and what Congress can do it about.

Let me tell you a bit about how this issue is affecting us in Michigan specifically: Last year alone, an estimated 1.2 billion robocalls were made to people who live in Michigan. Experts are estimating that, already in 2019 Michiganders have already received over 784 million robocalls.

It feels like they're getting worse—and they are: the number of robocalls in Michigan has already gone up 143% since this time last year.

It's important to note that this problem is more than just a daily annoyance—these calls are scamming consumers out of their money and stealing personal information.

Americans lost an estimated \$10.5 billion dollars this year due to robocall scams. These scammers prey on the most vulnerable among us, particularly seniors.

We also know that scammers use “number spoofing” to make it look like they're calling from a local number.

This causes serious problems in our communities as people have begun ignoring calls they don't recognize from their same area code.

This can have serious ramifications when you think about healthcare professionals, business-owners, parents,

Clearly, this problem is pervasive and serious. Everywhere I go in Michigan's 8th district, I get the question, “by the way, is there anything you can do about those pesky robocalls?”

The good news is that we can.

I was proud to see the Stopping Bad Robocalls Act, a bill that was introduced in this committee and which I co-sponsored, pass in the House yesterday.

This bill is a really important first step to stemming the scourge of robocalls, and I sincerely hope the Senate takes it up.

And I am here today to say: let's keep our foot on the gas. I want to encourage this committee to take up the pending legislation you are considering on this topic, so that we can put an end to these bothersome and threatening robocalls.

This is an issue that has broad bipartisan support, and directly responds to a pervasive issue that affects our constituents' daily lives.

That is our duty as Members of Congress, and I'm glad that we get to do it on an issue where there is such strong demand from our constituents.

Thank you.

Mr. PALLONE. And I appreciate your emphasis on the robocalls bill that passed yesterday. We will keep our foot on the gas. There is a Senate equivalent. It's not exactly the same.

But we are working with the Senate and we think we can get this done. So thanks so much. Appreciate it.

Ms. SLOTKIN. Great. Thank you, Mr. Chairman.
And now we go to Mr. Perry.

OPENING STATEMENT OF HON. SCOTT PERRY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PERRY. Thank you, Chairman Pallone and Ranking Member Shimkus, members of the committee and staff. I appreciate the opportunity to testify this morning regarding some of my priorities within the committee's jurisdiction.

As the focus of the nation's energy policy has shifted in recent years towards reducing greenhouse gas emissions, the policies pursued have increasingly been to the benefit of the wealthy and politically connected at the expense of the American people.

The Solyndra scandal, the various environmental tax credits that go to most—that go almost exclusively to wealthy individuals, the regulatory effort, and the last administration at the behest of the environmental organizations intent to eliminate the coal industry, et cetera.

Not only do these regressive policies have an outsized impact on the most vulnerable among us, they have significantly degraded the American people's trust in their government.

Yesterday's Environment and Climate Change Subcommittee hearing entitled "Building America's Clean Future: Pathways to Decarbonizing the Economy" was the next step in this disturbing trend.

Giving legitimacy to the fringe "keep it in the ground" movement—that is what that did. The proposed ideas would have crippling effects on the bottom line of each and every one of our constituents while having little to no impact on global greenhouse gas emissions.

Despite the usual platitudes about just transitions for affected workers or environmental justice and the like, there was no real answer to how destroying the economic driver of my home state of Pennsylvania as well as numerous others could be done in a just manner.

Little explanation of how these climate actions would be and could be tailored in a way to create economic opportunity for low-income communities and even less evidence was presented showing that this would work.

Similar environmental policies are currently being pursued in the state of California and these same promises were made to low-income Californians.

The result? According to a study by the Center for Demographics and Policy at Chapman University, and I'll read, "In summary, the imposition by the state's Democratic Party leaders of highly regressive climate schemes have engendered disparate financial hardships on middle- and lower- income workers and minority communities while providing direct economic subsidies to wealthier Californians in environmentalist strongholds," end quote.

In light of these findings, I think it's imperative that the conversation shifts from an all-out attempt to destroy entire industries to a more productive conversation about the impact of such actions on the financial wellbeing of our constituents as well as the mas-

sive restrictions on personal freedoms required by this type of policy.

If the majority is dead set on imposing onerous restrictions on reliable sources of energy, the least it can do is try to blunt the negative impacts to the American people. Yet, in many cases, mitigating efforts are being stalled either through overt action by this committee or a failure to act.

Continuing to prioritize the development of intermittent renewable sources through subsidies and incentives comes at the expense of baseload power operators, many of whom have closed their doors.

This government intrusion into the market is unhelpful and actually increases emissions where nuclear plants close. The issues of intermittence, frequency, cost effectiveness, supply chain security and integrity, and land use requirements' impact on endangered species and environmental degradation is conveniently left out of the conversation about wind, solar, and battery storage.

However, these are very real issues and need to be addressed before any attempts to decarbonize the economy are pursued.

In the meantime, if the committee wants to take actions that will result in increased renewable generation, not just capacity, it should move forward with the efforts to remove the regulatory burdens inhibiting the further development of the only baseload renewable power source, hydropower.

Federally imposed regulatory burdens leave hydropower projects with the longest and most complex development time lines of any renewable technology, often in excess of 10 years, while wind and solar can easily go from concept to development in two to three years.

This disparate treatment of the only baseload renewable source is nonsensical and significantly undermines any regulatory framework aimed at lowering greenhouse gases as it drives private capital away from hydropower projects. These burdens are a major limiting factor on the ability of the industry to expand its footprint.

Currently, only three percent—only three percent of the 80,000 dams in the United States generate electricity so there is a significant potential growth in the industry if these burdens are lessened or removed.

Despite the significant regulatory burden on hydropower and the preferential tax treatment received by wind and solar projects, hydropower still accounted for 52 percent of all domestic renewable generation in 2018.

This is both a testament to hydropower's reliability and a damning indictment of wind and solar power. The playing field could not be more favorable for wind and solar and yet, combined, they don't make up a majority of generation.

And I'll close with this. Rather than pursuing a policy to replace working power generation with one that can continue to fail in the most favorable of market environments, we should be leveling the playing field and allowing the free market to drive down prices and clean up the environment as it has for the past century.

And with that, I thank the committee and I yield.

[The prepared statement of Mr. Perry follows:]

PREPARED STATEMENT OF HON. SCOTT PERRY

Chairman Pallone and Ranking Member Walden, I'd like to thank the Energy and Commerce Committee for the opportunity to testify this morning regarding my priorities within the committee's jurisdiction. As the focus of the nation's energy policy has shifted in recent years toward reducing greenhouse gas emissions; the policies pursued have increasingly been to the benefit of the wealthy and politically connected at the expense of the American people—the Solyndra scandal, the various “environmental” tax credits that go almost exclusively to wealthy individuals, the regulatory effort under the last administration at the behest of environmental organizations intended to eliminate the coal industry, etc. Not only do these regressive policies have an outsized impact on the most vulnerable among us, but they have significantly degraded the American people's trust in their government.

Yesterday's Environment and Climate Change Subcommittee hearing entitled, “Building America's Clean Future: Pathways to Decarbonize the Economy” was the next step in this disturbing trend; giving legitimacy to the fringe “keep it in the ground” movement. The proposed ideas would have crippling effects on the bottom line of each and every one of our constituents while having little to no impact on global greenhouse gas emissions. Despite the usual platitudes about “just transitions for affected workers, environmental justice”, and the like, there was no real answer to how destroying the economic driver of my home state of Pennsylvania as well as numerous others could be done in a “just” manner. Little explanation of how these climate actions could be tailored in a way to create economic opportunity for low-income communities and even less evidence was presented showing that this would work.

Similar environmental policies are currently being pursued in the state of California and these same promises were made to low-income Californians. The result, according to a study by the Center for Demographics and Policy at Chapman University:

“In summary, the imposition by the state's Democratic party leaders of highly regressive climate schemes have engendered disparate financial hardships on middle and lower income workers and minority communities, while providing direct economic subsidies to wealthier Californians in environmentalist strongholds.”

In light of these findings, I think it is imperative that the conversation shifts from an all-out attempt to destroy entire industries to a more productive conversation about the impact of such actions on the financial well-being of our constituents as well as the massive restrictions on personal freedoms required by this type of policy.

If the Majority is dead-set on imposing onerous restrictions on reliable sources of energy, the least it can do is try to blunt the negative impacts to the American people. Yet, in many cases, mitigating efforts are being stalled either through overt action by this committee or a failure to act. Continuing to prioritize the development of intermittent renewable sources through subsidies and incentives comes at the expense of baseload power operators; many of whom have closed their doors. This government intrusion into the market is unhelpful and actually increases emissions where nuclear plants close. The issues of intermittency, frequency, cost-effectiveness, supply-chain security and integrity, land use requirements, impact on endangered species and environmental degradation is conveniently left out of the conversation about wind, solar, and battery storage. However, these are very real issues and need to be addressed before any attempts to “decarbonize” the economy are pursued.

In the meantime, if the committee wants to take actions that will result in increased renewable generation, not just capacity, it should move forward with efforts to remove the regulatory burdens inhibiting the further development of the only baseload renewable power source; hydropower. Federally imposed regulatory burdens leave hydropower projects with the longest and most complex development timeline of any renewable technology, often in excess of 10 years while wind and solar can easily go from concept to development in two to three years.

This disparate treatment of the only baseload renewable source is nonsensical and significantly undermines any regulatory framework aimed at lowering greenhouse gases as it drives private capital away from hydropower projects. These burdens are a major limiting factor on the ability of the industry to expand its footprint. Currently, only three percent of the 80,000 dams in the U.S. generate electricity so there is significant potential growth in the industry if these burdens are lessened or removed. Despite this significant regulatory burden on hydropower and the preferential tax treatment received by wind and solar projects, hydropower accounted for 52 percent of all domestic renewable generation in 2018. This is both a testament to hydropower's reliability and a damning indictment of wind and solar power.

The playing field could not be more favorable for wind and solar and yet, combined they don't make up the majority of generation.

Rather than pursuing a policy to replace working power generation with one that continues to fail in the most favorable of market environments, we should be leveling the playing field and allowing the free market to drive down prices and clean up the environment; as it has for the past century.

Mr. PALLONE. I thank the gentleman.

Dr. Burgess, did you want to make a point?

Mr. BURGESS. Yes. It was this committee, after all, that did pass the Energy Policy Act of 2005 when Joe Barton was chairman and part of that was loans for the development of nuclear electricity or nuclear power.

And, unfortunately, since then we haven't done much with that. In fact, the loans have been changed through subsequent administrations and gone to projects that actually haven't really delivered very much in the way of energy as they were diverted to renewable energy.

I really don't think you can seriously talk about a zero carbon future regardless of the time frame if you do not include nuclear energy as part of your baseload, and this committee should remember that.

So I thank you for bringing it back to our attention.

Mr. PALLONE. And I don't want to belabor the point because I know we have got to move on. But we really stressed yesterday at the hearing that, you know, we were technology neutral.

We are not, you know, saying that this is all—this goal is reached just with renewables. Hydropower is important. We certainly want to include nuclear, carbon capture. You know, so I don't want you to think that we are just saying that this goal has to be reached just with renewables.

But I know we have got to move on. So thanks again.

Next is—oh, yes, the gentlewoman from New Mexico. And I did want to mention, because I know you're—you and your colleague from Kansas, right, are the first American Indian or Native American women—Congresswomen.

You may not even mention it but we are determined that in the fall we will have a hearing on the Native—on the Indian Health Care Improvement Act because I know that that's a commitment that I made and I just wanted to mention it to you.

Ms. HAALAND. Thank you. Thank you, Chairman.

Mr. PALLONE. So thank you.

Ms. HAALAND. Thank you.

OPENING STATEMENT OF HON. DEBRA HAALAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Chairman, ranking member, members of the committee, thank you for the opportunity to testify.

My district has over 300 days of sunshine each year and abundant wind resources. That's why I am working with several of my colleagues on legislation to set a nationwide goal of 100 percent clean energy economy by 2050.

Thank you, Chairman Tonko, for being part of this effort. This will protect public health and our environment, create millions of

jobs, and mitigate the impacts of climate change for all communities and all generations, especially those disproportionately impacted.

I urge the committee to support this effort broadly and through intermediate steps that will enable the transition to clean energy.

The transition to clean energy requires a modernized smart electric grid to increase integration of renewable energy and support adoption of zero emission vehicles.

I urge you to encourage deployment of smart meters and other technologies which make our electric grid more responsive and capable of supporting distributed energy resources.

I recommend improving the performance, affordability, and deployment of energy storage systems to enhance grid flexibility and reliability, and expanding advanced transmission technologies to get power to demand centers more efficiently.

Improving energy efficiency and transitioning from fossil fuels to electricity are keys to a clean energy future. I urge you to increase energy efficiency in new and existing public and private housing, and provide incentives to implement energy efficiency retrofits in public buildings.

I also recommend that you help homeowners shift from gas-powered appliances to electric, expand consumer choices for power consumption and production, and support the development and integration of new technologies such as advanced insulation windows, HVAC systems, and lighting.

It's essential to make these measures affordable for low-income families by providing grants to utilities to make energy efficient upgrades accessible to these communities while also providing direct assistance to individual families and Indian tribes.

The Federal Government can also reduce our impact on the climate and environment by providing grants to communities to build recycling and composting facilities and promote waste prevention.

Composting reduces greenhouse gas emissions from landfills and incinerators, returns carbon to the ground, and reduces the need for chemical fertilizers. These investments can help us move toward a national goal of zero waste.

As chair of the Native American Caucus, I am working to address the federal neglect and under investment in Indian Country.

One of the most pressing needs is broadband service in tribal and rural areas and, of course, that is a necessary addition for family farms across the country.

The FCC reports that 92 percent of Americans have access to high-speed internet compared to 65 percent of Indian Country, more comparable to a developing country than the world's most prosperous nation.

The federal government is creating new digital reservations for Native Americans, leaving Indian Country to fall farther and farther behind.

As you work on broadband policy, I urge the committee to pay particular attention to the needs and challenges in Indian Country and rural America, which not only include education and healthcare but also public safety and which includes remedies to the crisis of missing and murdered indigenous women.

American Indian and Alaska Native communities also face a maternal mortality crisis. According to the U.S. Commission on Civil Rights' "Broken Promises" report, Native American women are 4.5 times more likely than non-Hispanic white women to die while pregnant or within 42 days post-partum.

To address this crisis, I joined Congresswomen Gwen Moore and Debbie Dingell to introduce the Mamas First Act. I urge the committee to support this bill that would allow Medicaid reimbursements for doulas and midwives to combat maternal mortality among the nearly two million on Medicaid giving birth each year.

I thank you so much for the opportunity to address you this morning.

Thank you, Chairman.

[The prepared statement of Ms. Haaland follows:]

PREPARED STATEMENT OF HON. DEBRA HAALAND

Chairman Rush, Ranking Member Upton, members of the committee, thank you for the opportunity to testify.

My district is blessed with over 300 days of sunshine each year and abundant wind resources. That is why I am working with several of my colleagues on legislation to set a nationwide goal of a 100 percent clean energy economy by 2050. This will protect public health and our environment; create millions of well-paying green jobs; and mitigate the impacts of climate change for all communities and all generations, especially those disproportionately impacted by its effects. I urge the committee to support this effort broadly and through intermediate steps that will enable the transition to clean energy.

The transition to clean energy will require a modernized, smart electric grid to increase integration of renewable energy and support adoption of zero-emissions vehicles. I urge you to encourage deployment of "smart" meters and other technologies, which make our electric grid more responsive and capable of supporting distributed energy resources. I recommend improving the performance, affordability, and deployment of energy storage systems to enhance grid flexibility and reliability; and expanding advanced transmission technologies to get renewable power to demand centers more efficiently.

Improving energy efficiency and transitioning from fossil fuels to electricity are keys to a clean energy future. I urge you to increase energy efficiency in new and existing public and private housing and provide incentives to implement energy efficiency retrofits in municipal buildings, hospitals, and schools. I also recommend that you help homeowners shift from gas-powered appliances to electric; expand consumer choices for power consumption and production; and support the development and integration of new technologies such as advanced insulation, windows, appliances, HVAC systems, and lighting. It is essential to make these measures affordable for low-income families by providing grants to utilities to make energy efficient upgrades accessible to low-income communities while also providing direct assistance to individual families and tribes.

The Federal Government can also reduce our impact on the climate and environment by providing grants to communities to build recycling and composting facilities and promote waste prevention. Composting reduces greenhouse gas emissions from landfills and incinerators, returns carbon to the ground, and reduces the need for chemical fertilizers for crops. These investments can help us move toward a national goal of zero waste.

As co-chair of the Native American Caucus, I am working to address the federal neglect and underinvestment in Indian Country. One of the most pressing needs is broadband service in tribal and other rural areas.

The FCC reports that 92 percent of Americans are able to access high-speed internet compared to just 65 percent of Indian Country, more comparable to a developing country than the world's most prosperous nation. The Federal Government is creating new digital reservations for Native Americans, leaving Indian Country to fall further behind in the twenty-first century. As you work on broadband policy, I urge the committee to pay particular attention to the needs and challenges in Indian Country and rural America.

American Indian and Alaska Native communities also face a maternal mortality crisis. According to the U.S. Commission on Civil Rights "Broken Promises" report,

Native American women are 4.5 times more likely than non-Hispanic white women to die while pregnant or within 42 days post-partum. To address this crisis, I joined with Congresswomen Gwen Moore and Debbie Dingell to introduce the Mamas First Act. I urge the committee to support this bill that would allow Medicaid reimbursements for doulas and midwives to combat maternal mortality among the nearly two million on Medicaid giving birth each year.

Thank you again for the opportunity to testify.

Mr. PALLONE. Thank you, and let me just say quickly, you know, part—last week when we did a full committee sort of marathon markup we had this energy efficiency package that has provisions for grants to communities and a lot of the things that you mentioned, and that is part of this LIFT America Act, which is sort of our infrastructure—our piece of an infrastructure bill if we ever get to one, you know, with the president and with the Senate, and that has \$40 billion for expansion of broadband in underserved areas, and part of that was in reaction to mine and others visiting some of the reservations.

I remember we went to the Gila River in Arizona and this is all they talked about was how, you know, so many of the tribes don't have access to the internet. So a lot of the ideas that you are including, you know, we want to move on. So thanks again. Appreciate it.

Ms. HAALAND. Thank you, Chairman. Thank you.

Mr. PALLONE. Thank you.

And now we go to Congresswoman Shalala, who needs no introduction. So proud of the things that we did when you were the secretary and so progressive on so many things and working with this committee. Thanks for being here.

OPENING STATEMENT OF HON. DONNA E. SHALALA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. SHALALA. Thank you, Chairman Pallone. Thank you very much.

I, as you can imagine, had 25 things I wanted to talk to you about but I picked out three.

This week we will celebrate the 29th anniversary of the signing of the Americans with Disabilities Act—the ADA. So I have come today to talk to those who often don't have a voice.

This crucial landmark civil rights legislation prohibits discrimination against people with disabilities in all areas of public life, including at work, at school, and public accommodations.

Last month was the 20th anniversary of the landmark Olmstead case. This case affirmed the rights of Americans with disabilities under the ADA to live independently and in their communities.

Despite this recognition that the ADA prohibits the segregation of people with disabilities into institutions, integration has not yet been achieved. We have a lot more work to do.

States have long wait lists for community services and many people with disabilities are not able to receive them. Many people with disabilities live in fear that their fundamental right to live in their communities, the communities that they love will be taken away from them and they will be forced into an institution.

This must change and I am hopeful that this committee will consider in the coming months legislation to ensure that all people

have the fundamental right to remain in their communities and in their homes.

Earlier this year, Congressman Sensenbrenner introduced legislation called the Disability Integration Act, which would create a right to home and community-based services as an alternative to institutionalization.

This bill is bipartisan, bicameral. I am the lead Democrat. It now has 234 co-sponsors in the House. I hope this committee will consider this critical legislation in this Congress.

In a similar vein, it is my hope that the committee will consider H.R. 3215, the Disaster Relief Medicaid Act, which I introduced earlier this year with Congressman Langevin and Congresswomen González-Colón and Holmes Norton.

Natural disasters are occurring at increased rates across this country and in the aftermath of such disasters thousands of people are often forced to abandon their homes and relocate, often to a different state.

After Hurricane Katrina over one million evacuees relocated to another state. More recently, after Hurricane Maria, between 140,000 and 180,000 people left Puerto Rico. Many of them moved to Florida.

The stress of moving after a natural disaster is immense, but it is even greater for individuals and families that are eligible for Medicaid healthcare and long-term services and supports.

These are the most severely disabled people that we knew. The move from one's home state to a host state as a result of disaster can mean the loss of access to critical long-term services and supports.

In this bill we fill a very important niche. You'll remember that after these disasters we often allocate money but it often takes months or even years for the money to reimburse the states.

In this Act, the Disaster Relief Medicaid Act would ensure that individuals eligible for Medicaid who need these long-term services that are forced to relocate during a disaster that they are able to continue their Medicaid supported services.

In other words, we would reimburse the states—the host states—at 100 percent for some period of time. So as Dr. Burgess will confirm, their services are seamless so they can go to the host state and get those long-term care services without the state having to absorb the costs.

Between wildfires and floods and tornadoes and hurricanes, all of our constituents are threatened by natural disasters. No one should have to choose between evacuating and losing access to life-saving services and staying and possibly losing their life to a natural disaster.

Finally, I want to implore this committee to consider the critical issue of youth tobacco and e-cigarette usage. Many of us in this room have been working on this for decades.

We have achieved one of the great public health achievements of both the last and this century. We have driven down the number of kids that are smoking, and I joined you, Mr. Chairman, in introducing the Reversing the Youth Tobacco Epidemic Act of 2019.

We have made extraordinary progress in this area, and the FDA and CDC have now reported an alarming 78 percent increase in e-cigarette use by high school students.

Something has to be done to combat youth use of e-cigarette products and our legislation would raise the age to buy tobacco products to 21, which now has bipartisan and bicameral support.

It would also create a universal ban on flavors on all tobacco products and prohibit the marketing of e-cigarette products to people under the age of 21.

This will be our second big public health accomplishment certainly of this century and it's very important to do, and I hope you'll be able to markup the bill in this session.

Thank you very much.

[The prepared statement of Ms. Shalala follows:]

PREPARED STATEMENT OF HON. DONNA E. SHALALA

Chairwoman Eshoo and Ranking Member Burgess, thank you for having me today. I would like to touch on a few things that are important to me and my district which I hope the committee will consider this Congress.

Disability Integration Act

This week we will celebrate the 29th anniversary of the signing of the Americans with Disabilities Act -the ADA. This landmark civil rights legislation prohibits discrimination against people with disabilities in all areas of public life, including at work, in school, and in public accommodations.

And last month was the 20th anniversary of the Olmstead case. This case affirmed the rights of Americans with disabilities under the ADA to live independently and in their community-as most people want to do.

Despite the Supreme Court recognizing that the ADA prohibits the segregation of people with disabilities into institutions-in practice this has not come to pass. More work needs to be done.

States have long wait lists for community services and many people with disabilities are not able to receive them. Many people with disabilities live in fear that their fundamental right to live in the community that they love will be taken away from them and they will be forced into an institution.

This must change. I am hopeful that this committee will consider in the coming months legislation to ensure a right to remain in your community.

Congressman Sensenbrenner introduced legislation called the Disability Integration Act which would provide home and community-based services as an alternative to institutionalization. This bill is bipartisan and bicameral-I am the lead Democrat-and it now has 234 cosponsors.

I hope this committee will consider this critical issue and legislation this Congress.

Medicaid and Disasters

In a similar vein, it is my hope that the committee will consider H.R. 3215, The Disaster Relief Medicaid Act which I introduced earlier this year with Congressman Langevin, Congresswomen Gonzalez-Colon and Holmes Norton.

Natural disasters are occurring at increased rates across this country and in the aftermath of such disasters thousands of people are often forced to abandon their homes and relocate. It happened after Hurricane Katrina when over on million evacuees relocated to another state. More recently, after Hurricane Maria an estimated 140,000 to nearly 185,000 left the island-many of whom moved to Florida.

The stress of moving after a natural disaster is immense, but it is even greater for individuals and families that are eligible for Medicaid healthcare and long-term services and supports. The move from one's home state to a host state as a result of a disaster can mean the loss of access to long-time services and supports.

The Disaster Relief Medicaid Act would ensure that individuals eligible for Medicaid who are forced to relocate due to a disaster are able to continue to access their Medicaid supported services. It would also provide states with resources to support the Medicaid needs of individuals forced to relocate following a disaster.

This legislation would designate an individual who resides in an area covered under a presidential disaster declaration as a Relief-Eligible Survivor and allow

them to continue to access their Medicaid services if they are forced to relocate to another state as a result of the disaster.

All of our constituents are threatened by natural disasters—whether it is a wildfire, a flood, a tornado or a hurricane. No one should have to choose between evacuating and losing access to lifesaving services and staying and possibly losing their life to a natural disaster.

Tobacco

I would also implore this committee to consider the critical issue of youth tobacco and e-cigarette usage.

Recently, I joined Chairman Pallone in introducing the Reversing the Youth Tobacco Epidemic Act of 2019.

The FDA and CDC have reported an alarming 78 percent increase in e-cigarette use by high school students and a 48 percent increase among middle school students from 2017 to 2018.

Something must be done to combat the youth use of e-cigarette products and to continue our longstanding public health battle against smoking and tobacco use.

Our legislation would raise the age to buy tobacco products to 21—which now has bipartisan and bicameral support. It would also create a universal ban on flavors in all tobacco products and prohibit the marketing of e-cigarette products to people under the age of 21.

Thank you for having me today and I look forward to working with the committee on these issues as well as a number of other issues that you have within in your jurisdiction.

Mr. PALLONE. Thank you. And again, as you know, I really value your expertise, you know, not only because you were the secretary but spent so much time over the years on so many of these health issues.

With regard to the disabilities, it's really important that we do whatever we can to keep people in their homes and the community, not have them institutionalized. We will work—we will continue to work on that, and all your work on tobacco we appreciate.

And I really appreciate too that you didn't just say, you know, we need to raise the age to 21. I know Senator Collins has been, you know, stressing that. But we need to address vaping and, you know, the flavored cigarettes and these other things.

Ms. SHALALA. Exactly. Clearly, the tobacco companies pivoted to find—to target youth again. So now we need to do another piece of legislation to prevent that, and the American people are right there with us.

Mr. PALLONE. Thank you.

Dr. Burgess?

Mr. BURGESS. Well, Mr. Chairman, as you know, we took a bipartisan field hearing to Puerto Rico. It's been almost two years ago. I think it's appropriate to consider a follow-on to the island.

Basically, we were concerned about electricity grid problems at the time but healthcare is, obviously, a big issue for the island and we ought to include that in a field hearing in the near future.

Ms. SHALALA. Thank you.

Mr. PALLONE. Thank you, Dr. Burgess, and thank you, Secretary Shalala. Appreciate it.

Now, I just so I am told that, you know, we are trying to follow the order that we said when we asked people to come. So that's going to mean, what, that we have Congresswoman Meng next, Congressman Sablan, and then we are going to go to Chairman Roybal-Allard—the two together, I guess.

So is that accurate? All right. We will go to Congresswoman Meng. Thank you.

OPENING STATEMENT OF HON. GRACE MENG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Ms. MENG. Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo and Ranking Member Burgess, and distinguished members of this committee, thank you for this opportunity to discuss several of my priorities as it pertains to the Subcommittee on Health but also more broadly across the full house committee.

I sincerely ask this committee to move forward with the following bills and priorities.

Protecting women and children from harmful chemicals is one of my top priorities. That is why I introduced a package of bills to ensure safeguards are in place to bolster consumer confidence that the products they purchase are safe for their loved ones.

First, H.R. 2267, the Infant Formula Act, would prohibit the sale of expired baby formula. Although regulations require expiration dates to be placed on formula, federal law does not prohibit the sale of infant formula after its expiration has passed.

I was shocked to learn that parents who unknowingly bought these expired formulas reported their infants being violently sick. Busy parents need to be able to rely on the safety of products, like formula, that they buy in grocery stores to make sure their newborns are well-fed and healthy.

Second, H.R. 2268, the Menstrual Products Right To Know, would require companies to list ingredients in feminine hygiene products, such as scented and unscented pads, cups, scented and unscented tampons, and therapeutic douche apparatuses.

We can easily see the ingredients used in the shampoo we put in our hair or in the foods that we eat. The same transparency requirements must apply to products that touch, or are inserted to, our most sensitive and absorbent parts of the body.

Third, H.R. 2269, the Get Additives Out Act, would require a GAO report on the physical and behavioral health risks of food additives on children.

The food additives and its effects are dramatically understudied, particularly on the impact on children as they enter critical stages of development.

I am committed to ensuring more transparency in the foods that we eat and the foods that my boys eat.

In the coming months, I will also be introducing legislation to address the Consumer Product Safety Commission's inability to effectively oversee recalls, particularly with products that threaten the safety of infants and children.

The Britax jogging stroller recall rollout was a shameful fiasco with failed missteps and a clear abuse of consumers' trust. Sadly, this incident is not the exception, which is why I will tackle this issue head on.

As the co-chair of the Congressional Hepatitis Caucus, I also recently introduced H. Res. 505, which recognized July 28th as "World Hepatitis Day."

This legislation also encourages people from across the world to take preventative action and urges greater partnerships between federal, state, and local health departments to eliminate new infections in the U.S.

Another one of my priorities is to ensure access to affordable menstrual hygiene products. One might think these products are ubiquitous and cheap, but many women face difficulty when it comes to affording and accessing them.

I know this because I have heard the heartbreaking testimonies from girls and women across our nation. That is why I introduced H.R. 1882, the Menstrual Equity for All Act, which is a comprehensive solution to ensuring this basic healthcare need for over 51 percent of the U.S. population.

No girl should have to choose between their dignity or their education, no one should have to lose their dignity just because they are incarcerated, and no family should have to choose between buying these products or groceries.

Additionally, I am deeply committed to the issue of our environment and its impact on the health of our constituents and their families. That is why, yesterday, I introduced the Safe Drinking Water in Playgrounds and Parks Act, which would ensure that states, schools, and municipalities have the necessary resources to replace drinking water fountains in those places.

As you know, no amount of lead is safe for consumption, and if consumed, its effects are dangerous to children. Furthermore, aviation noise is a critical issue that impacts my district in Queens. That is why, as the founding member and former co-chair of the Quiet Skies Caucus, I introduced H.R. 3001, the Quiet Communities Act.

This bill would reestablish the Office of Noise Abatement and Control in the U.S. Environmental Protection Act. Chronic exposure to excessive noise can have short and long-term negative health impacts, including hearing loss, stress, high blood pressure, and diminished cognitive performance.

Noise pollution is not just a minor inconvenience; it is a health issue that needs to be addressed.

Thank you again to the subcommittee and the committee for allowing me to testify. I ardently hope that we can work together on the priorities I have set forth today.

[The prepared statement of Ms. Meng follows:]

PREPARED STATEMENT OF HON. GRACE MENG

Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo and Ranking Member Burgess, and distinguished members of this committee, thank you for this opportunity to discuss several of my priorities as it pertains to the Subcommittee on Health—but also more broadly across the Full House Committee on Energy and Commerce. I sincerely ask this committee move forward with the following bills and priorities.

Protecting women and children from harmful chemicals is one of my top priorities. That is why, I introduced a package of bills to ensure safeguards are in place to bolster consumer confidence that the products they purchase are safe for their loved ones.

First, H.R. 2267—the Infant Formula Act would prohibit the sale of expired baby formula. Although regulations require expiration dates to be placed on formula, federal law does not prohibit the sale of infant formula after its expiration has passed. I was shocked to learn that parents who unknowingly bought these expired formula reported their infants being so violently sick. Busy parents need to be able to rely on the safety of products, like formula, that they buy in grocery stores to make sure their newborns are well-fed and healthy.

Second, H.R. 2268—the Menstrual Products Right To Know would require companies to list ingredients in feminine hygiene products, such as scented and unscented

pads, cups, scented and unscented tampons, and therapeutic douche apparatuses. We can easily see the ingredients used in the shampoo we put in our hair, or in the foods that we eat; the same transparency requirements must apply to products that touch, or are inserted to, our most sensitive and absorbent parts of the body.

Third, H.R. 2269—the Get Additives Out Act would require a GAO report on the physical and behavioral health risks of food additives on children. The food additives and its effects are dramatically under-studied, particularly on the impact on children as they enter critical stages of development. I am committed to ensuring more transparency in the foods that we eat—and the foods that my two boys eat.

In the coming months, I will also be introducing legislation to address the Consumer Product Safety Commission's inability to effectively oversee recalls, particularly with products that threaten the safety of infants and children. The Britax jogging stroller recall rollout was a shameful fiasco with failed missteps and a clear abuse of consumers' trust. Sadly, this incident is not the exception, which is why I will tackle this issue head-on.

As the co-chair of the Congressional Hepatitis Caucus, I also recently introduced H.Res.505—which recognizes July 28th as “World Hepatitis Day.” This legislation also encourages people from across the world to take preventative action, and urges greater partnerships between federal, state, and local health departments to eliminate new infections in the United States.

Another one of my priorities is to ensure access to affordable menstrual hygiene products. One might think these products are ubiquitous and cheap, but many women face difficulty when it comes to affording and accessing them. I know this, because I have heard the heartbreaking testimonies from girls and women across our nation. That is why I introduced H.R. 1882—the Menstrual Equity for All Act, which is a comprehensive solution to ensuring this basic healthcare need for the 51 percent of the U.S. population. No girl should have to choose between their dignity or their education; no one should have to lose their dignity just because they are incarcerated; and no family should have to choose between buying these products or groceries.

Additionally, I am deeply committed to the issue of our environment and its impact on the health of our constituents and their families. That is why, yesterday, I introduced the Safe Drinking Water in Playgrounds and Parks Act which would ensure that states, schools, and municipalities have the necessary resources to replace drinking water fountains in those places. As you know, no amount of lead is safe for consumption, and if consumed, its effects are dangerous to children.

Furthermore, aviation noise is a critical issue that impacts my district of Queens. That is why, as the founding member and former co-chair of the Quiet Skies Caucus, I introduced H.R. 3001—the Quiet Communities Act. This bill would reestablish the Office of Noise Abatement and Control in the U.S. Environmental Protection Act. Chronic exposure to excessive noise can have short and long-term negative health impacts, including hearing loss, stress, high blood pressure, and diminished cognitive performance. Noise pollution is not just a minor inconvenience; it is a health issue that needs to be addressed.

Thank you again to the subcommittee and the committee for allowing me to testify. I ardently hope that we can work together on the priorities I have set forth today.

Mr. PALLONE. Thank you, and we will certainly follow up on those bills. I am not surprised there is so much emphasis on kids when I see you, you know, taking those two boys around all the time. So thanks again.

Did you—Mr. Griffith, go ahead.

Mr. GRIFFITH. Mr. Chairman, I do think we should probably take a look at the food additives and the impact they have on folks. I have a number of food additives that I avoid. So it's not just children, but children may not know what's going on. Usually I can, through elimination, figure out what's causing the reaction. But it's something we should probably take a look at.

Mr. PALLONE. Absolutely. All right.

Thanks again, unless you wanted to say something else.

Ms. ESHOO. I do.

Mr. PALLONE. Oh, I am sorry.

Ms. ESHOO. That's all right.

Mr. PALLONE. The chairwoman of our Health Subcommittee, Ms. Eshoo.

Ms. ESHOO. Thank you.

I want to thank our colleagues that are at the witness table. I have to say it's refreshing to have other members that—members that are not on the committee come in and be with us.

You have important ideas and what—in terms of the jurisdiction of my subcommittee, I am going to take your bills seriously. So this is not a waste of your time here.

Grace, thank you for your work on Quiet Skies. My congressional district is practically turned inside out upside down by that new FAA program NextGen, and I don't know if other members realize this but the FAA there is no responsibility today for noise—no responsibility—and other health impacts. So I want to work with you on that.

So thank you to each one of you. It's wonderful to see you. You're wonderful legislators. You're great friends and you're always welcome here.

Mr. PALLONE. Thank you, and as Chairwoman Eshoo said, you know, this Members Day is not just you come here and that's the end of it. Do not hesitate to contact us or have your staff contact our staff to follow up on these things that you mentioned, please.

Thank you.

Mr. Sablan, good to see you.

Mr. SABLAN. Good morning.

Mr. PALLONE. Good morning.

Mr. SABLAN. Good morning, Mr. Chairman.

Mr. PALLONE. Well, I guess it's the afternoon actually, but go ahead.

[Laughter.]

OPENING STATEMENT OF HON. GREGORIO SABLAN, A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF THE MARIANA ISLANDS

Mr. SABLAN. OK. Well, I'd like to thank Chairs Pallone and Eshoo and to Ranking Members Walden and Burgess for the opportunity to provide testimony to the Health Subcommittee today and to the full committee actually, and thanks to all the members for reporting favorably the REACH Act last week.

This health extenders package is good news for the Marianas and all the insular areas. It reauthorizes critically important Community Health Centers, of which the Marianas has one.

Most importantly, it includes the Territories Health Care Improvement Act and addressing the Medicaid cliff the insular areas face when special Obamacare funding ends this year.

Thanks also to Mr. Soto and Mr. Bilirakis of the committee for understanding the urgency of this insular Medicaid crisis. They put together the Territories Health Care Improvement Act with myself and seven other original bipartisan co-sponsors to give Puerto Rico the help it needs, and the bill also becomes the means to help the four insular areas.

It provides just what the Marianas Medicaid director told this committee she needed—\$60 million per year. No local match is required for the first two years, of which will allow the Marianas gov-

ernment to direct more money to help recover from last year's typhoons. And after six years, we will get the best FMAP that any state is currently offered.

This legislation will make the insular Medicaid programs more state-like in other important ways. New program integrity requirements, which I support, assure that every federal dollar is used as intended.

Having a better record of utilization, enrollment, and expenditures will allow for a greater understanding of the unique healthcare challenges the insular areas face and, I hope, provide a basis for the policy that comes after.

Because, as grateful as we are that the Medicaid cliff is being addressed, and in a way that matches need, we know three things from experiences with the ACA's Medicaid fix.

Time will pass quickly. The ACA fix lasted eight years. Then we had the present crisis. The current legislation will last for six years.

Perhaps with the better understanding we expect to gain over that time we will be able to fix the problem once and for all and treat Americans living in the insular areas like all other Americans when it comes to Medicaid.

The second lesson—humility. We may think that the funding we are providing to each insular area meets their needs and their capacity to use the money. But we learned over the course of the ACA that our predictions are not always accurate.

Some of the insular areas used their ACA money. Some did not. Some ran out of funding because their needs were greater than Congress foresaw and Congress had to intervene with stopgap measures. Some areas are leaving money unspent after eight years.

We should learn from that experience. Emergencies arise that cannot be predicted. The recently-enacted disaster supplemental included my amendment to provide an additional \$36 million in Medicaid funds for the Marianas because with last year's typhoons our program was down to its last dollars.

In the seven weeks since enactment 60 percent of those funds are already expended and the balance is scheduled for expenditure by September 30. Emergencies arise.

So I would humbly suggest that some mechanism be built into the REACH Act to make sure its funds can be reallocated, if necessary.

I know our staffs have discussed this problem but without resolution, and I would suggest that all of us ask our staffs to work a little harder so we do not repeat that mistake of the Affordable Care Act.

I thank the Health Subcommittee for favorably reporting the Territories Health Care Improvement Act and I thank the full committee for bundling it into the REACH Act.

You have made a great step forward to ensure that healthcare in the insular areas can be as good as healthcare anywhere in America.

And finally, and always, gratitude. I am ever so grateful to the American people for the assistance they provide to my constituents in the Northern Mariana Islands.

Medicaid provides the means to keep our only hospital open and to allow specialized services to patients who need to travel off island for their services.

I say this with full sincerity. I am always truly grateful for America's help for so many of the needs of Americans in the insular areas, especially the Northern Mariana Islands.

So for the many Americans in the Northern Marianas and from a grateful nonvoting delegate, Mr. Chairman and other members of the committee, thank you.

Thank you very much.

[The prepared statement of Mr. Sablan follows:]

PREPARED STATEMENT OF HON. GREGORIO SABLAN

Thanks to Chairs Pallone and Eshoo and to Ranking Members Walden and Burgess for the opportunity to provide testimony to the Health Subcommittee today. And thanks to all the members of the committee for reporting favorably the Reauthorizing and Extending America's Community Health "REACH" Act last week.

This health extenders package is good news for the Marianas and all the insular areas. It reauthorizes critically important Community Health Centers, of which the Marianas has one. Most importantly, it includes the Territories Health Care Improvement Act, addressing the Medicaid cliff the insular areas face, when special Obamacare funding ends this year.

Thanks, also, to Mr. Soto and Mr. Bilirakis of the committee for understanding the urgency of this insular Medicaid crisis. They put together the Territories Health Care Improvement Act with myself and seven other original, bipartisan cosponsors to give Puerto Rico the help it needs. And the bill also becomes the means to help the four smaller insular areas.

It provides just what the Marianas Medicaid director told this committee she needed - \$60 million per year. No local match is required for the first two years, which will allow the Marianas government to direct more money to help recover from last year's typhoons. And, after six years, we will get the best FMAP that any state is offered.

This legislation will make the insular Medicaid programs more "state-like" in other important ways. New program integrity requirements, which I support, assure that every federal dollar is used as intended. Having a better record of utilization, enrollment, and expenditures will allow for a greater understanding of the unique healthcare challenges the insular areas face and, I hope, provide a basis for the policy that comes after.

Because, as grateful as we are that the Medicaid cliff is being addressed—and in a way that matches need—we know two things from experience with the ACA's Medicaid fix:

1) Time will pass quickly. The ACA fix lasted eight years. Then we had the present crisis. The current legislation will last for six years. Perhaps, with the better understanding we expect to gain over that time we will be able to fix the problem once and for all, and treat Americans living in the U.S. insular areas like all other Americans when it comes to Medicaid.

2) The second lesson: Humility. We may think that the funding we are providing to each insular area meets their needs and their capacity to use the money. But we learned over the course of the ACA that our predictions are not always accurate. Some of the insular areas used their ACA money. Some did not. Some ran out of funding because their needs were greater than Congress foresaw—and Congress had to intervene with stopgap measures. Some areas are leaving money unspent after eight years.

We should learn from that experience. Emergencies arise that cannot be predicted. The recently enacted disaster supplemental included my amendment to provide an additional \$36 Million in Medicaid funds for the Marianas, because with last year's typhoons our program was down to its last dollars. In the seven weeks since enactment 60% of those funds are already expended and the balance is scheduled for expenditure by September 30.

Emergencies arise. So, I would humbly suggest that some mechanism be built into the REACH Act to make sure its funds can be reallocated, if necessary. I know our staff have discussed this problem, but without resolution. And I would suggest that all of us ask our staff to work a little harder, so we do not repeat that mistake of the Affordable Care Act.

Again, I thank the Health Subcommittee for favorably reporting the Territories Health Care Improvement Act. And I thank the full committee for bundling it into the REACH Act. You have made a great step forward to ensure that healthcare in the insular areas can be as good as healthcare anywhere in America.

Mr. PALLONE. Thank you, Mr. Sablan. You know, I really appreciate your input and that of the representatives from the other territories not only on the Medicaid issue which, as you mentioned, from Ms. Eshoo's subcommittee—we addressed that pretty long-term considering where we have been before with these stopgap measures, and we are hoping that, you know, in the fall that we can take this issue up very quickly.

But I know we have to address so many of these concerns in the territories and make sure that whether it's healthcare or energy or whatever else that it's equal to, you know, continental U.S. or whatever.

And you have been very helpful in pointing things out and, you know, giving us ideas about what we need to do. So I want to thank you for that in particular.

Thanks for being here.

Now we are going to go to—I understand that we have two Congresswomen who kind of wanted to testify together here on—I think it was on maternal health issues. But I am not surprised because I several times saw Ms. Beutler on the—with her—what was the—Azzana, was that it?

Ms. HERRERA BEUTLER. Isana.

Mr. PALLONE. Isana was—you're carrying her around, and I asked you what it meant and you said strong willed or something like that.

Ms. HERRERA BEUTLER. Strong willed woman.

Mr. PALLONE. All right. Well, do you want to start or Lucille? Lucille will start. OK. Chairwoman of the Appropriations and Homeland Security Subcommittee.

OPENING STATEMENTS OF HON. LUCILLE ROYBAL-ALLARD A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA AND HON. JAIME HERRERA BEUTLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

And thanks for—I am glad we were able to work things out last night. I know we were here late but we finally got the bill done. So that was good.

Ms. ROYBAL-ALLARD. Before this meeting.

Ms. HERRERA BEUTLER. Yes.

Ms. ROYBAL-ALLARD. Thank you.

Mr. Chairman, thank you for this opportunity to submit our testimony in support of maternity caucus priorities in Congress.

Ms. HERRERA BEUTLER. We co-founded the bipartisan congressional caucus on maternity care to raise awareness about the status of childbirth in this country and the challenges facing America's maternity care system.

It often takes a visible catalyst to get the attention of policy makers and for maternity care that catalyst has been the worsening maternal mortality crisis, which this committee, I know, has delved into.

The CDC estimates 700 women die every year because of pregnancy or delivery complications and, tragically, 60 percent of those losses are preventable.

Ms. ROYBAL-ALLARD. We must do everything that we can to ensure the safety of women. It is also critical to recognize that maternal mortality is just the tip of the iceberg.

More than 50,000 women experience severe complications of pregnancy that adversely impact their health. Our infant mortality rates are higher than 33 other similar wealth countries and we have made some of the slowest progress in the world in reducing stillbirth rates.

Adding to these concerns is the extraordinary cost of U.S. maternity care, estimated at over \$50 billion. With Medicaid financing 43 percent of all births, the Federal Government must ensure cost effective maternal newborn care.

Ms. HERRERA BEUTLER. Our communities also face growing shortages of maternity care providers. The March of Dimes estimates that more than five million women in the U.S. live in a maternity care desert, including areas in our district—southwest Washington—or greater Los Angeles.

We believe it's time to make these issues a national priority. We encourage this committee to schedule more hearings to address the maternal and infant health issues and explore solutions to advance safe and cost-effective maternity care for mothers and babies.

Ms. ROYBAL-ALLARD. We have several policy recommendations for your consideration.

One, midwives are a critical part of the solution to addressing these problems in our maternity care system. But compared to many other countries, they are vastly underused as providers.

Increasing access to midwives will help address maternity care shortages while lowering costs and providing high-quality care.

Last week as co-chairs of the maternity care caucus we introduced H.R. 3849, the Midwives for Moms Act, to expand midwifery education and address the lack of provider diversity by prioritizing students from minority and disadvantaged communities. We hope that you will consider this legislation.

Ms. HERRERA BEUTLER. The bipartisan Preventing Maternal Deaths Act was signed into law in December and was the first legislation of this kind. This will improve data collection on maternal—excuse me, number two. I switched. You probably figured that out.

It's the first of its kind and it's going to improve that data collection on maternal mortality so we can begin understanding why mothers are dying.

This was a critical first step but this is just a first step. More work needs to be done and we believe there are bipartisan opportunities to ensure that vulnerable populations of women have access to care during pregnancy and the post-partum period.

We would also like to work with you on implementing best practices through initiatives like the Alliance for Innovation on Maternal Health.

Ms. ROYBAL-ALLARD. Number three, despite World Health Organization recommendations to eliminate unnecessary childbirth interventions, the U.S. continues to have some of the highest Ce-

sarean birth and induction rates, and yet continues to under use proven models of care such as group model prenatal care and birth centers.

After the August recess we will be introducing the Moms and Babes Act to prioritize evidence-based care across all federal maternity care programs and promote research about physiological birth and best practices to achieve optimal birth outcomes. We would like to work with you on this effort.

Ms. HERRERA BEUTLER. As members of the House Appropriations Subcommittee on Labor, Health, and Human Services and Education, we have worked in a bipartisan fashion to support critical programs and initiatives to improve the lives of both mom and baby, including robust funding for the maternal mortality review committees, the maternal and child health block grant, Healthy Starts, and many others.

We look forward to working collaboratively with this committee to build on this work.

Ms. ROYBAL-ALLARD. Mr. Chairman, Chairwoman Eshoo, and Ranking Member Burgess, we thank you for your leadership and we look forward to partnering with you to advance solutions to improve maternity care outcomes for all our nation's mothers and their children.

Together, we can make maternal and infant health a national priority. We believe this is long overdue.

Thank you.

Ms. HERRERA BEUTLER. Thank you.

[The prepared statements of Ms. Roybal-Allard and Ms. Herrera Beutler follows:]

PREPARED STATEMENTS OF HON. ROYBAL-ALLARD AND HON. HERRERA BEUTLER

We thank Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the subcommittee for today's opportunity to submit our testimony in support of the Congressional Caucus on Maternity Care priorities for the 116th Congress. We ask unanimous consent to submit extended testimony for the hearing record.

First, please allow us to express our appreciation for your many years of public service and dedication to protecting and improving the health of this nation. Your bipartisan leadership is an example for the rest of the House, and we are honored to appear before you today.

We started the Maternity Care Caucus in the 114th Congress to raise awareness among our Congressional colleagues about the status of childbirth in this country and the challenges facing America's maternity care system. At that time there was a widespread perception in Congress that childbirth was safe and that the U.S. had the best maternity healthcare system in the world.

Childbirth advocacy groups had been trying to raise the alarm for years that this was not the case. The U.S. spends significantly more per capita on childbirth than any other industrialized nation. However, despite this investment, America continues to rank far behind almost all other developed countries in birth outcomes for both mothers and babies.

But as so often happens, it takes a visible catalyst to get the attention of policy makers. That catalyst was the worsening maternal mortality crisis in this country. According to the CDC, each year about 700 women die because of pregnancy or delivery complications, or about two women every day. Despite many other countries around the world having successfully reduced their maternal mortality rates since the 1990s, the U.S. rate remains higher than most other high-income countries, and the U.S. maternal mortality rate has increased over the last few decades.

The racial and geographic disparities in these maternal mortality numbers are staggering: African-American women have nearly a four-time greater risk of dying from pregnancy-related complications than their White counterparts, and Native

American women are dying at two to three times the rate of White women. And these disparities in maternal deaths for African-American women have not improved in more than 20 years. Maternal mortality is also significantly higher in rural areas. Scientific American analyzed public mortality data from the CDC and found that in 2015 the maternal mortality rate in large central metropolitan areas was 18.2 per 100,000 live births - but in most rural areas it was 29.4 per 100,000 live births.

The Maternal Mortality crisis in our minority and rural communities is alarming, and we absolutely must do everything we can to address it and ensure the safety of all childbearing women. But it is also critical that this subcommittee keeps sight of the fact that maternal mortality is just the tip of the iceberg when it comes to problems in our maternity care system.

According to the CDC, Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years and is currently estimated to affect more than 50,000 women in the United States. That means that more than 135 expectant and new mothers each day endure dangerous and even life-threatening complications that have an adverse effect on their health.

And mothers are not the only victims of our maternity care system.

Infant mortality, the death of an infant before his or her first birthday, is an important marker of the overall health of a society. According to the United Health Foundation, the infant mortality rate in the United States in 2018 was 5.9 deaths per 1,000 live births. While this rate has been slowly decreasing it has not kept up with other wealthy countries, and in 2018 the U.S. ranked 33 out of 36 other developed nations. The CDC reports that Black and Native American infants are two to three times more likely to die than their white counterparts.

Additionally, each year about 24,000 babies are stillborn in the United States, and we have made some of the slowest progress in the world in reducing our stillbirth rates, behind 154 out of 159 other countries. We also have unacceptably high rates of preterm births and cesarean sections in this nation. We are not adequately diagnosing and treating postpartum depression, and preventive care is underused and poorly integrated in our maternity care system.

All these poor outcomes are even more concerning because we face a growing shortage of trained maternity care providers. According to the March of Dimes, there are currently more than five million women in the United States who live in a maternity care desert. This includes women in both of our districts in Southwest Washington and greater Los Angeles areas who live in a maternity care desert area. An estimated 1,085 counties in the United States have hospitals without services for pregnant women, nearly half the counties in the United States do not have a single ob-gyn and 56 percent are without a certified nurse-midwife or certified midwife. And the American Congress of Obstetricians and Gynecologists estimates these shortages will grow significantly: there will be a shortage of up to 8,800 OB-GYNs by 2020, with the shortfall approaching 22,000 by 2050.

Adding to all these concerns is the extraordinary economic burden of U.S. maternity care, with cumulative costs estimated to be well over \$50 billion. According to AHRQ, Maternity and newborn care constitutes the single biggest category of hospital payouts for most commercial insurers and state Medicaid programs. And the Kaiser Family Foundation reports Medicaid is the largest single payer of pregnancy-related services, financing 43% of all U.S. births in 2016. In five states and DC, Medicaid covers more than 60% of all births. With this significant investment, the federal government has a major responsibility for ensuring the quality and value of maternal-newborn care.

As Co-Chairs of the Maternity Care Caucus, we believe it is time for policymakers to prioritize optimal birth outcomes for all families in the United States. Towards that end we encourage the Energy and Commerce Health Subcommittee to schedule hearings to address the inequities in birth outcomes and the looming maternity care shortage, and to explore the most promising solutions to advance safe and cost-effective maternity care for all mothers and babies in all communities.

We have several policy recommendations we would like this subcommittee to consider:

1. Increase Access to Midwives

Midwives are widely cited as being an important part of the solution to addressing these problems in our maternity care system. However, Midwives currently attend less than 10 percent of all births in the United States, compared to countries like Great Britain where midwives deliver half of all babies, and Sweden, Norway and France where midwives oversee the majority of expectant and new mothers. All

these countries have much lower rates of maternal and infant mortality than we do in the US.

Last week we introduced H.R. 3849, the Midwives for Maximizing Optimal Maternity Services, or Midwives for MOMS Act to address the growing maternity care provider shortage, to improve maternity care outcomes for mothers and babies, and to reduce maternity care costs for families and state and federal governments, by expanding educational opportunities for Midwives.

- This bill will establish two new funding streams for midwifery education, one in the Title VII Health Professions Training Programs, and one in the Title VIII Nursing Workforce Development Programs.

- Additionally, the bill will address the significant lack of diversity in the maternity care workforce by prioritizing students from minority or disadvantaged backgrounds.

2. Take the next steps towards Reducing Maternal Mortality

The Preventing Maternal Deaths Act that was passed in the 115th Congress and signed into law in December 2018 will vastly improve data collection on the maternal mortality crisis so we can begin to understand why mothers are dying from preventable causes. It will also help states to sustain the health of mothers during the entire pregnancy cycle. This was a critical first step to addressing maternal mortality, but there are more work to be done.

We believe there are bipartisan opportunities to ensure that vulnerable populations of women have access to care during pregnancy and throughout the postpartum period. Additionally, supporting the implementation of best practices throughout hospital systems is something we would like to work with the Committee to address.

3. Prioritize Evidence Based Maternity Care and Optimal Physiologic Birth Outcomes

In 1996, the World Health Organization called for the elimination of unnecessary intervention in childbirth. However, two decades later the United States still has some of the highest primary and repeat Cesarean birth rates, labor induction and augmentation practices, and regional anesthesia usage. At the same time, we are underusing proven models of care such as group model prenatal care and birth centers, and practices such as smoking cessation intervention and continuous labor support. In 2018 a multidisciplinary group of maternity care experts found that “Current maternal-newborn practice involves evidence-practice gaps and unwarranted practice variation, reflecting overuse of unneeded practices, underuse of beneficial practices and limited use of implementation science and quality improvement methods.”

After the August recess we will be introducing the Maximizing Optimal Maternity Services and Building a Best Evidence System, or MOMS and BABES Act that is based on the recommendations in the 2018 Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing. In that blueprint these experts recommended that “mobilizing innate capacities for healthy childbearing processes and limiting use of consequential interventions that can be safely avoided ... can contribute to health equity across the childbearing population.”

We look forward to working with the Subcommittee to prioritize evidence-based care in all federal maternity care efforts, to ensure consumers have access to the best evidence in maternity care practices and outcomes, and to promote research that will further our knowledge base about physiologic birth and the best practices to achieve optimal birth outcomes for all women.

As members of the House Appropriations Committee, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, we have worked in a bipartisan fashion to support critical programs and initiatives to improve the lives and health of both mom and baby. We are proud to have helped secure robust funding for programs such as Safe Motherhood Maternal Mortality Review Committees, the Title V Maternal and Child Health Block Grant, Healthy Start, the Alliance for Innovation on Maternal Health, Breastfeeding Promotion, the Task Force for Research in Pregnant and Lactating Women, and so many others. Additionally, we were able to commission a National Academies of Science Study on Research Issues in Birth Settings that is currently underway and will be concluding with consensus policy recommendations in early 2020. We will continue our work to support maternal health in the federal appropriations process and we look forward to working collaboratively with the Committee to build on this work.

Chairwoman Eshoo and Ranking Member Burgess, we thank you for your leadership and for extending us this opportunity to share our major priorities with the Subcommittee. We look forward to working with you to advance awareness, education and solutions to improve maternity care outcomes for all our nation’s mothers

and their children. Together we can make maternal and infant health a national priority. We believe this is long overdue.

Mr. PALLONE. Well, thank you both for being here and being here on a bipartisan basis. You both are appropriators so, you know, obviously, you can—we can work with you on a lot of these things and we certainly will take them up.

You know, I do think it's a disgrace when we talk about maternal mortality and, you know, how we compare with other countries, and just one thing and I am supposed to move on here.

But, you know, when you mention C-sections—and it's a while ago now, but I remember with my wife, you know, we have three kids and the first two were born—were C-section, right. But she always wanted to have—to not do the C-section if she could.

And so when the third one came along, you know, she said, well, if it's at all possible I'd rather not have the C-section, and all the doctors, oh, you already had two—you just—it's not a good idea. You should have a C-section again. Let's just schedule in advance. And she absolutely refused and our daughter was born without the C-section. Sort of proved them wrong.

But that's always been the case and it's still the case that they always try to push a C-section when it's not necessarily—not necessary sometimes. So I appreciate you bringing that up. But there are so many of these issues that you raise that are just so important.

Chairwoman Eshoo and the Dr.—

Ms. ESHOO. Thank you, Mr. Chairman.

I want to thank both of you for being here today and all of the work that you're doing with your caucus, the legislation that you highlighted today, and I love the way you double teamed it.

At the Health Subcommittee, we have been trying to find out from CRS if the Health Committee has ever had a hearing on the state of women's health in the United States of America and we can't find one, and I think it's about time that we do one.

You know that as we—when we are part of a congressional delegation to a foreign country on one of the first pages of the handbook from the State Department is how that country is measured.

One of the yardsticks is infant mortality and maternal mortality, and now our numbers keep going up. So your work is critically essential and I look forward to post-August where we actually do something that will represent and, hopefully, touch the lives of the largest percentage of our country and that is women. So bravo to you. Bravo to you for your beautiful work. Thank you.

Mr. PALLONE. Thank you.

Dr. Burgess?

Mr. BURGESS. Well, I just—I don't know if people recognize what an extraordinary accomplishment it was for Jaime Herrera Butler to get that stand-alone maternal mortality bill through and signed in the last Congress. It really was a milestone. There were days I didn't think it was actually going to happen.

Certainly, the representatives put a lot of effort into it. Our subcommittee staffs on both sides of the dais did and did get it across the finish line. Another milestone that we were able to accomplish in the last Congress was on the health professions shortage areas including maternal care providers.

Without actually changing the appropriation we changed the authorizations that we could include maternity care providers in health profession shortage areas.

So we can build on those accomplishments. I know the past is just a prelude and we can continue to do that. I've got some ideas and we will continue to work on those things.

So I appreciate you both being here. It is an important topic and one that we need to maintain our focus.

Thank you.

Mr. PALLONE. Thank you, and thank you both, really, for what you're doing. We appreciate it. Continue to work with us.

And now we will go to my friend, Congresswoman Napolitano. Thanks for being here.

OPENING STATEMENT OF HON. GRACE F. NAPOLITANO A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. NAPOLITANO. Thank you for having me, Mr. Chairman, and thank the ranking member.

My bill is H.R. 1109, which I feel we must pass—the Mental Health Services for Students Act. This is my sixth Congress and I am hoping this time we will be able to get it off the ground.

I have a Senate co-sponsor. Senator Tina Smith of Minnesota has the companion bill, Senate bill 1122. Sixteen members of the House Energy and Commerce Committee—this committee—support my bill: Cárdenas, Barragán, Tonko, Clarke, Rush, Matsui, Castor, McNerney, Welch, Luján, Kennedy, Dingell, Veasey, Kuster, Kelly, and Soto, and we hope to add more.

My bill would provide \$200 million per year for five years for 100 school-based pilot programs on mental health nationwide. It expands the scope of the Project Advancing Wellness and Resilience Education called AWARE—the program—by providing on-site licensed mental health professionals in schools in the community.

The funding for the program would do the following: provide for comprehensive staff development for school personnel and personnel working in the schools. It includes administrators and teachers assistance to recognize mental health issues.

It would support and implement comprehensive culturally and linguistically appropriate services. It would deliver assistance to local communities in the development of policies to address their own child and adolescent childhood trauma and mental health issues, and violence when and if it occurs.

Establish mechanisms for children and adolescents to report incidents of violence or plans by other children, adolescents, or adults to commit violence.

It would also promote positive mental health education and support for parents and siblings and other family members of children with mental health disorders, as well as concerned members of the community.

H.R. 1109 is supported by the Mental Health Liaison Group, which consists of 51 mental health organizations. It's supported by the Los Angeles County Board of Supervisors, also by the National Education Association, the American Federation of Teachers, and others.

The bill is modeled off of a school-based mental health program developed in 2001. The Pacific Clinics and I started with half a million dollars for SAMHSA with seed money, which ended in 2009.

SAMHSA no longer funds it. It is taken over by the county of Los Angeles and been instrumental and have grown the project to 35 schools instead of four.

The program began in three middle schools and one high school and as I said, it has already grown and we are hoping to add more schools pretty soon.

But I thank you very much for the opportunity and I hope that you will consider this in the future.

Thank you.

[The prepared statement of Mrs. Napolitano follows:]

PREPARED STATEMENT OF HON. GRACE F. NAPOLITANO

Chairwoman Eshoo and Ranking Member Burgess, thank you for the opportunity to testify today.

It is vital that we pass my bill, HR 1109, the Mental Health Services for Students Act. In the Senate, Senator Tina Smith of Minnesota has a companion bill, S. 1122. Sixteen members of the House Energy and Commerce Committee are currently cosponsors of my bill: Cárdenas, Barragán, Tonko, Clarke, Rush, Matsui, Castor, McNerney, Welch, Luján, Kennedy, Dingell, Veasey, Kuster, Kelly, and Soto.

My bill would provide \$200 million per year for five years for 100 school-based mental health programs nationwide. It expands the scope of the Project Advancing Wellness and Resilience Education (AWARE) program by providing on-site licensed mental health professionals in schools across the country, and funding will be distributed by the Substance Abuse and Mental Health Services Administration (SAMHSA), which will set guidelines and measure the outcomes of the funded programs.

Funding for this program would:

- Provide for comprehensive staff development for school and personnel working in schools
- Support and implements comprehensive culturally and linguistically appropriate services
- Deliver assistance to local communities in the development of policies to address child and adolescent trauma and mental health issues, and violence when and if it occurs
- Establish mechanisms for children and adolescents to report incidents of violence or plans by other children, adolescents, or adults to commit violence
- Promote positive mental health education and support for parents, siblings, and other family members of children with mental health disorders, as well as concerned members of the community
- HR 1109 is supported by the Mental Health Liaison Group (which consists of 51 Mental Health Organizations), Los Angeles County Board of Supervisors, National Education Association, and the American Federation of Teachers.

The bill is modeled off of a school-based mental health program Pacific Clinics and I started in 2001 with a half a million dollars in SAMSHA seed money. The program began in three middle schools and one high school and has since grown to thirty-five schools. The Los Angeles County Board of Supervisors and the County Department of Mental Health have also been instrumental in the success of this program, taking over funding the program in 2009.

Thank you again for the opportunity to testify.

Mr. PALLONE. We certainly will consider it and we know that a lot more needs to be done with regard to mental health issues. So thanks again. I appreciate it.

Next is the gentlewoman from Georgia, Ms. McBath.

OPENING STATEMENT OF HON. LUCY MCBATH A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mrs. MCBATH. Thank you very much, Mr. Chairman, and the esteemed committee. Thank you so much for allowing me to discuss a very important topic to me once again as we have heard a little bit earlier today—maternal mortality.

I'd like to thank my colleague and member of this committee, Representative Robin Kelly, for being a champion on this issue. The importance of her legislation, the Mothers and Offspring Mortality and Morbidity Awareness Act, or MOMMA's Act, cannot be overstated, and that is House Bill H.R. 1897.

The United States has an atrocious record when it comes to maternal mortality. As many on this committee already know, our rates of maternal mortality are the highest among other developed nations in the world.

What's more concerning is that there has been a significant increase in the maternal death rate. From 1991 to 2004, the rate has more than doubled.

This is absolutely unacceptable. We need a comprehensive solution to this crisis. Progress on this important issue has stalled and represents an incredible failure.

It is a failure to women throughout this country, especially women of color, who experience maternal mortality at rates three times that of their white counterparts.

We have a responsibility to mothers and to their families to make sure that safety and health is our number-one priority.

The research is absolutely clear. Comprehensive care for pregnant women saves lives. According to the Centers for Disease Control and Prevention, 60 percent of maternal deaths are completely preventable.

Extending coverage for a full year will simply save the lives of many of those mothers, and while maternal mortality is certainly the worst outcome, it's not the only outcome.

Many women suffer from complex illnesses that complicate their pregnancy and endanger their health. I shared the story of a constituent of mine recently on the House floor. Her name is Phiffer. She struggles with a mental health disorder.

During her pregnancy in 2014, she had to have an immediate surgical correction for an irregularity in her cervix. The surgery failed, and at 20 weeks she was confined to bed rest for the duration of her pregnancy.

Her mental health was not addressed. At 30 weeks, she gave birth to a beautiful baby boy but then her mental health was yet again not addressed.

Almost immediately she began to suffer from post-partum anxiety. She abandoned many things that once gave her joy and it took 12 months for her diagnosis to actually come to fruition.

This story is just like millions of other mothers throughout our country. We must do more to improve the range of services available to these young mothers.

We must do more to care for the coordination for these young mothers. We must do everything that we can to give these young mothers the best possible care they deserve.

And so we are faced with a challenge. Make no mistake that maternal health in this country is in crisis. The MOMMA Act will help save the lives of mothers across the country.

The Congress has this opportunity to act in the interest of these mothers and their families. And as you know, the MOMMA Act would provide access to life-saving healthcare for a year after conception for women who use Medicaid.

It would also allow for Medicaid coverage of doulas and midwives, expanding access for people who lack access to an OB/GYN doctor.

Not only does this legislation extend coverage for low-income women, but it improves maternal health for all women by increasing care coordination by health systems and ensuring that every mother has access to the best possible care.

This legislation would help America keep the promise of safety and happiness to these new mothers and their infants.

Thank you for the opportunity to testify. Thank you so much for hearing my heart.

[The prepared statement of Mrs. McBath follows:]

PREPARED STATEMENT OF HON. LUCY MCBATH

Thank you for allowing me to appear before this committee to discuss an important topic to me, maternal mortality. I'd like to thank my colleague, and member of this committee, Rep. Robin Kelly, for being a champion on this issue. The importance of her legislation, the Mothers and Offspring Mortality and Morbidity Awareness Act, or Momma's Act, cannot be overstated.

The United States has an atrocious record when it comes to maternal mortality. As many on this committee know, our rates of maternal mortality are the highest among other developed nations. What's more concerning is there has been a significant increase in the maternal death rate. From 1991 to 2004, the rate has more than doubled.

That is unacceptable. We need a comprehensive solution to this crisis.

Progress on this important issue has stalled and represents an incredible failure. It is a failure to women throughout this country—especially women of color—who experience maternal mortality at rates three times that that of their white counterparts.

We have a responsibility to mothers, and their families, to make sure that safety and health is our number one priority.

The research is clear. Comprehensive care for pregnant women saves lives. According to the Centers for Disease Control and Prevention, sixty percent of maternal deaths are completely preventable. Extending coverage for a full year will save the lives of many of those mothers. And while maternal mortality is certainly the worst outcome, it's not the only outcome. Many women suffer from complex illnesses that complicate their pregnancy and endanger their health.

I shared the story of a constituent of mine recently on the House floor. Her name is Phiffer. She struggles with a mental health disorder. During her pregnancy in 2014, she had to have an immediate surgical correction for an irregularity in her cervix. The surgery failed, and at 20 weeks she was confined to bedrest for the duration of her pregnancy. Her mental health was not addressed. At thirty weeks, she gave birth to a beautiful baby boy. Her mental health was not addressed. Almost immediately, she began to suffer from postpartum anxiety. She abandoned many things that once gave her joy. It took 12 months for her to finally be diagnosed.

This story is just like millions of others throughout this country. We must do more to improve the range of services available to these young mothers. We must do more to improve care coordination for these young mothers. We must do everything we can to give these young mothers the best possible care.

And so, we are faced with a challenge. Make no mistake that maternal health in this country is in crisis.

The Momma Act will help save the lives of mothers across the country. This Congress has the opportunity to act in the interest of these mothers and families. As you know, the MOMMA Act would provide access to life-saving healthcare for a year after conception for women who use Medicaid. It would also allow for Medicaid cov-

erage of doulas and midwives, expanding access for people who lack access to an OB-GYN doctor.

Not only does this legislation extend coverage for low income women, but it improves maternal health for all women by increasing care coordination by health systems and ensuring that every mother has access to the best possible care. This legislation would help America keep the promise of safety and happiness to these new mothers and infants.

Thank you for the opportunity to testify and I yield back the balance of my time.

Mr. PALLONE. I agree when you said maternal health is in crisis and we need to address it, as you heard the testimony of your colleagues. So we will—we will follow through. Thanks so much.

My colleague from New Jersey is next.

**OPENING STATEMENT OF HON. BONNIE WATSON COLEMAN A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW
JERSEY**

Ms. WATSON COLEMAN. Thank you very much, Mr. Chairman, and to the ranking member and to members who are here today. Thank you very much for holding this Member Day Hearing.

I want to begin by stressing that the Affordable Care Act has been a literal lifeline for many in my district, New Jersey's 12th Congressional district, as well as in communities of colors across the nation.

Since 2010, the rates of uninsured African Americans have nearly been cut in half, going down from 20 percent to 11 percent.

In my district, if the ACA were to be struck down by the courts in *Texas v. Azar*, nearly 50,000 people would lose their healthcare insurance.

So while the law isn't perfect, I know you, Mr. Chairman, and your subcommittee are committed to protecting the ACA and expanding access to healthcare for all Americans.

And in the spirit of that, I come before you today to ask for your commitment to addressing the inequities that our healthcare institutions and structures create, which put women and patients of color at elevated risks for certain morbidities and even mortality.

For black mothers, who are often provided lower quality maternal care when they can access care at all, the ACA's requirement to cover pregnancy, labor, delivery, and newborn care as essential benefits in health plans was absolutely critical.

However, since nearly half of pregnancies are unplanned, many women don't have a plan when they find that they are pregnant. Or if they have a short-term plan, it doesn't cover pregnancy care.

Surprisingly, while our system currently considers getting married or giving birth to a child a "qualifying life event" allowing one to sign up for health insurance, pregnancy does not currently trigger one of these special enrollment periods.

This is particularly alarming when black maternal mortality rates in the United States are similar to rates in developing countries at 40 deaths per 100,000.

This is why, as a founding member of the Congressional Caucus on Black Women and Girls, I made it a priority to address the gaps in our healthcare system which result in black mothers dying at two to six times the rate of their white peers.

In addition to organizing stakeholder convenings to talk about this disparity, we are pushing legislation that is important to addressing health disparities among black women and girls.

One of the first bills that I introduced when I was elected to Congress was the Healthy Maternal and Obstetric Medicine Act, or commonly referred to as Healthy MOM Act.

The Healthy MOM Act would create a special enrollment period in the insurance market for women when they become pregnant so that they and their child are able to receive the healthcare that they need.

This Congress, the Healthy MOM Act is H.R. 2278 and currently has more than 75 cosponsors.

Chairman Pallone, as you and your committee explore ways to protect and expand access to healthcare for American families, I implore you to also work to address racial and ethnic disparities in our system. The Healthy MOM Act has the potential to be part of that solution.

Before I yield back, I would be remiss to not mention that this year is the 20th anniversary of the REACH program, which stands for Racial and Ethnic Approaches to Community Health.

REACH remains one of the CDC's only programs specifically dedicated to addressing racial and ethnic health disparities.

Started during the Clinton administration, REACH is unique because it follows a community-led model which includes robust engagement of the population impacted by health disparities, and multi-sector representation in all aspects of program planning, development, and implementation to successfully tailor programming for communities of color with the greatest chronic disease burdens.

As this subcommittee looks to address racial and ethnic disparities, I do hope you will look to REACH grantees for lessons learned in how to address racial health disparities and to incorporate them into your own policy proposals.

And with that I yield back and I want to thank you for this opportunity to address these issues today.

[The prepared statement of Ms. Watson Coleman follows:]

PREPARED STATEMENT OF BONNIE WATSON COLEMAN

I. Introduction—Affordable Care Act (ACA)

- Thank you, Chairwoman Eshoo, Ranking Member Burgess, and other members of the Subcommittee for holding this Member Day hearing.

- I want to begin by stressing that the Affordable Care Act (ACA) has been a literal lifeline for many in my district, New Jersey's 12th Congressional district, as well as in communities of color across the nation.

- Since 2010 the rates of uninsured African Americans have nearly been cut in half, going down from 20 percent to 11 percent.

- In my district, if the ACA were to be struck down by the courts in *Texas v. Azar*, nearly 50,000 people would lose their health insurance.

- So while the law isn't perfect, I know that you, Madame Chair, and this subcommittee are committed to protecting the ACA and expanding access to healthcare for all Americans.

- And in that spirit, I come before you today to ask for your commitment to addressing the inequities that our healthcare institutions and structures create, which put women and patients of color at elevated risks for certain morbidities, and even mortality.

- For black mothers, who are often provided lower quality maternal care when they can access care at all, the ACA's requirement to cover pregnancy, labor, delivery and newborn care as essential benefits in health plans was absolutely critical.

- However, since nearly half of pregnancies are unplanned, many women don't have a plan, when they find out they are pregnant. Or if they have a short-term plan, it doesn't cover pregnancy care.
- Surprisingly, while our system currently considers getting married or giving birth to a child a "qualifying life event" allowing one to sign up for health insurance, pregnancy does not currently trigger one of these "special enrollment periods."
- This is particularly alarming when Black maternal mortality rates in the United States are similar to rates in developing countries at 40 deaths per 100,000.

II. Healthy Mom Act

- This is why, as a founding member of the Congressional Caucus for Black Women and Girls, I made it a priority to address the gaps in our healthcare system which result in black mothers dying at 2-6 times the rate of their white peers.
- In addition to organizing stakeholder convenings to talk about this disparity, we are pushing legislation important to addressing health disparities among black women and girls.
- One of the first bills I introduced when I was elected to Congress was the Healthy Maternal and Obstetric Medicine Act, or Healthy MOM Act.
- The Healthy MOM Act would create a special enrollment period in the insurance marketplace for women when they become pregnant so that they and their child are able to receive the healthcare they need.
- This Congress, the Healthy MOM Act is HR 2278, and currently has [more than] 75 cosponsors.
- Madam Chair, as you and your Subcommittee explore ways to protect and expand access to healthcare for American families, I implore you to also work to address racial and ethnic disparities in our system. The Healthy MOM Act has the potential to be part of that solution.

III. Reach—Racial And Ethnic Approaches To Community Health

- Before I yield back, I would be remiss to not mention that this year is the 20th anniversary of the REACH program—which stands for Racial and Ethnic Approaches to Community Health.
- REACH remains one of the CDC's only programs specifically dedicated to addressing racial and ethnic health disparities.
- Started during the Clinton administration, REACH is unique because it follows a community-led model includes robust engagement of the populations impacted by health disparities, and multisector representation in all aspects of program planning, development, implementation to successfully tailor programing for communities of color with the greatest chronic disease burdens.
- As this subcommittee looks to address racial and ethnic disparities, I hope you will look to REACH grantees for lessons learned in how to address racial health disparities and incorporate them into your own policy proposals.
- And with that I yield back. Thank you for the opportunity to address these issues today.

Mr. PALLONE. Well, let me thank you. I know you have a long history of working on a lot of these healthcare issues both here and in the state legislature.

And, you know, I will certainly follow on the Healthy MOM's Act, and you know that the CDC for years has had this, you know, healthcare disparities issue that they highlight. I guess they have their brain trust—is that what it's called? Robin Kelly for a long time—I don't know if she still is—but was the head of that and she's on our committee now.

So, you know, we'll—we have incorporated some of those things but I know a lot more needs to be done so we will work with you. Thank you, Bonnie. Thank you.

Oh, and Chairwoman Eshoo wants to make—

Ms. ESHOO. I just wanted to say, Bonnie, thank you for the courage that you've exhibited to all of us and you—

Ms. WATSON COLEMAN. Thank you, Madam Chairman. Thank you.

Ms. ESHOO. Yes, and I think our prayers are answered and now we have got to get your legislation done.

Ms. WATSON COLEMAN. Thank you.

Mr. PALLONE. Thank you, Chairwoman Eshoo. Thanks, Bonnie.

Next, we have Mr. Levin of Michigan. Thanks for being here.

OPENING STATEMENT OF HON. ANDY LEVIN A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. ANDY LEVIN. Thanks so much, Chairman Pallone. I am learning while I am here. Of our four kids, the first three were all delivered by midwives. So I've got to get on board with the MOMMA Act, if I am not already.

So but I want to thank you and Ranking Member Walden, Chairwoman Eshoo, Ranking Member Burgess, members of the subcommittee or allowing me to testify today and I am here today to talk about drug pricing, a topic that I know has been a tremendous priority for this subcommittee and for our constituents.

And I want to applaud the hard work that Energy and Commerce has already done this year to tackle this issue. But, as you know and all of us know, we have more work to do.

Personally, my family knows this all too well because two of my sons live with Crohn's disease, and actually in the anteroom I got a call from someone trying to get to one of my sons to give him an infusion that he needs, you know, to be healthy and survive.

My wife, Mary, and I would do anything to keep our kids healthy, and I know parents across this country feel the exact same way, even if it means waiting to pay another bill or neglecting necessities for themselves.

Families in every community are making incredibly hard choices for the sake of their kids. They should not have to. I came to Congress to raise the standard of living for working people in Michigan's 9th District and across our country and to ensure that the deck isn't stacked against American families.

That is why I've introduced the Stop The Overuse of Petitions and Get Affordable Medicines to Enter Soon, or the STOP GAMES Act. This common-sense bipartisan bill that I authored with Congressman Francis Rooney of Florida will help to stop pharmaceutical companies from gaming the system to block competition.

There have been multiple reports of drug makers attempting to use the Food and Drug Administration's "citizen petition" tool to keep generic competition from coming to market.

While the citizen petition is meant to ensure that stakeholders can flag legitimate issues with drugs awaiting FDA approval, reports indicate that drug makers have filed baseless petitions to protect their monopolies.

In fact, in October, then FDA Commissioner Scott Gottlieb listed the misuse of citizen petitions among anti-competitive techniques of concern.

Even if FDA doesn't ultimately agree with a petition's argument, the agency must investigate and respond to what are sometimes unsubstantiated claims. This prevents more affordable drugs from reaching consumers quickly, forcing American families to pay more.

For example, in 2017, the Federal Trade Commission filed a complaint arguing that ViroPharma's use of the citizen petition process constituted an anti-trust violation.

According to the FTC, ViroPharma’s “repetitive, serial, and meritless filings lacked any supporting clinical data” and “succeeded in delaying generic entry at a cost of hundreds of millions of dollars.”

The STOP GAMES Act would, as the title suggests, stop these kinds of games. Our bill outlines circumstances under which the FDA can promptly reject a petition meant to delay the approval of a generic competitor and directs the secretary of Health and Human Services to report any such incidents to the FTC.

The bill also requires drug makers to file a petition within 60 days of learning the information it’s based on, not right before a patent or exclusivity period expires and rival drugs are ready to come to market.

Finally, the bill requires enhanced reporting to keep Congress informed of efforts to game the FDA approval process.

As your subcommittee continues its important work to bring down drug prices, I urge you to consider the STOP GAMES Act and ensure the FDA’s citizen petition tool cannot be misused to keep prices high.

I thank the members of this committee who have already co-sponsored the bill—Congressman Tonko and Congresswoman Schakowsky—and I would welcome the chance to talk with more of you about this important fix.

Again, I want to thank you all for the privilege of testifying before your subcommittee and truly look forward to working with you on this bill and others on behalf of working families.

[The prepared statement of Mr. Andy Levin follows:]

PREPARED STATEMENT OF HON. ANDY LEVIN

Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo, Ranking Member Burgess, members of the subcommittee: thank you for allowing me to testify before you today.

I am here today to talk about drug pricing—a topic that, I know, has been a tremendous priority for this subcommittee and for our constituents. And I want to applaud the hard work Energy and Commerce has already done this year to tackle this issue.

But, as you all know, we have more work to do.

My family knows this all too well. Two of my sons live with Crohn’s disease. My wife, Mary, and I would do anything to keep our kids healthy, and I know parents across this country feel the exact same way—even if it means waiting to pay another bill, or neglecting necessities for themselves, families in every community are making incredibly hard choices for the sake of their kids. They should not have to.

I came to Congress to raise the standard of living for working people and ensure the deck isn’t stacked against American families. That is why I’ve introduced the Stop The Overuse of Petitions and Get Affordable Medicines to Enter Soon—or “STOP GAMES”—Act. This commonsense, bipartisan bill that I authored with Congressman Francis Rooney will help stop pharmaceutical companies from gaming the system to block competition.

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Again, I want to thank you all for the privilege of testifying before your subcommittee, and truly look forward to working with you on this bill and others on behalf of working families.

Mr. PALLONE. Let me thank the gentleman and, you know, you certainly raise issues that we care a lot about, you know, in terms of trying to reduce drug prices. You know, this is bipartisan.

Mr. LEVIN. Right.

Mr. PALLONE. It includes the president as well. You know, we did the generic competition bills—passed the House. We did transparency bills last week.

They are going to come to the floor probably in September. And I know that, you know, the citizen petitions, you know, has been abused. So we will certainly follow up.

Mr. LEVIN. Thank you so much. I really appreciate your help. Thank you, and I yield back.

Mr. PALLONE. Thanks. I am going to ask Mr. Schweikert to replace Mr. Levin because he has come back and forth several times and we have passed him over so why don't you go next because we have passed you over several times, and then we will go to another three? Thanks.

OPENING STATEMENT OF HON. DAVID SCHWEIKERT A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SCHWEIKERT. Thank you, Mr. Chairman, Mr. Griffin.

So this is where all the cool kids hang out, right?

Mr. PALLONE. Yes, right.

[Laughter.]

Mr. SCHWEIKERT. And I appreciate doing this and having sat up there through the Ways and Means Member Hour, I know sometimes it's interesting seeing the inbound of different concepts and thoughts coming from fellow members.

I have two. One I just want to share with you. It's a little conceptual though we are working on the legislation. And the other it's a bill that's sat in the Energy and Commerce for a couple years now.

One, I want to argue just conceptually, and this is for every Republican and Democrat. We are having the wrong argument about healthcare over and over and over. So if you and I were to strip away some of the noise, the ACA—who got subsidized, who had to

pay. Our Republican alternative—who got subsidized, who got to pay.

I want to argue we are living in a world right now that if we could legalize technology—there are wearables coming, something coming very soon where you can blow into it and it would diagnose whether you have a viral infection or a bacterial infection. The algorithm can write a prescription.

There is technology coming and it's on the cusp right now if we can remove the barriers to it that can crash the price of healthcare.

Wouldn't it be a much more—if we really care about our comments about, we need to reduce the price of this or the price of that—it's time for that sort of Blockbuster video moment where one day you stop going and picking up this little silver disc because you're hitting a button at home. That technology exists, and yes, it is going to be disruptive.

We are going to have hallways full of incumbents who are saying, you're putting us out of business—why are you letting an algorithm write a prescription—why are you allowing data to actually be. We know that data is actually the Holy Grail in healthcare.

So please, we are working on it. We are actually working on it with a couple members of your committee, both Republican and Democrat, who sort of see the vision that we are at that inflection point where we can use technology to crash the price of healthcare.

And as a simple request also, I had Congressman Andy Briggs grab me, sitting here, and he just asked me to put his testimony and a letter into the record if—

Mr. PALLONE. Without objection, so ordered.

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

Mr. SCHWEIKERT. So I will put that—hand that to staff.

So here's the piece of legislation we have had in the committee now for a couple years. Let me also make sure I have the right number for this year. It is H.R. 1284.

Think about how many members will come in front of you today and actually express real concern about the environment. Are we tracking what's happening out there? Do we know what's happening?

Back to that same sort of techno utopia that's rolling out right now, there is now sensors you can wear on yourself that talk to your supercomputer we call your smart phone.

How about the concept of crowd sourcing environmental data? And why this is so important—it's not Republican or Democrat—it's just data. But the elegance of it if you have some clowns painting cars in the back yard behind your house, how do you catch them?

In today's environmental regulatory system, it's a paperwork system. So we have our fixed towers that cost about a million dollars a year to maintain and then we have manufacturers, companies, those, fill out lots and lots and lots and lots of paperwork.

Does paperwork shoved into file cabinets make our environment cleaner? I want to argue how about a system that's less about the paperwork and actually more about keeping the air cleaner?

And now that there's this revolution of these new sensors that we could have a few thousand in a community that tell you, hey,

we have a bad act happening over here—hey, a business over here may be having a problem with its scrubbers.

Instead of spending two years putting paperwork in a file cabinet so one day you can sue them, how about knocking on the door and saying, hey, we have a hot spot here—let's fix it?

Now, it's a revolutionary concept because you have to understand the current environmental regulatory model in many ways is lots of people sitting in office chairs processing paperwork.

How about the concept just like you may use Waze when you're driving through a crowded area, it's the collection of the data that gets you there faster?

Why wouldn't we do that same technology, that citizen science technology, to say maybe file cabinets full of paperwork isn't the best way to protect our environment but living data of—is there something of difficulty here.

For those of us that live in the desert Southwest we actually have real concerns because we don't know some of our baseline numbers. What's baseline ozone? How much stuff comes in from the L. A. basin and blows in?

And if you have enough data points—if you have enough data points that the crowd sourcing—it's much more elegant in being able to protect the environment.

And I would argue that whether it be air or in Flint, Michigan, the simple little thing they could have put under a faucet that's under \$100 that would have told you there's a problem. It's time we embrace the fact there's a technology disruption that can fix so many of these goals and it—yes, it's a threat to the bureaucracy. But the benefit is we live in a cleaner world.

With that, I yield back, Mr. Chairman.

[The prepared statement of Mr. Schweikert follows:]

PREPARED STATEMENT OF HON. DAVID SCHWEIKERT

Chairman Pallone, Ranking Member Walden, Subcommittee Chairman Tonko and Ranking Member Shimkus, and members of the committee, thank you for allowing me this opportunity to speak with you today.

I'd like to talk with you today about one of my priorities in this Congress, which is ensuring technology can play a key role in our environment, including measuring our air quality.

We all have the same common goals when it comes to the environment: accurate data that is publicly available, achievable compliance standards, and ultimately a cleaner environment.

The current system of monitoring environmental quality, assessing the quality of the data, and enforcement around that information, is entirely dependent on EPA's stationary monitors throughout the country. The current system by which a state must prove compliance, known as 'attainment', could be vastly improved and benefit our environmental process.

We can and should practice better science by leveraging publicly available, crowdsourced data.

Currently, stationary monitoring stations, at times in precarious locations, create a rigid algorithm of measurements that fail tell a complete story. But what if we incorporated mobile monitoring devices to increase the size, scope, and density of data collected?

Imagine if affordable air monitors, some that can be seamlessly purchased on places like Amazon, are deployed on city or private commuting vehicles. Or if your child has asthma and wants to go play at the neighborhood park. I challenge you to consider the magnitude of data these mobile monitors could provide a city or better inform parents or schools. This form of robust data collection is being used by Google Maps and WAZE produces, but its potential value for being deployed to improve the environment is, by comparison, untapped.

I have introduced legislation, H.R. 1284, the Crowd Sourcing of Environmental Data Act of 2019, that would amend the Clean Air Act to give States the option of monitoring covered criteria air pollutants in designated areas by greatly increasing the number of air quality sensors in exchange for greater regulatory flexibility in the methods of monitoring.

My bill enjoys bipartisan support, including from Congressman Cárdenas, a member of this committee, as well as Congressman Aguilar. I thank them both for their support.

This legislation would provide a city, county or state with optionality, not a mandate. Under this legislation, states would annually produce the information gathered from their own crowdsourced environmental data for submission to the state's EPA for technical review. Upon review, and if the data is found to be as good or better than the current data collected by the EPA's stationary monitors, it is then submitted to the federal EPA Administrator for final verification.

Upon successful review, the state is granted a year of authority to monitor and act upon its own data faster and more effectively. All the while, the current EPA monitoring stations are running in the background to ensure that a failure in the state's monitoring would not result in a lack of environmental data collection.

Imagine being able to identify bad actors to the specificity of city blocks rather than an entire county. Through this technology we could tackle the problems in non-attainment areas and factually see where the bad actors operate.

I very respectfully urge this Committee consider my legislation, H.R. 1284, and please join me in harnessing 21st century technology.

Thank you again Mr. Chairman and ranking member for holding this hearing.

Mr. PALLONE. Well, thank you. I am sorry you had to keep coming back. But I love all these innovative ideas and use of technology because that's kind of what we pride ourselves on on this committee. So——

Mr. SCHWEIKERT. Well, you—Mr. Chairman, you have the legislation. If your Environment Subcommittee would ever—and I have Republican and Democrat sponsors.

Mr. PALLONE. Take a look.

Mr. SCHWEIKERT. I know you've been incredibly busy but it has sat here now for a couple years.

Mr. PALLONE. Yes, we will take a look at it and thank you for coming. Appreciate it.

OK. Congressman Trone, you're next. Thank you.

OPENING STATEMENT OF HON. DAVID TRONE A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. TRONE. Thank you, Mr. Chairman, and members of the committee for this opportunity to testify.

As many of you know, addressing the addiction crisis in America is my number-one priority in Congress. My constituents sent me here in large part because we firmly agree that more must be done to stop the 192 drug overdose deaths happening every day, two-thirds of which involve opioids.

Every death from addiction connects another family and community to the crisis. My own connection is devastating but will sound all too familiar.

On New Year's Eve in 2016, my nephew, Ian Trone, died from a fentanyl overdose. He was 24. He died alone in a hotel room.

One of my first actions as a representative was creating the Freshmen Working Group on Addiction. I know our historic freshman class could make real progress if we worked together across party, geographic, and demographic lines.

It's bipartisan with 64 members from 31 states across the country. Despite our diverse backgrounds and viewpoints, we are united

in our understanding of the necessity to put aside our differences and come together to save lives.

Members of our working group, 64 strong, have introduced legislation to ease access to naloxone, to put sanctions on producers of illegal fentanyl, increasing training for prescribers and law enforcement, and to require better warning labels, beef up research on addiction, and coordinate and track federal demand reduction activities.

I was proud to work with fellow freshmen Representatives Denver Riggleman, Kelly Armstrong, and Mikie Sherrill to introduce H.R. 2466, the State Opioid Response Grant Authorization Act.

This bill would authorize \$1 billion in funding for State Opioid Response Grants and Tribal Opioid Response Grants for each of the next five years to fight the opioid epidemic in every community across the country.

Each state receives at least \$4 million through the program, with additional funding to the ten states with the highest mortality rates due to drug overdoses.

The bill came from conversations with real people in our districts. In the early days of our roles, we toured our districts. We spoke with health departments, hospitals, first responders, elected officials, police officers, incarcerated individuals, mental health professionals, early childhood organizations, and, of course, those suffering from addiction.

We heard loud and clear we need additional and, most importantly, consistent funding to end this crisis—funding that allows local communities to provide individualized and specific services to their community.

This legislation does just that. It gives certainty—the certainty that states need that will provide them the funding so they can expect that to continue for at least the next five years.

There is no committee better positioned to make real and impactful progress on this issue than the Energy and Commerce Committee. You hold the power to advance legislation to authorize additional funding for prevention and treatment programs, require more robust training for our medical professionals, ease restrictions on prescribing lifesaving medication-assisted treatment, and so much more.

I urge you to use the power of that to take further meaningful steps to combat the addiction crisis, including passing a large package of legislation that will dramatically increase our response to the worst public health crisis our country has ever seen.

I recognize the committee has taken bold action in the past by passing the Comprehensive Addiction and Recovery Act, CARA, the 21st Century CURES Act, and the SUPPORT for Patients and Communities Acts.

I commend you for that and thank you. But the last two years we have lost 141,000 people from our country—141,000 people in the last two years.

This is a call to action. It's important what we have done. But we need to continue to take bold action to save lives.

Thank you for the chance to share our thoughts with you today and for your engagement in this important work, and we'd like to partner with you in these efforts.

[The prepared statement of Mr. Trone follows:]

PREPARED STATEMENT OF HON. DAVID TRONE

Thank you Chairman Pallone and members of the committee for the opportunity to testify.

As many of you know, I consider addressing the addiction crisis in America to be my number one priority in Congress. My constituents sent me here in large part because we firmly agree that more must be done to stop the 192 drug overdose deaths happening every day, two-thirds of which involve opioids.

Every death from addiction connects another family and community to this crisis. My own connection is devastating but will sound all too familiar. On New Year's Eve in 2016, my nephew Ian died from a fentanyl overdose. He was 24 years old, and he died alone in a hotel room.

One of my first actions as a Representative was creating the Freshmen Working Group on Addiction. I knew that our historic freshman class could make real progress if we worked together—across party, geographic, and demographic lines. It's bipartisan—with 64 members from 31 states across the country. Despite our diverse backgrounds and viewpoints, we are united in our understanding of the necessity to put aside our differences and come together to save lives.

Members of our working group have introduced legislation to ease access to naloxone, to put sanctions on producers of illegal fentanyl, to increase training for prescribers and law enforcement, to require better warning labels, to beef up federal research on addiction, and to coordinate and track federal demand reduction activities.

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The bill came from conversations we had with real people in our districts. In the early days of our roles, we toured our districts. We spoke with health departments, hospitals, first responders, elected officials, police officers, incarcerated individuals, mental health professionals, early childhood organizations, and those suffering from addiction. We heard loud and clear that we need additional and consistent funding to end this crisis—funding that allows local communities to provide individualized and specific services to their community. And this legislation does just that. It gives certainty to states that we will provide them funding, and they can expect that to continue for at least the next five years.

There is no committee better positioned to make real and impactful progress on this issue than the Energy and Commerce Committee. You hold the power to advance legislation to authorize additional funding for prevention and treatment programs, to require more robust training of our medical professionals, to ease restrictions on prescribing life-saving medication-assisted treatment, and so much more. I urge you to use that power to take further meaningful steps to combat the addiction crisis, including passing a large package of legislation that will dramatically increase our response to the worst public health crisis our country's ever seen.

I recognize the committee has taken bold action in the past by passing the Comprehensive Addiction and Recovery Act (CARA), the 21st Century CURES Act, and the SUPPORT for Patients and Communities Act. I commend you for that. Over 141,000 have died from drug overdoses in the last two years. We should see this as a call for additional action. What this committee has done is important, but we must continue taking action in order to save lives.

Thank you for the chance to share these thoughts with you today. You are engaging in important work, and I would like to be a partner with you in these efforts.

Mr. PALLONE. Well, I want to thank the gentleman. I mean, you're right on point in terms of raising the issue of fentanyl you mentioned with your nephew, unfortunately.

We just had a hearing on that. And we know that we have to do more in terms of funding. The biggest concern I have is that, you know, that \$6 billion that we appropriated on a bipartisan basis over two years—\$3 billion a year—that expires in February.

So if we want to continue with the state grants we have to, you know, come up with a way of funding that.

And, you know, there's a lot of concern. Also Congressman Cummings came to visit me earlier this week about getting that money—you know, getting money or grants down to the county and the local level as well.

So we are going to definitely follow up and I appreciate your bringing this to our attention, and go ahead, Mr. Griffith.

Mr. GRIFFITH. Thank you, Mr. Chairman.

I do appreciate your comments. You know, the Washington Post has been doing a whole series of articles on opioids, and my district has been particularly hard hit and that's one of the reasons I would agree with Mr. Cummings.

We need to get down to the local level as well because while the state of Virginia has issues—I don't know whether it's in the top ten—but the Washington Post article pointed out that the most number of pills, number one was in my district.

Number two was in my district—two communities that were one and two on the rank of pills that were sent out from '06 to '12. We have had a number of deaths. A book has been written, "Dopesick" by Beth Macy about the problem in the Appalachian region of Virginia in the Shenandoah Valley.

The other parts of the state may not have as many deaths per capita as we have. And so we may need to look at some of the programs where we can go into the hot spots and deal with those as opposed to look—because some of the states like Texas are huge. Texas, California—they are huge. Some of the smaller states may have hot spots that need help but they may not register because they are not as large as some of the others.

But we also—in talking about treatment, the deepest part of my district in coal country there are no treatment facilities. No overnight treatment facilities. You can get some day stuff but that's about it. So we need to work on that.

And I think we need Mr. Chairman to push the FDA to come up with non-opioid-based pain relievers and to push those as hard as we can—non-addictive pain relievers.

But I will say this has been a bipartisan effort by this committee and, Mr. Chairman, I know that will continue and we are going to all work together to try to see what we can do and I am so sorry that—it hits every family but not a death hits every family and I am so sorry for your family that a death resulted from an addiction.

Mr. PALLONE. Thank you.

Chairwoman Eshoo?

Ms. ESHOO. Thank you, Mr. Chairman.

Mr. Trone, thank you for coming and testifying today and for your passion for running and coming to Congress with this as your top issue.

Regarding the Washington Post article, it is a blockbuster and I really think that post-August recess that we have a hearing on this because there are some very important responsibilities that federal agencies have in this issue and I think that we have to learn from what has taken place so that it doesn't repeat itself with another product down the road.

But for those that have—that are affected by it, we have to do much better. I mean, what my colleague just described that in coal country there are simply no services, we can't have that in our country.

So you carry the weight of the loss of your family. But I do think that as you carry that, that that story can help change the overall story in our country.

So thank you for being here today, and I look forward to working with you.

Mr. TRONE. Thank you.

Mr. PALLONE. Thank you, Chairman.

Mr. Griffith go ahead.

Mr. GRIFFITH. Mr. Chairman, if I might add, too. I know that Subcommittee Chairwoman Diana DeGette and you and I and some others worked really hard on trying to make sure that our agencies are doing what they are supposed to and particularly the DEA—that we don't have some glitches in the law that prevents us from doing the things we need to do to stop the flow of these horrible drugs into our community.

So I know that we will continue to work on that and hopefully we will have a hearing in Oversight, as the gentle lady suggested.

Mr. PALLONE. Thank you, and thank you, Mr. Trone.

Now, the bells went off. We are down to 13 minutes. I'd like to get some of you in but I don't think we can get all four, right?

So what's the order?

Chairman McGovern, Mr. Lipinski. We can certainly get two. I don't know if we can get three.

Why don't the—we are never going to get to——

Mr. MCGOVERN. I'll read fast.

Mr. PALLONE. All right. We are not going to get to Malinowski then, I don't think.

All right. Do you want to come back?

Mr. MCGOVERN. No, I——

Mr. PALLONE. No, not you. I am going to try to get the three of you in. But Tom, can you come back after the votes?

We will see.

Mr. MALINOWSKI. I'll try. Yes.

Mr. PALLONE. All right. All right. Go ahead, Jim.

OPENING STATEMENT OF HON. JAMES P. MCGOVERN A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. MCGOVERN. Well, thank you, Mr. Chairman, members of the committee. I am here to testify on behalf of two bills, H.R. 2502, the Medical Nutrition Equity Act, and H.R. 3332, which would provide coverage for medical wigs under Medicare.

Mr. Chairman and members of the committee, Americans struggle every day to navigate treatments for life-threatening health conditions and all too often this battle comes with cost barriers that prevent people from securing treatments that fit their health and personal needs.

A few months ago, Congresswoman Herrera Beutler and I introduced H.R. 2501, the bipartisan Medical Nutrition Equity Act. Each year, more than 7,000 infants are diagnosed with an inher-

ited metabolic disorder. These life-threatening conditions prevent patients from digesting or metabolizing most “normal” foods.

Patients often manage their complex nutritional needs with prescribed specialized formulas and, without them, risk brain damage, repeated hospitalizations, and in some cases, even death.

Currently, children and adults who are diagnosed with serious digestive disorders must pay out-of-pocket for medically necessary food, which can often cost four to five times as much as the foods that we find at a grocery store.

And to make matters worse, most health insurance companies do not cover medically necessary nutrition unless the medication is administered through a surgically placed tube—a costly and, ultimately, dangerous procedure that in some cases can be avoided.

While 35 states have already passed laws to ensure some level of coverage for medical necessary nutrition, that coverage is highly variable and excludes all patients covered under federal programs.

The Medical Nutrition Equity Act would establish treatment parity by requiring coverage for specialized formulas, including medically necessary foods, vitamins, and amino acids under private insurance, Medicare, Medicaid, and the Children’s Health Insurance Program.

And by the way, this coverage—this is coverage that Congress already approved for military families enrolled in TRICARE.

The other important piece of legislation that I am here to talk about is H.R. 3332, which would amend Title 8 of the Social Security Act to provide coverage for wigs as durable medical equipment under the Medicare program.

Many patients living with medical hair loss suffers from a variety of diseases, including cancer, alopecia areata, and for those undergoing chemotherapy or suffering from alopecia areata, an incurable autoimmune skin disease that causes unpredictable hair loss, a wig is not just medically necessary but also essential to alleviating the emotional and social burdens of hair loss.

I was inspired to introduce this bill after meeting with one of my constituents, Mary Aframe, who runs the Women’s Image Center located in Worcester and Leominster, Massachusetts.

Ms. Aframe has worked tirelessly to help raise awareness about the many women undergoing chemotherapy who have trouble affording wigs, particularly those who use Medicare.

Wigs can cost thousands of dollars and are out of reach for many patients without help from their insurance provider. While many private insurance plans cover wigs for those undergoing treatments that cause hair loss, this bill re-categorizes wigs as durable medical equipment to allow Medicare to provide coverage if a doctor certifies that the wig is medically necessary.

This bill will help ensure that every cancer patient and alopecia patient who loses their hair can afford a wig and undergo treatment with the dignity and respect they deserve.

So, Mr. Chairman, I strongly encourage you to consider hosting hearings and markups on H.R. 2501 and H.R. 3332, and I look forward to the opportunity to work with you and the members of the Energy and Commerce Subcommittee on this, and I think we need to do right by our constituents and ensure that consistent coverage

is standard for all Americans no matter the illness they have or the healthcare coverage they require.

Thank you.

[The prepared statement of Mr. McGovern follows:]

PREPARED STATEMENT OF HON. JAMES P. MCGOVERN

I want to thank Chairman Pallone and Ranking Member Walden for allowing me the opportunity to testify in support of H.R. 2501, the Medical Nutrition Equity Act, and H.R. 3332, which would provide coverage for medical wigs under Medicare.

Mr. Chairman, Americans struggle every day to navigate treatments for life-threatening health conditions and all too often, this battle comes with cost barriers that prevent people from securing treatments that fit their health and personal needs.

A few months ago, Congresswoman Herrera Beutler and I introduced H.R. 2501, the bi-partisan Medical Nutrition Equity Act. Each year, more than 7,000 infants are diagnosed with an inherited metabolic disorder. These life-threatening conditions prevent patients from digesting or metabolizing most "normal" foods. Patients often manage their complex nutritional needs with prescribed, specialized formulas and without them, risk brain damage, repeated hospitalizations, and in some cases, death.

Currently, children and adults who are diagnosed with serious digestive disorders must pay out-of-pocket for medically necessary food, which can often cost four to five times as much as the foods we find in grocery stores. And to make matters worse, most health insurance companies do not cover medically necessary nutrition unless the medication is administered through a surgically placed tube—a costly and ultimately dangerous procedure that in some cases can be avoided.

While thirty-five states have already passed laws to ensure some level of coverage for medical necessary nutrition, that coverage is highly variable and excludes all patients covered under federal programs. The Medical Nutrition Equity Act would establish treatment parity by requiring coverage for specialized formulas, including medically necessary food, vitamins, and amino acids under private insurance, Medicare, Medicaid and the Children's Health Insurance Program—and by the way, this is coverage that Congress already approved for military families enrolled in TRICARE.

The other important piece of legislation that I'm here to talk about is H.R. 3332, which would amend title XVIII of the Social Security Act to provide coverage for wigs as durable medical equipment under the Medicare program.

Many patients living with medical hair loss suffer from a variety of diseases, including cancer and Alopecia Areata. For those undergoing chemotherapy or suffering from Alopecia Areata—an incurable autoimmune skin disease that causes unpredictable hair loss—a wig is not just medically necessary, but also essential to alleviating the emotional and social burden of hair loss.

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Wigs can cost thousands of dollars and are out of reach for many patients without help from their insurance provider. While many private insurance plans already cover wigs for those undergoing treatments that cause hair loss, this bill re-categorizes wigs as durable medical equipment to allow Medicare to provide coverage if a doctor certifies that the wig is medically necessary. This bill will help ensure that every cancer patient and Alopecia patient who loses their hair can afford a wig and undergo treatment with the dignity and respect they deserve.

Mr. Chairman, I strongly encourage you to consider hosting markups and hearings on H.R. 2501 and H.R. 3332 and I look forward to the opportunity to work with you and the Energy and Commerce Health Subcommittee on advancing this legislation. We need to do right by our constituents and ensure that consistent coverage is standard for all Americans—no matter the illness they have or healthcare coverage they require.

Mr. PALLONE. Thank you, Chairman McGovern. You've been very helpful to us in the Rules Committee. I appreciate that. And Congresswoman Herrera Beutler actually mentioned the bill that you

highlighted earlier. So we are going to—we will follow up. Thanks again.

Mr. Lipinski?

OPENING STATEMENT OF HON. DAN LIPINSKI A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. LIPINSKI. Mr. Pallone and Mr. Griffith—Chairman Pallone and Mr. Griffith, Chairwoman Eshoo, I want to thank for the opportunity to testify today.

I want to draw the committee's attention to H.R. 1165, a bill I introduced to address the serious public health issue from a chemical called ethylene oxide, or EtO.

Just outside my district in Willowbrook, Illinois, a company called Sterigenics has been using EtO to sterilize medical equipment. This sterilization method is used at many facilities across the country.

EtO is a known carcinogen. Last summer, the EPA released a report indicating disturbingly high cancer risk in communities across the country that are home to commercial sterilization facilities including Sterigenics that admit EtO.

The risk was determined after a lengthy advisory Integrated Risk Information System, or IRIS, process, which included extensive reviews of the scientific literature.

This review found that the probable cancer risk posed by EtO is 30 times greater than previously estimated. Further, a report released in April by the Illinois Department of Public Health found that certain types of cancer linked to EtO exposure were higher in the Willowbrook community than elsewhere in the state.

Specifically, when looking at neighborhoods near the Sterigenics facility, the report found higher rates of Hodgkin's lymphoma in women, pediatric lymphoma in girls, as well as ovarian, breast, and pancreatic cancers.

This was, obviously, frightening news for every community and family in the vicinity of Sterigenics and a cause of great alarm to others with similar facilities nearby.

Thankfully, the Illinois EPA stepped in last February to issue a CO order at Sterigenics and prevent it from using EtO in its sterilization process.

But just last week, an agreement was reached to allow the facility to reopen pending approval by a district court. Meanwhile, the EPA has stated for months that it is considering new emission standards for facilities that use EtO, which would be based on the most recent risk data available.

This would provide for direct EPA regulation of EtO emissions and protect people living in communities around EtO-emitting facilities.

But the EPA has still not promulgated the standard, slow-walking an issue of profound concern to my constituents. It is also unclear whether the EPA will continue utilizing the best available science to inform the standard by basing its decision on rigorously reviewed IRIS risk values.

The EPA must not be allowed to undermine the integrity of scientific process by ignoring established research methods that may reveal unfavorable results.

I've been very vocal about this issue because I not only represent thousands of people who live and work downwind of the Sterigenics facility, but I also live nearby.

In order to get the EPA to act, earlier this year I introduced H.R. 1165, the EtO is Toxic Act. This bill requires the EPA to take IRIS assessment data into consideration when setting an EtO emissions standard.

I request the committee to act on this bill to ensure that EPA decisions on this matter use the best science available. Further, I urge the committee to use its oversight authority over the EPA to investigate whether it's taking appropriate action to protect public health from the dangers of EtO.

After years of breathing air with an unsafe cancer-causing pollutant, my constituents and others across the country cannot wait.

I thank you for your time and your attention, and I yield back.
[The prepared statement of Mr. Lipinski follows:]

PREPARED STATEMENT OF HON. DAN LIPINSKI

Thank you, Chairman Pallone, Ranking Member Walden, and all members of the committee on Energy and Commerce, for the opportunity to testify today about important issues within the committee's jurisdiction. The primary topic I wish to address is the problem of skyrocketing prices for healthcare and medicine. This committee has recently taken action to move forward legislation to start addressing this problem, including legislation dealing with surprise bills and drug pricing, some of which I have cosponsored. I look forward to this legislation moving to the floor so we can pass it and get it signed into law. But we must do more. I urge the committee to promote healthcare price transparency as it prepares to bring healthcare legislation to the House floor.

Every single one of us has hundreds and thousands of constituent families who have struggled with the high prices of medical care - including sky-high charges for drugs and incomprehensible bills from hospitals and other providers. But even aside from the charges patients directly see, the economy as a whole suffers from the runaway growth in healthcare spending as charges covered by insurance are passed on to patients in the form of higher insurance premiums and higher taxpayer costs for public programs. Even with a lifesaving drug like insulin, which was first discovered nearly 100 years ago, prices are climbing through the roof—something I have seen firsthand as a diabetic. I have also directly seen how inflated hospital bills can be after being treated for a bike accident. But my own experiences are just a drop in the ocean of the experiences of millions of patients across the U.S.

Earlier this month, the courts derailed an attempt to fight the high cost of prescription drugs by blocking an Administration rule requiring drug companies to include the price of a drug when it is advertised on TV. This is an idea that drug companies fought against - they clearly believe they have something to be hide. But Congress has the power to fix this court decision. I joined on as a co-sponsor of the Drug Price Transparency for Medicare Patients Act, which would give the Administration the authority it needs for this rule. While there are many of the President's policies I and many others in this room disagree with, this should be one we can all get behind. I urge the committee to consider this bill or similar proposals as legislation is prepared for a vote on the floor.

Similarly, I urge the committee to support transparency into hospital prices. The first bill I introduced after I was first elected was the Hospital Price Reporting and Disclosure Act in 2006. I will shortly introduce an updated version which will build on and strengthen an ACA requirement for hospitals to publish their list of standard charges on their websites. My bill will create penalties for non-compliance with the ACA rule; require an identical format for published data so that information can be easily compared create a central website for collecting charge information; facilitate access to this data by the public so they can create new consumer tools from the data; require HHS to develop a way to provide insight into actual negotiated charges while taking steps to prevent market collusion or price increases from this data; and require reporting on trends in standard and negotiated charges over time, including trends in comparison to Medicare rates.

In addition to the issue of healthcare costs and prices, I also want to draw the Committee's attention to a public health issue from a pollutant called ethyne oxide,

or EtO. Just outside my district in Willowbrook, IL, a company called Sterigenics has been using EtO to sterilize medical equipment. The EPA released an updated National Air Toxics Assessment last summer, which indicated a significantly elevated cancer risk in the surrounding communities because of EtO emissions. This risk was determined after a lengthy Integrated Risk Information System, or IRIS, process, which included extensive reviews of the scientific literature. The EPA has stated for months that it is considering an emissions standard for facilities that use EtO, which would protect people living in communities around them. However, the EPA has still not promulgated such a standard. Furthermore, it remains unclear whether the EPA will continue utilizing the best available science to inform any potential standard by basing its decisions on rigorously reviewed IRIS risk values.

I worked with my colleagues to introduce the Expanding Transparency of Information and Safeguarding Toxics Act, or the EtO is Toxic Act for short. That bill requires the EPA to take IRIS assessment data into consideration when setting an emissions standard with respect to EtO. I request the committee's support for this bill to ensure that EPA decisions on this matter use the best science available. Additionally, I urge the committee to use its oversight authority over the EPA to investigate whether it is taking appropriate action to protect public health from the dangers of EtO.

Thank you for your time and attention.

Mr. PALLONE. Thank you, Mr. Lipinski. I want to comment but we are running out of time before the vote. So thanks again for being here.

Mr. Golden, if you want to be quick, we could do it now. But if not, we'd ask you to come back. What do you prefer?

Mr. GOLDEN. I'll go ahead and be as fast as I can.

Mr. PALLONE. All right. All right. Thanks.

Mr. GOLDEN. And I am sure you're trying to keep on track today.

Mr. PALLONE. All right. Thanks.

Mr. GOLDEN. Thank you very much. Of course, I defer to you if you would prefer to wait.

**OPENING STATEMENT OF HON. JARED GOLDEN A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE**

Chairman Pallone, Mr. Griffith, Ms. Eshoo, thank you very much for the opportunity.

I am here to testify to testify about the FLAT Prices Act, H.R. 1188. It's a bill that I am proud to lead to address the issue of rapid increases in prescription drug prices.

I am honored to have the support of Mr. Casten, Ms. Slotkin, Mr. Cisneros, Mr. Rose, Ms. Pingree, and Ms. Finkenauer. I am glad to be working in partnership with Senator Durbin, who leads a companion bill in the Senate.

Traveling around Maine's 2nd District, this is a top issue—the rising price of prescription drugs. We are a very old state. We, in fact, per capita we are the oldest state—my constituents. Prescription drug prices is critically important to them.

And we have seen, obviously, over the years a lot of coverage about spiked prices, efforts to make a quick buck on the backs of people who are relying upon these prescription drugs.

Examples such as Martin Shkreli, raising the price of HIV/AIDS drugs, you know, by about 5,000 percent. I know you're all familiar with this. Mylan and EpiPen prices going from \$50 to over \$600. Insulin prices have consistently increased in recent years as well with the average price nearly doubling between 2012 and 2016.

This issue isn't just a few well-known bad actors. According to AARP, retail prices for a set of more than 250 widely-used brand

name prescription drugs increased by an average of more than 10 percent each year from 2012 to 2016.

These price increases have forced some families, particularly seniors, to make very difficult decisions between buying lifesaving medications and putting food on the table, paying rent. In a place like Maine—very cold in the wintertime—often that tradeoff has to do with heating your home or getting your medications.

I've introduced the FLAT Prices Act with this data and these real-world impacts in mind. The bill would help put a stop to immoral price gouging by helping generic competition come to the market faster.

The FLAT Prices Act would reduce a drug's market exclusivity period if its price spikes by more than 10 percent in one year, 18 percent over two years, or 25 percent over a three-year period.

The penalty for exceeding these thresholds would be a reduction of 180 days for the drug's exclusive monopoly period, and the period would shorten by an additional 30 days for each five percent price increase above these thresholds.

With this bill in place, pharmaceutical companies would be discouraged from steeply hiking their prices, and if they did so anyway, consumers would have less time to wait before generic alternatives would become available to them.

I applaud this subcommittee for its recent action to advance a number of bills related to drug pricing, and I hope that you will consider including the FLAT Prices Act, which has been referred to this committee in a future set of bills to control healthcare costs.

I particularly like the bill because I think it takes a tiered approach that matches the issue. For those who are most abusive, this bill would be most effective in doing something about price gouging.

For those who perhaps, you know, are price gouging a little bit less so than some of these worst of examples it would be less of a penalty.

But it does recognize that these companies have an exclusivity period because they have made big investments up front. You know, they start with a price and costs may increase.

We are not—we are not trying to stop companies from recovering the investments they have made. We are just trying to protect consumers from abusive behaviors.

[The prepared statement of Mr. Golden follows:]

PREPARED STATEMENT OF HON. JARED GOLDEN

Chairwoman Eshoo, Ranking Member Burgess, distinguished members of the committee: I appreciate the opportunity to testify about the FLAT Prices Act, H.R. 1188, a bill that I am proud to lead to address the issue of rapid increases in prescription drug prices.

I am honored to have the support of Mr. Casten, Ms. Slotkin, Mr. Cisneros, Mr. Rose, Ms. Pingree, and Ms. Finkenauer on this bill, and I am glad to be working in partnership with Senator Durbin, who leads a companion bill in the Senate.

As I travel around Maine's Second District, one issue I hear about constantly is the rising price of prescription drugs. For too long, big pharma has spiked prices to make a quick buck on the backs of those who cannot survive without these treatments.

We all remember the "Pharma Bro" Martin Shkreli (Skrell-ee), whose company Turing Pharmaceuticals raised the price of the HIV/AIDS drug Daraprim from \$13.50 per pill to \$750 per pill—a 5,000% price increase.

Similarly, Mylan, a company that has exclusive rights to distribute the lifesaving allergy medication auto-injector “EpiPen”, raised the price from \$50 to over \$600. Additionally, insulin prices have consistently increased in recent years, with the average price nearly doubling between 2012 and 2016.

This issue isn’t just about a few well known bad actors. According to AARP, retail prices for more than 250 widely used brand name prescription drugs increased by an average of more than 10% each year from 2012 to 2016.

These price increases have forced some families to make the excruciating decision between buying life saving medications and putting food on the table, or paying rent.

I introduced the FLAT Prices Act with this data—and these real-world impacts—in mind. The bill would help put a stop to immoral price gouging by helping generic competition come to the market faster. The FLAT Prices Act would reduce a drug’s market exclusivity period if its price spikes by more than 10% in one year, 18% over two years, or 25% over a three-year period.

The penalty for exceeding these thresholds would be a reduction of 180 days for the drug’s exclusive monopoly period, and the period would shorten by an additional 30 days for each 5% price increase above these thresholds.

With this bill in place, pharmaceutical companies would be discouraged from steeply hiking their prices, and if they did so anyway, consumers would have less time to wait before generic alternatives would become available to them.

I applaud this subcommittee for its recent action to advance a number of bills related to drug pricing, and I hope that you will consider including the FLAT Prices Act, which has been referred to this subcommittee, in a future set of bills to control healthcare costs.

Thank you again for the opportunity to testify today.

Mr. PALLONE. Well, thank you, and we have just got to wrap up. But, obviously, this is a huge priority for us in the fall.

You know, we are going to be having—we are going to moving—you know, be moving and looking at these various bills on negotiated prices under Medicare and we know the problem is particularly acute for seniors.

And Ms. Eshoo is certainly—this is a priority for her, too. So I am just going to adjourn now if that’s all right. We are going to—not adjourn. We are going to recess until 2:00 o’clock.

But I thank the gentleman from Maine.

Mr. GOLDEN. Thank you for the opportunity.

[Recess.]

Mr. PALLONE. The committee will reconvene and I assume Mr. Wittman is—thank you for being here.

Proceed.

OPENING STATEMENT OF HON. ROBERT J. WITTMAN A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. WITTMAN. Thank you, Mr. Chairman. I want to thank you and the committee members for the opportunity to come and speak to you today.

I represent the 1st District of Virginia, which faces a number of unique challenges in expanding broadband. The 1st District spans the I-95 corridor in Northern Virginia, which includes some of the foremost tech companies and data centers in the nation and continues southeast to the Northern Neck and Middle Peninsula, which is home to some of the most underserved rural populations in Virginia.

Citizens in more urban areas in the northern part of my district benefit from the highest quality broadband the market has to offer.

With access to speeds upwards of one gigabit, these citizens have unfettered access to services such as telemedicine, online edu-

cation, and modern business applications and technologies that allow businesses to compete in the 21st century.

These services are a convenience that many folks have come to take for granted in 2019. This is not the case in the more rural parts of my district. As population density decreases, the business case for providers simply is not there to extend service to these unserved areas.

Many communities and neighborhoods throughout the Northern Neck, Middle Peninsula, and stretches of Stafford County and localities east of Richmond, like the localities of New Kent and Hanover, struggle to gain access to reliable broadband.

As a resident of this area who drives back and forth to DC every day during session, I understand firsthand the plight of rural residents when it comes to gaining quality high-speed access.

In rural areas, broadband is oftentimes the top issue I hear about as mothers and fathers complain about late nights sitting in the McDonald's parking lot as their kids use the WiFi to finish their homework; children of elderly parents plead for quality broadband to access telemedicine services so their parents don't have to drive an hour plus to the nearest health facility; or business owners that know better quality broadband would allow them to grow their businesses.

Demand for high-speed broadband has never been greater.

Closing the digital divide is the key to lifting up countless communities and populations in unserved areas. While Congress has made great strides in tackling this issue, more can and should be done.

Further emphasizing policies that promote public-private partnerships is essential. As I mentioned earlier, as the population densities decrease in rural areas, P3s incentivize providers through an influx of capital funds to build in areas where the business case would often not exist without it.

Addressing our nation's broadband mapping capabilities is also important to closing the digital divide. It is no secret our broadband maps can be wildly inaccurate and often lead to overbuilding on already existing networks.

I am an original co-sponsor of H.R. 3162, The Broadband Data Improvement Act of 2019, which would require providers to report data on a geolocation basis to create an improved National Broadband Map that better targets funding to the areas that need it most.

Another important element in preventing overbuilding is through instituting challenge processes. H.R. 3162 establishes a periodic challenge process at the FCC by which the public and incumbent providers may challenge data on the National Broadband Map.

The FCC must then analyze any challenges that may suggest the map is inaccurate and resolve any disputes to update the map accordingly.

I strongly urge the committee to markup and pass this legislation and any other similar legislation with such measures so that we can advance them to the floor for a vote.

Lastly, we must continue to eliminate the labyrinth of red tape and regulations that continue to hinder shovel-ready projects and streamline our federal permitting process.

Mr. Chairman, I want to thank you and Ranking Member Walden and members of the committee for the opportunity to testify today.

Thanks so much for your leadership, and as co-chair of the Rural—House Rural Broadband Caucus, I offer my assistance on the subject and would certainly love to work with you on these items to help close the digital divide not only in my district but across our United States.

[The prepared statement of Mr. Wittman follows:]

PREPARED STATEMENT OF HON. ROBERT J. WITTMAN

Chairman Doyle and Ranking Member Latta, I represent the First District of Virginia, which faces unique challenges to expanding broadband. The First District spans the I-95 Corridor in Northern Virginia, which includes some of the foremost tech companies and data centers in the nation and continues southeast to the Northern Neck and Middle Peninsula, which is home to some of the most unserved rural populations in Virginia.

Citizens in more urban areas in the northern part of my district benefit from the highest quality broadband the market has to offer. With access to speeds upwards of one Gigabit, these citizens have unfettered access to services such as telemedicine, online education, and modern business applications and technologies that allow businesses to compete in the 21st Century. These services are a convenience that many folks have come to take for granted in 2019.

This is not the case in the more rural parts of my district. As population density decreases, the business case for providers simply is not there to extend service to these unserved areas. Many communities and neighborhoods throughout the Northern Neck, Middle Peninsula, stretches of Stafford County and localities east of Richmond struggle to gain access to reliable broadband. As a resident of this area who drives back and forth to DC every day during session, I understand first-hand the plight of rural residents when it comes to gaining quality high-speed internet.

In rural areas, broadband is oftentimes the top issue I hear about—as mothers and fathers complain about late nights sitting in the McDonalds parking lot as their kids use the WiFi to finish their homework; children of elderly parents plead for quality broadband to access telemedicine services so their parents don't have to drive an hour to the nearest health facility; or business owners that know better quality broadband would allow them to grow their businesses. Demand for high-speed broadband has never been greater.

Closing the digital divide is the key to lifting up countless communities and populations in unserved areas. While Congress has made great strides in tackling this issue, more can and should be done.

Further emphasizing policies that promote Public-Private Partnerships (P3s) is essential. As I mentioned earlier, as the population densities decrease in rural areas, P3's incentivize providers through an influx of capital funds to build in areas where the business case would often not exist without it.

Addressing our nation's broadband mapping capabilities is also important to closing the digital divide. It is no secret our broadband maps can be wildly inaccurate and often lead to overbuilding on already existing networks. I am an original co-sponsor on H.R. 3162, The Broadband Data Improvement Act of 2019, which would require providers to report data on a geolocation basis to create an improved National Broadband Map that better targets funding to the areas that need it most.

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I strongly urge the Committee to markup and pass this legislation so that it can advance to the floor for a vote.

Lastly, we must continue to eliminate the labyrinth of red tape and regulations that continue to hinder shovel ready projects and streamline our federal permitting process.

I want to thank Chairman Doyle, Ranking Member Latta, and members of the committee for this opportunity to testify today. As co-chair of the House Rural Broadband Caucus, I offer my assistance on the subject and would certainly love to work with you on these items to help close the digital divide in my district.

Mr. PALLONE. Thank you.

We—several members have talked about the need to expand broadband into rural and underserved areas, and that's one of the things that we definitely are striving for.

We have a bill called the LIFT America Act that would spend, like, \$40 billion on that as part of a larger infrastructure package.

So, you know, we are going to look at this very seriously. Thank you.

Mr. FLORES. I concur. Thanks, Rob, for joining us today.

Mr. PALLONE. Thanks a lot. Appreciate it.

Mr. WITTMAN. Thank you, Mr. Chairman.

Mr. PALLONE. Take care.

Mr. Malinowski, thank you for coming back after the votes.

Mr. MALINOWSKI. Thank you for having me back.

OPENING STATEMENT OF HON. TOM MALINOWSKI A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Thank you, Mr. Chairman, Mr. Flores, members of the committee. I very much appreciate the chance to testify.

You have a very broad jurisdiction. Obviously, I am going to focus on just one issue. I am here on behalf of the 168,000 people in New Jersey who have been hit with medical debt due to surprise billing.

Each year, through no fault of their own, in my state, in our state, these folks owe an extra \$420 million. We often hear about surprise billing happening during medical emergencies—a person is sick or injured. An ambulance is called, and later they are hit with a huge bill because either the ambulance or the hospital or the doctor they saw was out of network.

I recently spoke with a constituent whose husband had a cardiac emergency. She called local emergency services, who then called a local hospital to send an ambulance with cardiac equipment.

After her husband was release they received four separate bills totaling thousands of dollars. Their insurance was covering less than half.

While the hospital where he was taken was covered by the family's insurance, the couple was unaware that the ambulance, which was associated with the hospital, was out of network. How could they know? How could they be expected to know such a thing?

It is a true testament to how broken our healthcare system is that during our worst moments when we are most vulnerable, when we are sick, injured, worried about getting better, staying alive, we are also burdened with the responsibility of ensuring that our ambulance, our hospital, every single doctor that examines us is covered under the insurance we pay for each month.

Surprise billing, of course, does not just happen during emergencies. A patient can book an appointment with a doctor in network and only find out later that one of the medical professionals she saw actually worked for a third party and was not covered.

Anesthesiologists, radiologists, surgical assistants, often entire departments within an in-network facility might be operated by subcontractors and, therefore, be out-of-network.

Seven in ten people who have been hit with unaffordable out-of-network medical bills were not aware that the healthcare provider they saw was not in their plan's network at the time of receiving care.

Now, last year New Jersey passed our own law that clearly prohibits charging patients more than what we would normally owe under our insurance plans for urgent and medically necessary services or inadvertent out-of-network services.

There is no good reason why we should not do the same for every American. Patients who are no way at fault should not be responsible for astronomical fees they were not warned they were incurring.

Mr. Chairman, one last broader point on this. There are many things that Republicans and Democrats sincerely disagree about in this body. I don't think that this is one of them. I don't see any philosophical difference among us—amongst us about whether people should be stuck with massive surprise medical bills, just a challenge on agreeing on the practical details.

It is one thing to have gridlock when we disagree. If we cannot deliver on one of the few issues where we do stand on common ground that would further diminish our constituents' faith in this institution.

So I would say the stakes are pretty high.

I thank you for your work on this issue, which I know has been bipartisan in this committee. I look forward to being part of that and hope very much that we will come to a solution soon.

Thank you very much.

[The prepared statement of Mr. Malinoski follows:]

PREPARED STATEMENT OF HON. TOM MALINOSKI

Thank you Chairman Pallone and Ranking Member Walden. I appreciate the opportunity to testify in front of the House Energy and Commerce Health Subcommittee.

I am here today to advocate for the 168,000 New Jerseyans who have been hit with crippling medical debt due to surprise billing, including my constituents in the 7th district.

Surprise billing arises when an insured individual unknowingly receives care from an out of network provider, and is later hit with an unexpected medical bill.

Throughout New Jersey it is estimated that approximately \$420 million is owed by these patients each year due to surprise billing.

In many instances those out-of-network bills are shifted to health insurers, who then pass along their costs to an estimated five million residents who pay up to \$956 million more per year more for their commercial insurance premiums.

We often hear about surprise billing happening during medical emergencies. A person is sick or injured, an ambulance is called, and later they are hit with a huge bill because either the ambulance or the hospital or the doctor they saw was out of network.

I recently spoke with a constituent whose husband had a cardiac emergency. She called local Emergency Medical Services, who then called a local hospital to send an ambulance with cardiac equipment.

After her husband was released they received four separate bills totaling thousands of dollars, and insurance was covering less than half.

While the local hospital he was taken too was covered by their insurance, the couple was unaware that the ambulance, which was associated with the hospital, was actually out of network.

It is a true testament to how broken our medical system is that during a person's worst moments—when they are at their most vulnerable—they are also burdened with the responsibility of ensuring that their ambulance, their hospital, and every

single doctor that examines them, are covered under the insurance they pay for each month.

Surprise billing does not just come about during emergencies. A patient can book an appointment with a doctor in their network, and only find out later that one of the medical professionals they saw, actually worked for a third party and was not covered.

Anesthesiologists, radiologists, surgical assistants, often entire departments within an in-network facility might be operated by subcontractors and are therefore out of network.

Seven in ten individuals who have been hit with unaffordable out-of-network medical bills were not aware that the healthcare provider they saw was not in their plan's network at the time of receiving care.

According to a 2018 poll from the Kaiser Family Foundation Two-thirds of Americans say they are either "very worried" or "somewhat worried" about their ability to afford unexpected medical bills.

Last year New Jersey took steps to address surprise billing and increase transparency. Providers must now inform non-emergency patients anytime they will be responsible for any out of network fees. Changes were also made to lower costs for out of network care in emergency and urgent care scenarios.

There is still much to be done, and this issue needs to be addressed at a national level. Patients, who are in no way at fault, should not be responsible for astronomical fees they were not warned they were incurring. Billing should remain between the provider and the health insurance provider.

Party doesn't matter when you get hit with an unexpected medical bill. Congress must come together to provide solutions for Americans who are being saddled with debt they never agreed to take on.

Thank you, and I look forward to working with the Committee on this very important issue.

Mr. PALLONE. Well, thank you.

Ms. Eshoo?

Ms. ESHOO. I want to thank you for being here today and I agree with everything that you've said. Actually, the chairman and the ranking member of the full committee are the chief sponsors of what you just described.

And we have worked hard on the bill. It came through the Health Subcommittee to the full committee on a bipartisan basis, and I don't know if you've read the bill.

Mr. MALINOWSKI. I have, yes. Yes.

Ms. ESHOO. You have? And do you have any—if you have any particular views where you don't agree or you think the legislation can be improved, let us know.

Mr. MALINOWSKI. I will.

Ms. ESHOO. I think it's on its way and we look forward to it going to the floor for the full House to pass it post August recess.

Mr. MALINOWSKI. I hope so, too.

Mr. PALLONE. I appreciate what the gentlewoman has said.

The—I just want to make two remarks. First of all, I was surprised to find out that in our state, you know, generally, across the country the federal bill—well, I think there are about 12 states that have their own laws including California and New Jersey.

And so, obviously, for the states that don't this would be even more important, right, because they don't have any state legislation.

But even if the states that do, it generally doesn't cover, you know, the large self-insured, you know, ERISA plans. And we have figured that about a third of the people nationally, you know, are in those types of plans.

But interestingly enough, I had an event with the Speaker Coughlin, you know, who's from my district, and he said that in New Jersey it was reverse.

In other words, the state law only covers about a third and the federal law would cover the other two-thirds, which was, I thought, interesting.

Mr. MALINOWSKI. Yes. Even people covered by the state law don't always—aren't necessarily aware that they are protected. We have actually—my district offices have to help some of our constituents who actually are covered.

Mr. PALLONE. Yes.

Mr. MALINOWSKI. Obviously, you know, we have referred them to the state government, and the insurance companies and the hospitals have not fully adjusted to the new reality in our state.

So I think a national law, even in states where we have taken this step, would be very, very important in ensuring that everybody in the complicated system understands that this has changed and must change.

Mr. PALLONE. And then the other thing—not to belabor it—as you mention ambulances, we would very much like to cover ambulance. We do cover the air ambulance—the helicopters.

The problem in covering ambulances it was just so complicated because a lot of them are, you know, some's private. A lot in New Jersey, in particular, is, you know, the community for state squad, the local government.

So we are looking at it but it is—it is difficult for us to cover ambulances because the way they are set up and paid for. But we are looking at it so I wanted to mention that.

Mr. MALINOWSKI. Good. Thank you.

Mr. PALLONE. Did you want to add something, Mr. Flores?

Mr. FLORES. Yes. Mr. Malinowski, thanks for joining us today. This is an issue that cuts across all states and all populations, and we appreciate your input.

Mr. MALINOWSKI. Thank you, sir.

Mr. PALLONE. Thank you, Tom.

Mr. MALINOWSKI. All righty.

Mr. PALLONE. Thank you.

And now the gentlewoman from Puerto Rico. Good to see you here.

[Laughter.]

**OPENING STATEMENT OF HON. JENNIFFER GONZÁLEZ-COLÓN
A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY
OF PUERTO RICO**

Miss. GONZÁLEZ-COLÓN. Thank you, Chairman Pallone, for your visit to Puerto Rico and the commitment you have shown many years for the island. Ranking Member Flores, again, and Chairwoman Eshoo for all the help during the legislation of the past week, and same thing to Peters here today.

I want to thank all for giving me the opportunity to discuss legislation I have introduced that could be brought before the committee.

I also want to thank this committee for taking a critical action last week by passing the Territories Health Care Improvement Act,

which provides critically needed resources to the territory's Medicaid programs to ensure sustainability while a more permanent legislative solution is developed.

According to analysis undertaken by the Department of Health and Human Services, Americans living in poverty have significantly constrained budgets that limits their ability to pay out-of-pocket healthcare costs.

Those in poverty have literally no available income after they pay for their most basic necessities each month, necessities which do not include healthcare, childcare, or transportation.

People in poverty tend to be less healthy than those in higher—with higher incomes and therefore need more medical care. However, people in poverty are often unable to afford even nominal premiums and co-payments.

Research shows that they may forget necessary medical treatment as a result of required cost sharing. Having said that, Puerto Rico's population is a prime example of all these findings.

With a median annual income of \$19,000, close to half of Puerto Rico's residents live below poverty level and depend upon the public health system for their medical care.

Additionally, residents of Puerto Rico are ineligible for supplemental security income solely because they live on the island because of our zip code.

They are also ineligible to receive assistance in payments other than Medicare Part B and Part D premiums. Residents of Puerto Rico bear the heavier burden of healthcare costs than residents of the states and the District of Columbia.

In order to triage this situation while Congress develops a permanent solution, I filed the following bills that await action before this committee, all of them in a bipartisan way.

H.R. 813, the Puerto Rico Integrity in Medicare Advantage Act, gives Puerto Rico almost—more than 80 percent of our people are using the Advantage program. This bill revises the Medicare Advantage payments for three years by establishing a .7 percent adjusted general average floor to any county in the nation that exceeds this benchmark.

Two, it requires that at least half of the regional funding above and beyond the 85 percent rule be used to increase provider payments, and the reason for that is we are losing a lot of our physicians and service providers.

And it will support Medicare Advantage Coordinated Care Platform, which with performance base and equality standards in care, which serves as the backbone of the healthcare system in Puerto Rico as well.

I also introduce H.R. 2172, which removes the matching requirement for Medicare Part D drugs in Puerto Rico. While assistance is available for Medicare beneficiaries in the states and in the District of Columbia, beneficiaries who reside in the territories are not eligible for low-income subsidy or LIS.

In lieu of the LIS, Social Security provides a block grant to each territory for Medicaid coverage for low-income beneficiaries prescription drugs. In the case of the island, FMAP has been set to 55 percent.

Between fiscal years 2010 and 2016, Puerto Rico has been able to draw down only 51 percent of its available federal funding for prescription drugs and for low-income Medicare beneficiaries.

Lastly, I introduced H.R. 2310, the Fairness in Medicare Part B Enrollment Act, to address the fact that the residents of every states and territories other than Puerto Rico who are receiving Social Security benefits are automatically enrolled in both Part A, Part B with coverage beginning the first day of the month when they turn 65.

When someone who is receiving SSI in Puerto Rico turns 65, they are enrolled in Medicare Part A but not in Part B, which has resulted in 38,000 Medicare beneficiaries paying a lifetime late enrollment penalty of \$20 million a year.

And with that, Puerto Ricans deserve equality in healthcare just like every other U.S. jurisdiction by enrolling in Part B automatically.

Approximately 40 percent of the residents of Puerto Rico who are 60 years and older live below the poverty level with an annual income of less than \$12,000.

The Part B premium, or about 15 percent of their monthly income, can be cost prohibitive in the absence of other Medicare savings program options available across the nation.

With that, I would like to thank you all and, again, I ask the committee to take up these bills in a favorable way.

Mr. PALLONE. I thank the gentlewoman.

I mean, you know, I feel personally—I know a lot on this committee that we really need to do a lot more with Puerto Rico and the territories.

And when we went on that two-day mission or whatever CODEL with you and Stacey Plaskett we learned a lot and not only about what we had to do with Medicaid but also the electricity grid and so many other things that we will still follow up with.

And thanks for all your input in putting together the Medicaid plan, which we expect will move, you know, hopefully the first week or soon after we get back, and we are working with the Senate on it, too. So thanks again.

Did you want to add anything, Ms. Eshoo, or—

Ms. ESHOO. Well, I think that—I am very glad that we got the legislation done when we did, and it is—I think it's going to go a long way.

It's not going to close the loop on everything because the territories are still not going to be treated the way they should. There is not equity there in American citizens. But thank you for the work that you've done on it and I look forward to it passing when we come back, right?

Mr. PALLONE. Right. Thank you.

Ms. ESHOO. So we will have some good full floor days just from what comes out of our committee, Mr. Chairman.

Thank you.

[The prepared statement of Miss. González-Colón follows:]

PREPARED STATEMENT OF HON. JENNIFFER GONZÁLEZ-COLÓN

**CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN**

PUERTO RICO - AT LARGE

COMMITTEE ON ENERGY & COMMERCE**Remarks**

Last week, this Committee took a big step towards correcting the effects of decades of disparate treatment regarding healthcare programs in the territories by allocating critically needed resources to our Medicaid program and ensure its sustainability while a more permanent legislative solution is developed.

Pending before this Committee are 3 additional bills that I have introduced, which seek to correct this disparate treatment in federal healthcare programs in Puerto Rico and which are also critically necessary to meet the healthcare needs of our vulnerable populations:

H.R. 813, the PUERTO RICO INTEGRITY IN MEDICARE ADVANTAGE ACT

H.R. 2172, A BILL TO REMOVE THE MATCHING REQUIREMENT FOR MEDICARE PART D DRUGS

HR 2310, the FAIRNESS IN MEDICARE PART B ENROLLMENT ACT

I respectfully request from this Committee that it take these bills under advisement and act favorably for the benefit of those Americans living in Puerto Rico, who have been left behind by our healthcare system.

Background

According to an analysis undertaken by the Office of the Assistant Secretary for Planning and Evaluation of the U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES,¹ Americans living at the bottom of the income distribution often struggle to meet their basic needs on very limited incomes, even with the added assistance of government programs. Among the key findings are the following:

- Low-income individuals are especially sensitive to even nominal increases in medical out-of-pocket costs, and modest copayments can have the effect of reducing access to necessary medical care.
- Medical fees, premiums, and copayments could contribute to the financial burden on poor adults who need to visit medical providers.

¹ Analysis conducted by Lauren Frohlich, Kendall Swenson, Sharon Wolf, Suzanne Macartney, and Susan Hauan. Available at <https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>.

- The problem is even more pronounced for families living in the deepest levels of poverty, who effectively have no money available to cover out-of-pocket medical expenses including copays for medical visits.

Americans living in poverty have significantly constrained budgets that severely limit their ability to pay out-of-pocket health care costs; those in deep poverty have literally no available income after they pay for their most basic necessities each month, necessities which do not include health care, child care, or transportation. People in poverty tend to be less healthy than those with higher incomes and therefore need more medical care. But people in poverty are often unable to afford even nominal premiums and copayments, and research shows that they may forgo necessary medical treatment as a result of required cost-sharing.

Research shows that increases in cost-sharing in the form of copayments can discourage individuals with low income from accessing necessary medical care, which can have negative health consequences. An analysis of the Oregon Health Plan redesign implemented between 2003 and 2005 found that increased out-of-pocket costs such as mandatory copayments are associated with unmet health care needs, reduced use of care, and financial strain for already vulnerable populations.² A study of Utah's Medicaid program found that \$2 copayments for physician services resulted in Medicaid patients seeing doctors less often.³ The national RAND Health Insurance Experiment found that low-income individuals reduce their use of effective care by as much as 44 percent after being subject to copayments.⁴ The study also found that copayments lead to poorer health outcomes among low-income adults and children due to a reduction in the use of care, including worse blood pressure and vision and higher rates of anemia.⁵

Puerto Rico's current population provides a prime example of these findings. With a median annual income of approximately \$19,500, close to half of Puerto Rico's residents live below the poverty level and depend upon the public health system for their medical care.

² Wright, Bill J. *et al*, 2010. HEALTH AFFAIRS. "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out."

³ Ku, Leighton *et al.*, 2004. Center on Budget and Policy Priorities. THE EFFECTS OF COPAYMENTS ON THE USE OF MEDICAL SERVICES AND PRESCRIPTION DRUGS IN UTAH'S MEDICAID PROGRAM.

⁴ Newhouse, Joseph, 1996. FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT, Cambridge: Harvard University Press; Ku, Leighton. Center on Budget and Policy Priorities, 2003. CHARGING THE POOR MORE FOR HEALTH CARE: COST-SHARING IN MEDICAID. Effective care refers to services the researchers judged to be clinically effective in improving health outcomes.

⁵ *Id.*

	Puerto Rico	50 States & DC
Population Change (2010-2018)	-14%	+6%
<65 years	20%	15%
Poverty Index	45%	13%
Median Income	\$19,343 (85.5%)	\$60,336 (12.6%)
Medicaid/CHIP	40%	20%
Unemployment	8.5%	3.8%
Adults reporting poor health status	34%	18%
Adults with diabetes	13.7%	9.5%
Child Mortality (per 1,000)	7.1	5.9
HIV Diagnosis (per 100,000)	17.8	14.7

Residents of Puerto Rico are ineligible for Supplemental Security Income merely because of where they live.⁶ They are also ineligible to receive assistance in the payment of their Medicare Part B and Part D premiums. Thus, residents of Puerto Rico bear a heavier burden of healthcare costs than do those similarly situated residents of the States and the District of Columbia.

In order to ameliorate this situation while the Congress acts to come up with a permanent solution, I have filed the following bills which are currently pending before this Committee:

H.R. 813, the PUERTO RICO INTEGRITY IN MEDICARE ADVANTAGE ACT (PRIMA)
to amend title XVIII of the Social Security Act to provide for temporary
stabilization of Medicare Advantage payments following Hurricane Maria.

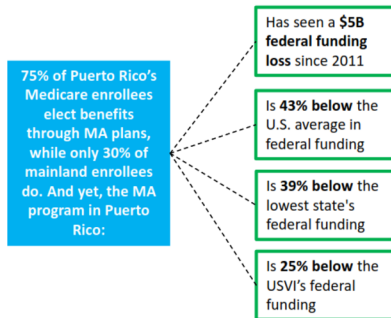
Puerto Rico depends upon Medicaid to cover a large low-income population; but we also depend upon Medicare Advantage to provide most funding to the Puerto

⁶ See H.R. 947, SUPPLEMENTAL SECURITY INCOME EQUALITY ACT to extend the supplemental security income program to Puerto Rico, the United States Virgin Islands, Guam, and American Samoa, and for other purposes. Available at <https://www.congress.gov/bills/116/congress/house-bill/947/titles?r=20&s=1>. For a discussion of the effects of the inapplicability of SSI to residents of Puerto Rico, please see the *amicus brief* filed in *United States of America v. Vaello Madero*, Civil no. 19-1390, before the U.S. District Court for the District of Puerto Rico (Nov. 7, 2018, docket 78).

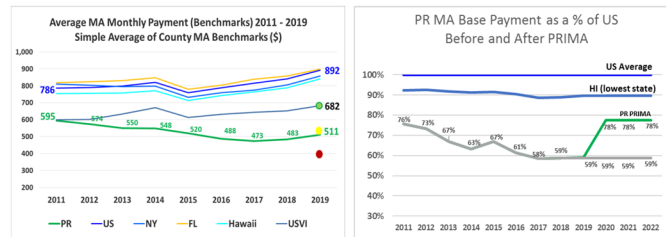
Rico healthcare system. Medicare Advantage accounts for nearly 50% of all health care funding to patients and providers in Puerto Rico.

Unlike the mainland, the vast majority (90%) of Medicare beneficiaries with Medicare Part A and Part B in Puerto Rico and almost all dual (97%) eligible beneficiaries receive their care through local Medicare Advantage (MA) Plans. Puerto Rico depends upon Medicare Advantage to cover its large senior population, with the 8th largest Medicare Advantage-covered population in the nation.

Like so many other federal health care programs, Medicare Advantage institutionalizes disparities by giving the territories second-tier funding. Medicare Advantage accounts for nearly half of all health care expenses in Puerto Rico. However, due to local particularities, the congressional Medicare Advantage rate-setting formula has caused Medicare Advantage rates to be severely underestimated for Puerto Rico, paying only 57% of the U.S. mainland average.

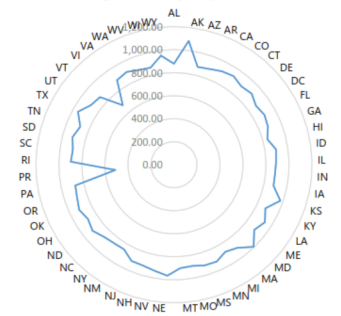


Medicare Advantage rates in Puerto Rico are shockingly low. In 2011, Puerto Rico Medicare Advantage rates were 24% lower than the national average. Medicare Advantage rates in Puerto Rico have fallen for 7 years to a level that is now 43% below the national average. When federal health care funding to Puerto Rico decreases, fewer resources and support pass through to patients and providers. Adding an economic crisis and the catastrophic devastation of Hurricane Maria has resulted in a health care system with sub-standard infrastructure and provider migration to the mainland.



The funding formula (found at 42 U.S.C. 1395w-23) works against MA plans in Puerto Rico due to Congress' decision in 2010 to set reimbursement based upon a healthcare cost basket, which, when accounting for grossly underestimated costs and artificially low salaries of physicians on the Island, resulted in rates far below the rest of the United States. This, in turn, set off a death spiral, where physician reimbursements were lowered to account for lower rates per member per month, which in turn drove MA rates lower still, and so on. **Today, CMS reimburses Puerto Rico plans approximately \$1 billion less than it did in 2011 – contrary to the trend across every state in the nation.**

Medicare Advantage Monthly Capitation Rates for 2019



Puerto Rico Medicare Advantage has been in freefall since the hurricanes. The story of how the hurricanes impacted the Island is well known. What is not common knowledge, however, is the impact the hurricanes had on the patients and providers under the Medicare Advantage program. The hurricanes unmasked and further exacerbated a longstanding problem of unequitable and chronic underfunding, which caused an accelerated exodus of patients and providers. Due

to the hurricanes' direct impact and the HHS Emergency Declaration, hundreds of thousands of residents of Puerto Rico left (temporarily, if not permanently) for the mainland (principally FL, NY, TX, NJ, and CT). Thus, physicians, who were already suffering from low salaries, suddenly had fewer patients to treat, and the Medicare Advantage organizations (due to the Emergency Declaration) had to pay for more expensive "out-of-network" care at U.S. mainland rates, even though the CMS Medicare Advantage payment was at the Puerto Rico rate. As a result, hundreds of physicians have left, the Island's Medicare infrastructure has been destabilized, and the potential Medicare Advantage success story has been put at risk, putting care for all residents of Puerto Rico in jeopardy. PRIMA breaks this death spiral in Medicare funding to PR by setting a floor to federal payments. Puerto Rico would still have the lowest levels of Medicare Advantage rates in the Nation, but we could begin to reverse the disparities, fully recover from the hurricanes, and fund the health care system Puerto Rico deserves.

PRIMA seeks to correct and stabilize the Medicare Advantage payment downward spiral. The current reimbursement formula is not working. The hurricanes have accelerated the decline in Medicare coverage and of healthcare in Puerto Rico. A solution is needed, and needed now, to remedy this challenge if the Island's healthcare system is to stabilize. The PRIMA Act would achieve these goals by doing the following:

- Revising Medicare Advantage payments for three years by establishing a 0.70 Adjusted General Average (AGA) floor to any county in the nation that exceeds this benchmark will help stabilize the free-falling MA base payment rate for Puerto Rico.
- PRIMA will support healthcare providers in Puerto Rico. Under existing law, Medicare plans are required to spend at least of 85% of funding on care (increasing provider reimbursement or expanding program benefits for beneficiaries) and may use the remaining 15% to cover administrative expenses. PRIMA requires that at least half of the additional funding (above and beyond the 85% MLR rule) for Puerto Rico be devoted to increase provider payments, incentivizing physicians to stay.
- Supporting Medicare Advantage's coordinated care platform, performance-based and quality standards that provide care to the the most fragile and needy Dual population in the island, which serves as the backbone of the healthcare system in Puerto Rico.

CBO has informally scored PRIMA as budget neutral.

**H.R. 2172, A BILL TO REMOVE THE MATCHING
REQUIREMENT FOR MEDICARE PART D DRUGS**

Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare, provided through private plans approved by the federal government. Beneficiaries can choose to enroll in either a stand-alone prescription drug plan (PDP) to supplement traditional Medicare or a Medicare Advantage prescription drug plan (MA-PD), mainly HMOs and PPOs, that cover all Medicare benefits including drugs. In 2018, more than 43 million of the 60 million people with Medicare are enrolled in Part D plans.

Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing. Through the Part D Low-Income Subsidy (LIS) program, additional premium and cost-sharing assistance is available for Part D enrollees with low incomes (less than 150% of poverty, or \$18,210 for individuals/\$24,690 for married couples in 2018) and modest assets (less than \$14,100 for individuals/\$28,150 for couples in 2018). ***While this assistance is available for Medicare beneficiaries in the States and in the District of Columbia, Medicare beneficiaries who reside in the territories are not eligible for the LIS.***

In lieu of the LIS, the Social Security Act provides a fixed amount of funding to each territory to provide Medicaid coverage of prescription drugs for low-income Medicare beneficiaries. Before accessing the federal funds, each territory government is required to contribute, or “match”, funds toward the payment of the Medicare Part D covered drugs. In the case of Puerto Rico, FMAP has been set by statute at 55%.

The territories (to varying degrees) have struggled to comply with the matching requirement and thus are not able to access the federal funding. ***Between Fiscal Year 2010 and Fiscal Year 2016, Puerto Rico has been able to draw down only about 51 percent of its available federal funding for prescription drugs for low-income Medicare beneficiaries.***

H.R. 2172 amends title XIX of the Social Security Act to remove the matching requirement before a territory can access and draw down the territory’s federal funds for Medicare Part D drugs. This bill is consistent with the recommendations made by the Congressional Task Force on Economic Growth in Puerto Rico.

Although a score has not yet been obtained, given that Puerto Rico’s FY2020 allotment for Medicaid coverage of prescription drugs for low-income Medicare beneficiaries is approximately \$59million, covering the 45% share currently required of the territorial government would be insignificant.

H.R. 2310, the FAIRNESS IN MEDICARE PART B ENROLLMENT ACT

to amend title XVIII of the Social Security Act to eliminate late enrollment penalties under part B of the Medicare program for individuals residing in Puerto Rico if such individuals enroll within 5 years of becoming entitled to benefits under part A of such program.

Medicare Part B provides coverage for physicians' services, outpatient hospital services, durable medical equipment, outpatient dialysis, and other medical services. Residents of every state and territory *other than Puerto Rico* who are receiving Social Security benefits are automatically enrolled in both Part A and Part B, with coverage beginning the first day of the month they turn 65.

Under federal law, when residents of Puerto Rico turn 65 and start receiving Social Security benefits, they are automatically enrolled in Part A, but not automatically enrolled in Part B. Instead, beneficiaries in Puerto Rico are required to take the affirmative step of enrolling in Part B during their seven-month initial enrollment period. If they fail to enroll, they are subject to a lifetime late-enrollment penalty of 10% for each 12-month period they were eligible but failed to enroll.

The lack of an automatic Part B enrollment process in Puerto Rico has resulted in a disproportionate number of Medicare beneficiaries in Puerto Rico paying the lifetime late-enrollment penalty. According to CMS, ***there are currently 38,343 Medicare beneficiaries in Puerto Rico who are paying lifetime penalties of \$20,383,705.00 a year for enrolling late in Part B.*** According to CMS, there are 108,678 individuals in Puerto Rico who are currently enrolled in Part A only, not Part B. Many of those individuals, if they do elect to enroll in Part B, will be subject to a lifetime late-enrollment penalty.

Data from the U.S. Census indicates that 40% of residents of Puerto Rico who are 60 years and over live below the poverty level.⁷ Given that the U.S. Census determined the Poverty Threshold for 2017 for individuals 65 and over at \$11,756,⁸ the annual Part B premium of \$1,626.00—or at least 15% of their monthly income—might be too costly for a large number of residents to pay.⁹

⁷ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Available at <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>.

⁸ U.S. Census Bureau, Poverty Thresholds for 2017 by Size of Family and Number of Related Children Under 18 Years. Available at <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html>.

⁹ Residents of Puerto Rico are ineligible to receive assistance for paying their Medicare premiums through the four different Medicare Savings Programs (the QUALIFIED MEDICARE BENEFICIARY PROGRAM, the SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM, the QUALIFYING INDIVIDUAL PROGRAM, and the QUALIFIED DISABLED AND WORKING INDIVIDUAL PROGRAM).

Thus, rather than propose the automatic enrollment in Part B of eligible Medicare beneficiaries in Puerto Rico, this bill maintains the automatic opt-out enrollment, but extends the period for Medicare beneficiaries in Puerto Rico to enroll in Medicare Part B to a total of five years. This extended period will allow beneficiaries to learn that, unlike the rest of the United States, they were not automatically enrolled in Part B and to determine if they can financially afford the cost of the Program.

Although a score has not yet been obtained, the financial impact of this legislation upon the federal budget should be negligible.

This Committee has acted swiftly to ensure continuing access to healthcare for Puerto Rico's Medicaid population. However, adequate Medicaid funding is only one part of the problem that this Committee must seek to correct. I ask the Committee's continued assistance in this endeavor.

I thank you for your time and for your availability.

Mr. PALLONE. And we will still look to, you know, beyond the four years, too. You know, we know we have to do a permanent replacement. So thanks again, Jenniffer. Thanks.

All right. Next we have the gentlewoman from Iowa, Ms. Finkenauser.

**OPENING STATEMENT OF HON. ABBY FINKENAUER A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA**

Ms. FINKENAUER. Well, thank you, Chairwoman Eshoo, and also Chairman Pallone for the opportunity to speak here today.

While I don't serve on this committee, I am proud to be a voice for Iowa's working families and am committed to making sure that they have a seat at the table on the issues affecting their lives.

And one of the most significant burdens Iowa families are facing is the skyrocketing cost of prescription drugs. It's something that I've heard from folks all around my district at town halls but then also things that I call "Conversations with your Congresswoman," which are modeled after kitchen table conversations I'd have with my grandfather and my uncle.

My grandfather was a Democrat. My uncle was a Republican. And we'd sit around the table talking about issues that mattered and I remember, you know, we could leave and, you know, disagree on some issues but still have respect for each other.

And when it comes to prescription drugs, that's something where Democrats and Republicans especially in my district are concerned about and can find common ground.

You know, in the first half of this year alone, we have seen over 3,400 drugs boost their prices. The average price hike? Ten percent—five times the rate of inflation.

The cost of insulin, for instance, has risen over 500 percent in recent years. It's left a lot of Iowans with diabetes who have been managing their condition for years wondering what's changed.

Seniors on fixed incomes are especially burdened by the rising costs. No one should have to choose between retiring in dignity, keeping their home, or affording the medicine that allows them to live their lives.

Yet, three in ten Americans report not taking their medicines as prescribed because of cost.

Stevie is a mom in Iowa. She has said she has her son's doctor write her son a prescription for a less effective medicine because that is all she could afford.

She couldn't afford to pay for the drug that the doctor originally prescribed for her son. She told the doctor that giving her son a less effective medicine was better than none.

No mother, no American, should be put in this situation. We live in the most innovative country in the world. There is no reason we cannot come together and find the best policy solutions to reduce costs, putting money back in the pockets of Iowa families and families across the country, and getting folks the care that they need.

I have proudly supported bills like the CREATES Act and the Protecting Consumer Access to Generic Drugs Act. I appreciate this committee's work to bring legislation to the House floor that would require more transparency from drug manufacturers and will make it faster and easier for more affordable generics to come to market.

I encourage this committee to just continue its important work to hold drug companies accountable and bring down the costs for patients through common sense bipartisan legislation.

I'll continue to work with anybody who is serious about helping Iowans and helping Americans get better, more affordable healthcare, and I am ready to work with you and I support you in your efforts to tackle the skyrocketing costs of prescription drugs.

I am truly grateful again, Chairwoman Eshoo, for inviting us today to have these voices heard and thank you for your efforts, and I am continuing ready to keep the work going with you guys.

Thank you.

[The prepared statement of Ms. Finkenauer follows:]

PREPARED STATEMENT OF HON. ABBY FINKENAUER

Thank you, Chairwoman Eshoo and Ranking Member Burgess, for the opportunity to speak today.

While I do not serve on this committee, I am proud to be a voice for Iowa's working families and am committed to making sure that they have a seat at the table on the issues affecting their lives.

And one of the most significant burdens Iowa families face is the skyrocketing cost of prescription drugs.

It's something that I'm hearing from folks at townhalls and Conversations with Your Congresswoman events across my district.

In the first half of this year alone, we've seen over 3,400 drugs boost their prices.

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The cost of insulin, for instance, has risen 500 percent in recent years. It's left a lot of Iowans with diabetes—who have been managing their condition for years wondering, what changed? Seniors on fixed incomes are especially burdened by these rising costs.

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I encourage this Committee to continue its important work to hold drug companies accountable and bring down costs for patients through common-sense, bipartisan legislation.

I'll continue to work with anyone who's serious about helping Iowans get better, more affordable healthcare. While I do not serve as a member of this Committee, I am ready to work with you and support your efforts to tackle the sky-rocketing costs of prescription drugs.

I am grateful to Chairwoman Eshoo and Ranking Member Burgess for the opportunity to speak about an issue that is important to me and to so many other Iowans.

Mr. PALLONE. Thank you, and, you know, many members today talked about prescription drugs as their priority, and we appreciate your mentioning that we did, as you know, move the—and these are bipartisan—the generic competition bills, the transparency bills, which we did last week, which should move when we come back and we are working on a negotiated prices bill under Medicare as well.

So, you know, you're right on point in terms of what we are trying to accomplish. Thank you.

And now we have the chairwoman of the Appropriations Labor HHS Education and practically everything else subcommittee, long time champion of trying to expand access and affordability for healthcare. Thank you for being here.

OPENING STATEMENT OF HON. ROSA L. DELAURO A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Ms. DELAURO. Thank you very, very much, Mr. Chairman. It's wonderful to be here with you today. I thank the ranking member. Please give him my best.

But also to my colleague, Congresswoman Eshoo, Dr. Burgess, Congressman Carter, and Mr. Peters, thank you all very, very much. This is a wonderful committee which is dealing with some of the most important issues that we do face in our country today and particularly those around healthcare.

I am here to advocate for Medicare for America, which is a proposal in your jurisdiction that I have introduced with the chair of the Consumer Protection and Commerce Subcommittee, Congresswoman Jan Schakowsky.

It is our proposal to achieve affordable quality universal healthcare. Right now, families are struggling with the skyrocketing costs of prescription drugs and healthcare costs, costs which continue to far outpace people's wages today.

They are paying more for worse coverage than they may have had previously. In fact, according to the Kaiser Family Foundation, premiums increased 65 percent in 10 years for a single person who gets their health insurance.

Meanwhile, their average deductible went from \$303 in 2008 to \$1,350 in 2018. As a result, one-third of Americans have delayed care due to cost, and that's according to Gallup.

All the while, the administration is making intentional policy choices to undermine the Affordable Care Act, raise prices for middle class families and for working people.

In the Labor, Health, and Human Services Subcommittee, we hosted a hearing about what—I regard this as sabotage of the Affordable Care Act.

A study out this week found that 15,600 deaths would have been prevented if all states expanded Medicaid and the Affordable Care Act as intended. It was those problems we aimed to solve long term with Medicare for America.

Medicare for America achieves universal affordable high-quality health coverage by creating a program based on Medicare and Medicaid.

It expands the benefits and services to include items like prescription drugs, dental, vision, hearing services, and long-term services and supports.

Medicare for America would be accessible to all Americans through auto-enrollment while maintaining private insurance for those employers who provide comprehensive, high-quality, and affordable plans.

Right now, 165 million Americans receive their coverage through their employer, and what we—and so what we do is to—we maintain employer-sponsored healthcare.

Many people are happy with it. Companies may continue, as I said, to offer these plans, or they can enroll employees in Medicare for America, contribute eight percent of annual payroll to the Medicare Trust Fund.

Employees have a choice as well. They can choose to enroll in Medicare for America instead of their employer-sponsored plan and have their employer contribute to it.

Medicare for America addresses costs. Annual out-of-pocket costs are no more than \$3,500 for individuals, \$5,000 for families on a sliding scale.

There are never out-of-pocket costs for preventive and for chronic disease services, long-term services and supports, and prescription drugs, generic or brand name as necessary.

There are also zero deductibles. Zero. And premiums are capped—no more than eight percent of income for enrollees. So for those between 200 and 600 percent of the federal poverty level—between \$50,000 and \$150,000 for a family of four—premiums are subsidized.

For those under 200 percent of the federal poverty level—\$50,000 for a family of four—there are zero premiums and zero out-of-pocket costs.

Second, we address benefits. Currently, healthcare benefits are largely dependent on your zip code, and Medicare for America fixes that.

Regardless of whether you live in Connecticut, Mississippi, Utah, and California, every single American should have robust comprehensive health coverage.

So we set a very high standard for benefits. We cannot wait for states to do the right thing and increase benefits and services. Doing so will only continue and compound the inequalities that we are trying to rid from our healthcare system.

Third, we ensure Americans have access to long-term services and supports, and this is with regard to disabilities as well, emphasizing home and community-based care that recognizes the central role that family care givers play.

Fourth, we restrain system-wide costs with all-payer rate setting and by allowing the government to negotiate for better prescription drug prices. What we have included as well in Medicare for America is how we will be paying for it.

Medicare for America sunsets the Republican tax bill. It imposes a five percent surtax on adjusted gross income including on capital gains above \$500,000.

It increases the Medicare payroll tax and investment income tax. We also increase the excise taxes on all tobacco products, beer, wine, liquor, and sugar-sweetened drinks.

State will also need to make maintenance of effort payments equal to the amounts that they currently spend on Medicaid and on CHIP.

This is a quick overview of the bill. When working people are struggling with stagnating wages, skyrocketing healthcare costs, we need to do more to help them out.

So as the committee continues to consider how to bring down costs for families of working people, I urge you to consider Medicare for America.

I believe it would achieve universal coverage, which is, I know, our shared goal, and I thank you so much for the opportunity to be with you today.

Thank you.

[The prepared statement of Ms. DeLauro follows:]

PREPARED STATEMENT OF HON. ROSA L. DELAURO

Thank you, Chairman Frank Pallone and Ranking Member Greg Walden for welcoming me today. I am here to advocate for Medicare for America, a proposal in your jurisdiction that I have introduced with the chair of the Consumer Protection and Commerce Subcommittee, Congresswoman Jan Schakowsky. It is our proposal, to achieve affordable, quality universal healthcare.

Right now, families are struggling with the skyrocketing costs of prescription drugs and healthcare, costs which continue to far outpace wages. They are paying more for worse coverage than they may have had previously. In fact, according to the Kaiser Family Foundation, premiums increased 65% in 10 years for a single person who gets their health insurance. Meanwhile, their average deductible went from \$303 in 2008 to \$1,350 in 2018.

As a result, one-third of Americans have delayed care due to cost, according to Gallup.

All the while, the Trump administration is making intentional policy choices to undermine the Affordable Care Act and raise prices for middle class families and working people. In the Labor-Health and Human Services subcommittee, we hosted a hearing about this sabotage. A study out this week found that 15,600 deaths would have been prevented if all states expanded Medicaid and the ACA as intended.

It was those problems we aimed to solve long term with Medicare for America.

Medicare for America achieves universal, affordable, highquality health coverage by creating a program based on Medicare and Medicaid. It expands the benefits and services to include items like prescription drugs, dental, vision, hearing services, and longterm services and supports. And Medicare for America would be accessible to all Americans through auto-enrollment, while maintaining private insurance for those employers who provide comprehensive, high-quality, and affordable plans.

Right now, 165 million Americans receive their coverage through their employer. Many are happy with it, and companies may contain to offer these plans. Or, they can enroll employees in Medicare for America and contribute 8% of annual payroll to the Medicare Trust Fund. Employees have a choice, too. They can choose to enroll in Medicare for America instead of their employer-sponsored plan and have their employer contribute to it.

Medicare for America address costs. Annual out of pocket costs are no more than \$3,500 for individuals and \$5,000 for families on a sliding scale.

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Second, we address benefits. Currently, healthcare benefits are largely dependent on your zip code, and Medicare for America will fix that. But, regardless of whether you live in Connecticut or Mississippi or Utah or California, every single American should have robust, comprehensive health coverage. And so, we set a very high standard for benefits. We cannot wait for states to do the right thing and increase benefits and services. Doing so will only continue and compound the inequalities that we are trying to rid from our healthcare system.

Third, we ensure Americans have access to long-term services and supports, emphasizing home and community-based care that recognizes the central role family caregivers play.

Fourth, we restrain system-wide costs: with all-payer rate setting and by allowing the government to negotiate for better prescription drug prices.

That is a quick overview of the bill.

When working people are struggling with stagnating wages and skyrocketing healthcare costs, we must do more to help. So, as the committee continues to consider how to bring down costs for families and working people, I urge to you to con-

sider Medicare for America. It would achieve universal coverage, which is our shared goal.

Thank you for the opportunity to talk with you today.

Mr. PALLONE. I thank the gentlewoman—the chairwoman.

You know, you have been involved with so many of these healthcare affordability and accessibility issues for so long I don't even know where to begin to thank you.

But I do want to say, obviously, we will take a look at Medicare for America. But in terms of what the committee has done, you know, in our first six months here before the August recess we have been trying to basically look at shoring up the existing programs and marketplace, you know, whether it's the Affordable Care Act or generic competition or the transparency bills.

But, you know, we are—in the fall we will start looking at, you know, innovative things. You know, when you talk about long-term care, you know, you and I both wanted to include a long-term care initiative in the Affordable Care Act and we just ran into the costs problem with CBO. I usually blame CBO for everything, in case you haven't noticed.

And, you know, in terms of the negotiated prices for Medicare, that is something that we are certainly working on. Home and community-based care—the list goes on.

So I just—you know, I just want to thank you. I want you to know that we are going to be looking at a lot of these gaps that exist because there are some and certainly, you know, idea of capping or trying to reduce out of pocket cost is very important as well.

So thank you. I don't know—

Ms. DELAURO. Appreciate that very much and long-time supporter of, obviously, the Affordable Care Act, and I don't see—I mean, what I do see is that, you know, our being able to achieve universal healthcare, build on that, take a look at new opportunities at the time when you can also be very, very mindful of employer-sponsored insurance and those 165 million people who take advantage of that, and you just can't put them aside.

But to allow them to be able to either opt in or their employer to opt in, and at the same time look at a way in which we begin to auto enroll people from birth so that we get—begin to get them into the system.

And above all, I know you're conscious about cost, and so that what we do do is to provide a way and to look at how one pays for this.

So appreciate the opportunity.

Mr. PALLONE. Absolutely. Thank you.

Dr. Burgess or Ms. Eshoo, did you want to say—no?

Chairwoman Eshoo?

Ms. ESHOO. Rose, I thank you for coming here today.

Your energy is infectious. You're a force of nature, and your ideas are always very important ones and large ones. It represents big thinking, but underneath it the thinking continues. It's not just the big tag line.

So I remember years and years ago in the Clinton administration we tried to set up an early buy-in to Medicare for people younger than 65. We weren't successful with that.

But I think that you make a very important point about the following. It's estimated to be anywhere from 165 million to 180 million people who receive their healthcare through their employer.

That is not something we can ignore. But those of us who have spent our adult lifetimes working for universal coverage for every person in this country so that every person in this country is covered, we want to make sure that they are not thrown on the scrap heap of humanity if they lose their jobs.

So we don't know what's going to happen to the Affordable Care Act. But I think that you've brought forward a thoughtful plan.

You might think of doing some workshops with members on both sides of the aisle so that they understand what are in—what's in your proposal, and what the estimates would be—you know, what it would cost a family, an individual, how long, what it would include.

I mean, you've talked about some of those things today. But thank you.

Ms. DELAURO. Thank you very, very much. Thank you for the suggestion. I appreciate it.

Ms. ESHOO. Good. And I'll come, too. Thank you.

Thank you. Thank you, Rosa.

Mr. BURGESS. So you brought some interesting ideas, most of which I probably don't agree with. But the concept that we should be talking about that—

Ms. DELAURO. Agree with universal healthcare, Dr. Burgess.

Mr. BURGESS [continuing]. In this committee I think is important, and the—I suppose a competing bill with yours would be the Jayapal bill. I know Representative Dingell on our committee has been interested in that.

We actually had a hearing in the Rules Committee much earlier in this Congress. I don't understand why it was the Rules Committee and not our committee. I think we are the committee. We are the authorizing committee of jurisdiction. This should be—this should be open for our consideration.

I know the chairman does not like association health plans but I think that is going to be part of the argument. Health reimbursement accounts, which recently were allowed under rulemaking by the administration and yes, I did complain about executive actions under the previous administration.

I do think we ought to be doing the—if ideas are good ideas, we ought to authorize them and bring them through the legislative process.

A health reimbursement account where a person is—where an employer is allowed to give a person a fixed amount of money outside of what would be taxable so that they could walk that into whatever exchange or insurance product that they want.

After all, that's what most members of Congress have in the DC exchange in the Affordable Care Act. So if it's good enough for Members of Congress it should be good enough for the general population.

But I am willing to consider all of these ideas and I think we should have a robust and lengthy hearing and hear—have this same sort of perhaps Member Day structure on this because I know many members do have their own ideas.

Interestingly enough, the—when all of the excitement was toward the Medicare for all when we had that hearing in the Rules Committee and, yes, as you point out it would end employer-sponsored insurance. It would end Medicare Advantage. It would end TRICARE.

So there were a lot of things that would—if people were doing today that they liked that they would lose and that—I think that is a valid consideration and one that I perhaps brought up that morning in the Rules Committee.

And then lost in the translation—the same day the Mueller report came out coverage numbers were released by the Congressional Budget Office, and I guess we have all—have our differences with the Congressional Budget Office. But 2.6 million more people had multi—I am trying to say the employer-sponsored insurance.

Two point six million people since January of 2017 now have this coverage. So that's a good thing and we should celebrate that. In my opinion, we shouldn't try to take that away from them.

So it's an interesting concept. This committee is where it belongs. We are the only committee that hasn't really had a hearing, and Budget Committee's had a hearing. Rules Committee has had a hearing. Ways and Means Committee has had a hearing. Our turn, and we are next.

Thank you.

Ms. DELAURO. Thank you very, very much. I appreciate staying in your lane, too. So I understand the relevance of the Energy and Commerce Committee.

Thank you.

Mr. PALLONE. Thank you, Madam Chairwoman.

The gentleman from Tennessee.

Mr. COHEN. Thank you, Mr. Chair.

I appreciate you and I appreciate Rosa for that pat on the back. That was nice of you.

Ms. DELAURO. North and South.

OPENING STATEMENT OF HON. STEVE COHEN A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. COHEN. And I want to thank the Members for allowing us to bring our suggestions to the Energy and Commerce Committee and this Subcommittee on Health. I appreciate your time and the leadership of Chairman Pallone and the committee in this 116th Congress.

As we meet in a room named for the champion of healthcare, Mr. Dingell, and as I look at Henry Waxman looking down on me, I know that there are giants in this committee that have done much for healthcare over the years. I am a proud sponsor of H.R. 117, the Nationally—it is an acronym, NEWBORN, and that's Nationally Enhancing the Wellbeing of Babies through Outreach and Research Now. Pretty good of an acronym. Thanks, staff. Which builds from the belief that healthcare is a basic human right.

The NEWBORN bill was introduced way back in, like, 2010 or 2009 the first time, and it was part of the Affordable Care Act. And it would have been included therein but for some mistake that Chris Dodd made. And I haven't forgiven him. The Democrats used it as a way to promote the healthcare, and it was a highlight of

what we were doing, without the members that we were going to have this NEWBORN Act as part of the healthcare bill.

I guess it is when we had to deal with the Senate bill that we had the problem.

The NEWBORN Act gives a voice to children who have been taken by our country's ongoing crisis of infant mortality. Fifty-four developed countries have lower rates of infant mortality than the United States. As the wealthiest country in the world, the United States, we should not be 55th. Members of Congress, we should be ashamed.

In fact, Jon whatever his name is of The Daily Show ought to be here giving us hell, Jon Stewart.

The NEWBORN Act would help address this problem by creating infant mortality-focused pilot programs in the highest risk areas of our country. The pilot programs should focus on addressing the top five reasons for infant mortality: birth defects, pre-term birth, and low birth rate, Sudden Infant Death Syndrome, maternal pregnancy complications, and injuries to the infant.

These deaths disproportionately affect black women. My district is proportionately, is predominantly black and predominantly black women. It is estimated that nine out of every 1,000 children born in the district will not see their first birthday. By focusing studies on the highest risk areas of our country, the NEWBORN Act directly confronts this disparity. Pilot programs will provide insightful data and immediate support to the areas with the highest rates of infant mortality.

So, I would encourage the committee, ask the committee, beseech the committee to have a hearing to consider the immediate threats the maternal and infant mortality crisis poses to women and children, especially African American women. It is our duty to act, and I believe the NEWBORN Act would be crucial, and a crucial step forward.

And I know Dr. Burgess knows these issues, too. As a pediatrician he sees it. It is really awful in Memphis. We have rights with Third World countries.

So that is my ask. And I appreciate the opportunity to address you.

[The prepared statement of Mr. Cohen follows:]

PREPARED STATEMENT OF HON. STEVE COHEN

Chairwoman Eshoo, Ranking Member Burgess, I want to thank you for allowing members to testify about our legislative priorities within the Energy and Commerce Committee's Subcommittee on Health. I appreciate your time and Chairman Pallone's leadership of the Committee in the 116th Congress.

As we meet in the room named for a champion of healthcare, I am reminded of Mr. Dingell's remarkable legacy of advocacy for access to comprehensive care.

I introduced H.R. 117, the Nationally Enhancing the Wellbeing of Babies through Outreach and Research Now (NEWBORN) Act, which builds from his belief that healthcare is a basic human right.

The NEWBORN Act gives a voice to children who have been taken by our country's ongoing crisis of infant mortality. Fifty-four developed countries have lower rates of infant mortality than the United States. As the wealthiest country in the world, the United States has no excuse. We as Members of Congress have no excuse.

The NEWBORN Act would help address this problem by creating infant mortality-focused pilot programs in the highest-risk areas of the country. The pilot programs would focus on addressing the top five reasons for infant mortality: birth de-

fects, preterm birth and low birth weight, sudden infant death syndrome, maternal pregnancy complications, and/or injuries to the infant.

These deaths disproportionately affect black women. In my district that is predominately black, it is estimated that nine out of every 1,000 children born will not live to see their first birthday.¹

By focusing studies in the highest-risk areas of the country, the NEWBORN Act directly confronts this disparity. Its pilot programs would provide insightful data and immediate support to areas with the highest rates of infant mortality.

I encourage the Committee to hold a hearing to consider the immediate threats the maternal and infant mortality crisis poses to women and children—especially black women. It is our duty to act, and I believe the NEWBORN Act would be crucial step forward.

Mr. PALLONE. I want to thank the gentleman. You know, I know your interest in this NEWBORN. It is very important and we are certainly going to take a look at it.

We did a Newborn Screening Act bill yesterday.

Mr. COHEN. Yes.

Mr. PALLONE. But this is different.

Mr. COHEN. This is different. It has a pilot program for the more difficult, highest districts with the highest risk.

Mr. PALLONE. Right, right. All right, so we will take a look at it and get back to you.

Mr. COHEN. When it was in the ACA everybody thought it was great.

Mr. PALLONE. Yes.

Mr. COHEN. Held it up, this is great. And Chris Dodd messed up. So we need to help Chris Dodd redeem his reputation.

Mr. PALLONE. All right. And let me mention to all of you, you know, we are having this hearing today but you can follow up with either of us on a member-to-member basis, or your staff, on anything that you might want to mention as well. So, thanks a lot, Steve.

Mr. COHEN. Thank you.

Mr. PALLONE. Thank you.

Mr. BURGESS. Mr. Chairman, just—

Ms. ESHOO. I just—

Mr. PALLONE. Oh, I am sorry. Go ahead, Chairwoman.

Ms. ESHOO. Thank you for coming Steve. I think that you have a very good bill. And as the chairman said, we will take it under consideration.

I just, I know that, I assume that you are just casting Chris' name around tongue in cheek; correct? Yes, OK. This is a brother friend, so we just have to make sure. OK.

Thank you.

Mr. PALLONE. Dr. Burgess.

Mr. BURGESS. I thank the chairman. Just to correct the record, I am not a pediatrician. My specialty was obstetrics and gynecology.

Mr. COHEN. Then you were even more informed, and I just knew it but didn't say it.

Mr. PALLONE. Thank you, Mr. Cohen.

Next is the gentleman from Ohio, Mr. Balderson.

¹ <https://wreg.com/2019/02/20/report-85-percent-of-tennessee-maternal-deaths-preventable/>

**OPENING STATEMENT OF HON. TROY BALDERSON A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Mr. BALDERSON. Thank you, Mr. Chairman, members of the subcommittee. I am here today to discuss an issue that is important not only to me personally but also to the thousands of Ohioans I represent.

Roughly a quarter of the district I represent, Ohio's 12th Congressional District, is comprised of rural area. I was born and raised in one of those rural areas, the Appalachian community of Zanesville, Ohio, where rural broadband is of critical importance.

As you know, this subcommittee has jurisdiction over telecommunications issue. Unfortunately, many of my constituents, as well as millions of Americans, don't currently have access to highspeed broadband internet, which puts them at great disadvantage to their peers who live in more urban connected areas. As a Congress, we are failing those Americans. In an increasingly digital era, rural Americans in Ohio—rural Ohioans and Americans from around the country require access to modern broadband e-connectivity as much as those in urban and suburban communities.

With a connection to highspeed internet, rural Americans gain every important access to healthcare services through the option of telemedicine, and tools to fight the opioid epidemic, have increased capacity to grow their small businesses by opening up the digital marketplace to small businesses so they can compete and benefit from drastically improved educational opportunities by providing rural students the same ability to research, access educational materials as their urban and suburban peers.

Without access to these high-speed internet standards, rural Americans suffer from a disadvantage in connectivity to the online world. According to the U.S. Census Bureau, one in five Americans live in a rural area. Rural farmers supply food for our country. Rural labor keeps our manufacturing base strong. And rural energy exports keep America powered.

Yet, for all they do for our country, the Federal Communications Commission recently found that more than 30 percent of rural America Americans do not have access to basic broadband services. In comparison, only two percent of urban Americans experience this same lack of connectivity.

We, as a Congress, have the opportunity to level the playing field by helping rural Americans access critical services by supporting rural broadband e-connectivity. According to the USDA, rural broadband e-connectivity puts the United States at the top of the world's productivity by fostering economic development, job growth, rural entrepreneurship, and innovative technologies.

The USDA also found that enhanced connectivity in rural communities leads to important markers for success, including an increase in productivity for farmers through use of smart farm equipment and crop-focused innovation; expansion of entrepreneurship in a global digital marketplace; an improvement in business operations through small towns' ability to respond to market conditions; support farmers' ability to predict production inputs, increase yields, and access potential customers worldwide; an expansion of educational opportunities; and, finally, an enhancement of

healthcare options by enabling healthcare professionals to spread awareness of local resources.

As you can tell, rural broadband access would do a world of good for millions of Americans currently living without this resource and would give our country an advantage in the global space. This is why I will continue to be a vocal advocate of this issue, and why I am a proud cosponsor of H.R. 3162, which would require broadband providers to create an improved national broadband map that is significantly more accurate and granular, as well as subject to an ongoing and multi-facet challenge and reinforcement process, refinement process.

I ask you all to consider the millions of Americans who are starving of access to rural broadband e-connectivity. These rural Americans are no less deserving of the opportunities to succeed than their peers.

Thank you all for your time, and I welcome any questions that you may have.

[The prepared statement of Mr. Balderson follows:]

PREPARED STATEMENT OF HON. TROY BALDERSON

Mr. Chairman, members of the subcommittee, I am here today to discuss an issue that is important not only to me personally, but also to the thousands of Ohioans I represent.

Roughly a quarter of the district I represent, Ohio's 12th Congressional District, is comprised of rural areas. I was born and raised in one of those more rural areas, the Appalachian community of Zanesville, Ohio, where rural broadband is of critical importance. As you know, this subcommittee has jurisdiction over telecommunications issues.

Unfortunately, many of my constituents, as well as millions of Americans, don't currently have access to high-speed broadband internet, which puts them at a disadvantage to their peers who live in more urban, connected areas. As a Congress, we are failing those Americans. In an increasingly-digital era, rural Ohioans and Americans from around the country require access to modern broadband e-Connectivity as much as those in urban and suburban communities.

With a connection to high-speed internet, rural Americans gain ever important access to healthcare services through the option of telemedicine and tools to fight the opioid epidemic, have increased capability to grow their small businesses by opening up the digital marketplace to small businesses so they can compete, and benefit from drastically-improved educational opportunities by providing rural students the same ability to research and access educational materials as their urban and suburban peers. Without access to these high-speed internet standards, rural Americans suffer from a disadvantage in connectivity to the online world.

According to U.S. Census Bureau, one in five Americans lives in a rural area. In my home of Central Ohio, we know that rural Americans are the backbone of our nation's economy. Rural farmers supply food for our country, rural labor keeps our manufacturing base strong, and rural energy exports keep America powered. Yet for all they do for our country, the Federal Communications Commission recently found that more than thirty percent of rural Americans do not have access basic broadband services. In comparison, only two percent of urban Americans experience this same lack of connectivity. We, as a Congress, have the opportunity to level the playing field by helping rural Americans access critical services by supporting rural broadband e-Connectivity.

According to the FCC, "Rural and Tribal areas continue to lag behind urban areas in mobile broadband deployment. Although evaluated urban areas saw an increase of 10 Megabits per second (Mbps) download and 3 Mbps upload mobile LTE from 81.9% in 2014 to 90.5 % in 2016, such deployment in evaluated rural and Tribal areas remained flat at about 70% and 64%, respectively. Approximately 14 million rural Americans and 1.2 million Americans living on Tribal lands still lack mobile LTE broadband at speeds of 10 Mbps download, 3 Mbps upload."

According to USDA, rural broadband e-Connectivity puts the United States "at the top of the world's productivity by fostering economic development, job growth, rural entrepreneurship, and innovative technologies." The USDA also found that en-

hanced connectivity in rural communities leads to important markers for success, including:

- An increase in productivity for farmers through the use of smart farm equipment and crop- focused innovation;
- An expansion of entrepreneurship in a global digital marketplace;
- An improvement in business operations through small towns' ability to respond to market conditions as well as the ability to manage their finances;
- Support for farmers' ability to predict production inputs, increase yields, and access potential customers worldwide;
- An expansion of educational opportunities by reversing current trends that show rural students suffer without access to high-speed internet because they lag behind in school, must drive miles into town for a Wi-Fi hotspot to do their homework, have trouble completing college applications, and fail to access important online learning tools that help students pursue a career in certain trades or attain a professional certification;
- And finally, an enhancement of healthcare options by enabling healthcare professionals to spread awareness of local resources, prevent prescribing mistakes and pharmacies through access to controlled substance registries, and provide addiction care in remote locations through telemedicine.

As you can tell, rural broadband access would do a world of good for millions of Americans currently living without this resource and would give our country an advantage in the global space. This is why I will continue to be a vocal advocate of this issue and why I am a proud cosponsor of H.R. 3162, which would require broadband providers to create an improved National Broadband Map that is significantly more accurate and granular as well as subject to an ongoing and multi-faceted challenge, validation, and refinement process. I ask you all to consider the millions of Americans who are starving of access to rural broadband e-Connectivity. These rural Americans are no less deserving of the opportunity to succeed than their peers.

Thank you all for your time and I welcome any questions you may have.

Mr. PALLONE. I want to thank the gentleman. We stressed earlier, you know, a number of the people, a number of our colleagues that have been here have talked about more attention to rural areas, particularly with broadband. And we are very much aware of that and want to prioritize expansion of broadband in rural and underserved areas. And that is part of our Lift America Act, you know, which would be a larger infrastructure bill.

So, I just want you to know that we are very cognizant and, you know, follow up on the things you mentioned.

Did either of you want to? No?

Go ahead, Dr. Burgess.

Mr. BURGESS. Mr. Chairman, I don't know if you're aware that Mr. Balderson, of course, joined us as a result of a special election last year. So this is not his first term technically. But his predecessor was my counterpart on the Ways and Means Committee, the chairman of the Health Subcommittee on Ways and Means, Pat Tiberi.

So, welcome, Mr. Balderson, we are glad you are here. I acknowledge, as the chairman does, that the issue that you bring to us is important. My district is, the district that I represent is no longer as rural as it was when I grew up. We are half rural and half urban now. But the rural half certainly the broadband issues are significant and an issue that I have worked on for several years.

We have worked on things like telehealth. It is important that that be available, reliable, and be within the range that people can use it.

So, thank you for bringing this to our attention.

Mr. BALDERSON. Thank you very much.

Mr. PALLONE. Thank you again.

And now we have—oh, I am sorry, Mr. Peters has a comment or question.

Mr. PETERS. I just want to quickly comment to Mr. Balderson, I have not heard any discussion of large infrastructure package in this building on either side of the aisle which doesn't include rural broadband. We see it as an access issue, as an investment issue, and as an infrastructure issue. And so we will look forward to working with you on that.

Mr. BALDERSON. Yes. Thank you very much.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

And now we go to Mr. Hern from Oklahoma.

OPENING STATEMENT OF HON. KEVIN HERN A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. HERN. Thank you, Mr. Chairman, and the members here for allowing me to testify today. I want to thank the Energy and Commerce Committee for passing H.R. 3375, the Stopping Bad Robocalls Act. This is an important piece of legislation that I proudly cosponsored and the House of Representatives passed overwhelmingly yesterday.

We have all received spam phone calls before. They are annoying, harassing, frustrating calls during all hours of the day and night. I sometimes get as many as 20 fake phone calls per day. These robocalls are frequently coming from your own area code, a trick that makes us all extra vulnerable to this epidemic.

Con artists are manipulating the incoming phone numbers in order to gain the trust of the American people to steal money and personal information from the unsuspecting victims. It is a criminal—it is criminal and it is long overdue that we do something about this breach of trust. It is urgent that we shine some light on the pressing and increasingly frustrating issues of robocalls. Currently robocalls make up about 50 percent of all phone calls.

In 2018, there were more than 47 billion robocalls in the United States, an increase of 17 billion from the previous year. And this is—and this year, according to AARP, we are on track to receive a record 60 billion illegal robocalls. In my home state of Oklahoma, robocalls are received over 55 million times per month, about 75,000 calls per hour. That is completely absurd.

Oklahoma state officials are working tirelessly to solve this issue on a local level, but the scope of this abuse requires federal intervention. Therefore, I want to thank Oklahoma's Attorney General Mike Hunter, who has met with Federal Communications Commission Chairman Pai, to do his part in ending the robocall epidemic in Oklahoma.

For rural Oklahomans, their phone may very well be their lifeline, and robocalls block the lines, putting their very lives in danger.

Additionally, robocall epidemic is also a public health crisis that is plaguing our hospitals and healthcare facilities' phone lines. For people with life-threatening illness and the elderly who rely on their phone as their lifeline these phone calls can get in the way of lifesaving help. When a person is trying to contact a hospital,

every second counts. A blocked phone line due to a spam call can mean life or death to a patient.

For example, in the heart of Boston, at Tufts Medical Center, administrators registered more than 4,500 calls within a 2-hour window just last year. Many hospitals around the country share this experience.

In Congress I have made it a priority to uphold consumer protections. Unsolicited calls and text messages violate these protections, which is why I support the Stopping Bad Robocalls Act. This legislation requires consumer consent to receive calls and text messages from automated dialing systems, and requires those who are sending robocalls to maintain records of consent they have received from consumers.

Consumers will also have the ability to withdraw consent from automated texts and calls. This legislation requires phone carriers to provide a call authentication technology so consumers can trust their caller I. D. again. It is required that this technology should not impose an additional line-item cost to a consumer's phone bill. There will be also a process to help rural carriers implement this call authentication technology. Consumers should be able to block harassing spam phone calls without being charged extra.

These harmful phone calls are defrauding our seniors and preventing our hospitals from providing timely care. Robocalls are a serious, pervasive, and persistent problem that are causing serious issues, particularly for our hospitals, seniors, and rural populations. These unwanted and unwarranted calls are illegal, and it is our responsibility to ensure that consumers are protected from these fraudulent calls.

Illegal robocalls put Americans at risk of scams and fraud. It is time that we stop this abuse and do something about robocalls.

I ask my colleagues in the Senate to join us in putting a stop to this nuisance to prevent violation of American consumers' right to privacy.

Once again, I want to thank you, Mr. Chairman, and the Energy and Commerce Committee, and the full House of Representatives for passing H.R. 3375, the Stopping Bad Robocalls Act. And thank you for having me here today. And I yield back.

[The prepared statement of Mr. Hern follows:]

PREPARED STATEMENT OF HON. KEVIN HERN

Thank you, Mr. Chairman and Ranking Member Walden, for allowing me to testify before your committee today. I want to thank the Energy and Commerce Committee for passing H.R. 3375, the Stopping Bad Robocalls Act. This is an important piece of legislation that I proudly cosponsor and that the House of Representatives passed overwhelmingly yesterday.

We've all received spam phone calls before. They are annoying, harassing, frustrating calls during all hours of the day and night. I sometimes get as many as 20 fake phone calls per day.

These robocalls are frequently coming from your own area code - a trick that makes us all extra vulnerable to this epidemic. Con artists are manipulating the incoming phone numbers in order to gain the trust of the American people to steal money and personal information from their unsuspecting victims. It is criminal and it is long overdue that we do something about this breach of trust.

It is urgent that we shine some light on the pressing and increasingly frustrating issue of Robocalls. Currently, Robocalls make up about 50% of all phone calls. In 2018, there were more than 47 billion robocalls in the U.S., an increase of 17 billion

from the previous year. And this year, according to AARP, we are on track to receive a record 60 billion illegal Robocalls.

In my home state of Oklahoma, robocalls are received over 55 million times per month, about 75,000 calls per hour. That is completely absurd.

Oklahoma's state officials are working tirelessly to solve this issue on the local level, but the scope of this abuse requires federal intervention. Therefore, I want to thank Oklahoma's Attorney General Mike Hunter, who has met with Federal Communications Commission Chairman Pai to do his part in ending the robocall epidemic in Oklahoma. For rural Oklahomans, their phone may very well be their life-line, and robocalls block the lines—putting their very lives in danger.

Additionally, the Robocall epidemic is also a public health crisis, as it is plaguing our hospitals and healthcare facilities' phone lines. For people with life-threatening illness and the elderly, who rely on their phone as their lifeline, these phone calls can get in the way of life-saving help.

When a person is trying to contact a hospital, every second counts. A blocked phone line due to a spam call can mean life-or-death to a patient. For example, in the heart of Boston, at Tufts Medical Center, administrators registered more than 4,500 calls within a two-hour window, just last year. Many hospitals around the country share this experience.

In Congress, I have made it a priority to uphold consumer protections. Unsolicited calls and text messages violate these protections, which is why I support the Stopping Bad Robocalls Act.

This legislation requires consumer consent to receive calls and text messages from automated dialing systems and requires those who are sending robocalls to maintain records of consent they have received from consumers. Consumers will also have the ability to withdraw consent for automated texts and calls.

This legislation also requires phone carriers to provide call authentication technology, so consumers can trust their caller ID again. It is required that this technology should not impose an additional line-item cost to a consumers' phone bill. There will also be a process to help rural carriers implement this call authentication technology.

Consumers should be able to block harassing spam phone calls without being charged extra. These harmful phone calls are defrauding our seniors and preventing our hospitals from providing timely care.

Robocalls are a serious, pervasive, and persistent problem that are causing serious issues—particularly for our hospitals, seniors, and rural populations. These unwanted and unwarranted calls are illegal, and it is our responsibility to ensure that consumers are protected from these fraudulent calls. Illegal robocalls put Americans at risk of scams and fraud. It is time that we stop this abuse and do something about robocalls.

Conclusion:

I ask my colleagues in the Senate to join us in putting a stop to this nuisance and prevent violation of the American consumer's right to privacy. Once again, I want to thank the Energy and Commerce Committee and the full House of Representatives for passing H.R. 3375, the Stopping Bad Robocalls Act.

Thank you for having me here today. I yield back the balance of my time.

Mr. PALLONE. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Hern, for coming and reinforcing what has really work for this committee, subcommittee, and full committee have been doing this year. As you know, we passed the bill yesterday on the floor.

During the markup in this committee Ms. Dingell and I actually had an amendment accepted that addressed the hospital portion that you bring up that is critically important. People need to know that when their hospital calls it is their hospital and not someone spoofing their hospital's number, particularly if they are giving out personally sensitive information.

So, I guess the next thing to do is for us all to robocall Senators Lankford and Inhofe so that—I mean that it passed so overwhelmingly here in the House yesterday, that my hope is that, you know, a big vote from the House will sometimes get the attention of the people over on the other side of the Capitol. But we can't let up

the gas, we can't take our foot off the gas, we have to keep going. This is what people want us to do.

And it was important work that got done yesterday. May not have done everything that you outlined in your remarks. To the extent that there needs to be fine tuning, or to the extent that there needs to be modification as it goes through the rulemaking process at FCC, so be it. But we have to start somewhere. This bill yesterday was a good start.

Mr. HERN. I thank the chairman for the Member Day. And this is an opportunity. You know, we, we don't often compliment one another across the aisle. I am a new freshman here, and I wanted to make sure that the Commerce Committee knew that we appreciated this on all sides of the aisle. I think America appreciates it.

And just as my colleague mentioned, we need to maybe put all our senators on robocalls and we could irritate them enough that they pass it over there.

Thank you so much.

Mr. PALLONE. Thank you so much. Thank you.

So, Mr. Delgado, you would normally be next, but Mr. Kilmer has asked if he could go before you because he has to chair a hearing or a markup of some sort. Is that OK?

All right. Mr. Kilmer, you are next.

Ms. ESHOO. Can I just thank,——

Mr. PALLONE. Oh, of course.

Ms. ESHOO [continuing]. Mr. Hern for being here? I love your idea about robocalls to the senators. So, thank you.

He is walking out, he doesn't know I am saying that.

Mr. PALLONE. I don't think I want to robocall mine.

Ms. ESHOO. Thank you. Thank you for your wonderful testimony.

Mr. PALLONE. You can robocall the New Jersey guy? Is that right.

Mr. Kilmer.

OPENING STATEMENT OF HON. DEREK KILMER A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. KILMER. Thank you, Mr. Chair, and the ranking member, and the members of the committee. And I want to thank my colleague from New York for letting me jump the queue.

And thanks for holding this Member Day. It is, I think it is really important for members who are not on the committee to be able to share some of the challenges our constituents face back home.

I am here to speak with you about something that keeps me up at night. Some of you may know I was born and raised in a timber town on the Olympic Peninsula. It is a beautiful region in Northwest Washington that I now have the honor of representing. And though many people think of the sprawling metropolis of Seattle when they think of the State of Washington, the area I represent is quite different. A majority of the land is actually quite rural.

And, Mr. Chairman, I think a lot of folks on this committee know this: rural hospitals are really struggling. A recent study found that 97 rural hospitals have closed since 2010. And earlier this year, Navigant found that 21 percent of rural hospitals are at a high risk of imminent closure. That equates to 430 hospitals in 43

states that employ over 150,000 people and, most importantly, that care for millions of our friends and neighbors.

And despite the growing problems facing rural hospitals, last year the Trump administration put forward a policy called Site-Neutral Payments that reduces reimbursement under Medicare for hospitals with affiliated clinics or care facilities. Those affected clinics and care facilities bring quality healthcare closer to folks in rural areas. But this rule cuts reimbursement by 30 percent in 2019, and 60 percent going forward to those facilities.

In a time when we should be protecting rural hospitals, this policy does exactly the opposite, it punishes hospitals for bringing medical care closer to the patients. In my district, that means Olympic Medical Center, the hospital where I was born, could face, could lose \$47 million over the next 10 years. A reduction in reimbursement from Medicare beneficiaries would go from \$118 to just \$47.

This rule is especially harmful because it impacts many hospitals serving health professional shortage areas, as designated by the Health Resources and Services Administration. Cutting reimbursements actually exacerbates that shortage by dramatically reducing the funds available to retain and hire healthcare professionals and purchase new medical equipment.

Earlier this year I went over to visit Olympic Medical Center and talked to them about the impacts of this rule. They told me that this rule has played a factor in OMC postponing a \$15 million planned construction project. It may cause elimination of some services, while also forcing the hospital to change plans to hire eight new primary care providers.

My district is not the only one impacted. In fact, it is not even on the list of the top 30 hospitals across the country, including Southwestern Vermont Medical Center, Central Vermont Medical Center in Mr. Welch's district, Dartmouth-Hitchcock in New Hampshire in Ms. Kuster's district, Cox Medical Center in Branson, Missouri in Mr. Long's district, all in the top 30, impacted worse than Olympic Medical Center.

Now, in 2018, as CMS was exploring this rule, 138 bipartisan members signed a letter urging CMS not to adopt this rule. But, unfortunately, CMS ignored this request. CMS argues that reducing these payments will increase competition with private providers. That argument is based entirely on flawed logic and faulty assumptions because it assumes that there are numerous private providers in every region, and that people who go to hospital clinics will be able to get seen by someplace else.

That misses the point that these hospitals tend to care for more medically complex cases and will care for every patient, even if they can't pay. Private providers have no such obligations, which means that as hospitals lose money and capacity, access to healthcare will be put in serious jeopardy, especially in those areas already suffering from a lack of healthcare.

Not only is this a bad—is this rule bad policy, it also exceeds the authority of CMS. Section 603 of the bipartisan Budget Act of 2015 affirmed that no existing off-campus hospital clinics should have their payment rates reduced. Additionally, in 2016, in the 21st Century Cures Act, Congress expanded those protections to cover

clinics that were in the process of being built when that bipartisan Budget Act of 2015 was passed.

So, the arbitrary rule actually violates both of these laws. It is essential that this Congress acts to ensure that legislative intent is upheld in law, and to prevent further damage. And out of concern for the damage this rule is doing to our hospitals I have introduced bipartisan legislation called the Protecting Local Access to Care for Everyone Act, or the PLACE Act. The PLACE Act would freeze—it is H.R. 2552—it would freeze the site neutral rule until December 31st, 2020, direct CMS to reimburse hospitals at the previous Medicare reimbursements rates for the money lost under the rule since the policy went into effect.

The American Hospital Association and the Federation of American Hospitals have both endorsed this bill.

I am asking for your help because Olympic Medical Center is literally the only game in town in one of the most remote rural regions in my district. And if these hospitals and clinics close, the next option for care can be hours away. And that is just dangerous. This is a really critical issue for the folks I represent and for a massive part of the country.

And I thank you for your attention and I ask for your help.

[The prepared statement of Mr. Kilmer follows:]

PREPARED STATEMENT OF HON. DEREK KILMER

Site Neutral Testimony

Mr. Chairman, thank you for having me here today and for holding this Member Day hearing—I think it’s really important that members not on committee have the opportunity to share some of the challenges their constituents face back home—and their ideas for how to address them—so I applaud you for taking advantage of this new opportunity created by Democratic leadership in the Rules Package earlier this year.

I’m here today to speak with you about something that keeps me up at night. Some of you may know that I was born and raised in a timber town on the Olympic Peninsula, it’s a beautiful region in northwest Washington that I now have the honor of representing. And though many people think of the sprawling metropolis of Seattle when they think of Washington State—the area I represent is quite different—and a major portion of it is largely rural.

Now I think many of you also represent Districts pretty similar to mine—and people are starting to realize what many folks across the country already know—rural hospitals are struggling.

A recent study found that 97 rural hospitals have closed since 2010—and earlier this year, Navigent found that 21% of rural hospitals are at “high risk of imminent closure.” This equates to 430 hospitals in 43 states that employ over 150,000 people and most importantly, care for millions of our friends and neighbors.

Despite the growing problems facing rural hospitals, last year, the Trump Administration put forward a policy called “site neutral payment” that reduces reimbursement under Medicare for hospitals with affiliated clinics or care facilities. (CMS–1695–FC).

These affiliated clinics and care facilities bring quality healthcare closer to folks in rural areas.

But this rule cuts reimbursement by 30% in 2019 and 60% going forward to those facilities. At a time when we should be protecting our rural hospitals, this policy does exactly the opposite—punishes hospitals for bringing medical care closer to patients.

In my district, this means Olympic Medical Center, the hospital where I was born, could lose \$47 million over the next ten years—and a reduction in reimbursement for Medicare beneficiaries would go from \$118.35 to just \$47.34.

This rule is especially harmful because it impacts many hospitals serving Health Professional Shortage Areas, as designated by the Health Resources and Services Administration. Cutting reimbursements exacerbates this shortage by dramatically reducing the funds available to retain and hire healthcare professionals and purchase new medical equipment.

Earlier this year I went over to visit OMC and talk to them about the impacts of the rule. And they told me that this rule has played a factor in OMC postponing \$15 million of planned construction projects and may cause the elimination of some services—while also forcing the hospital to change plans to hire eight new primary and specialty care providers.

My district is not the only one impacted. In fact, it’s not even on the list of the top 30. Hospitals across the country, including Southwestern Vermont Medical Center (Welch), Central Vermont Medical Center (Welch), Dartmouth Hitchcock in New Hampshire (Kuster) and Cox Medical Center in Branson, Missouri (Long) will all be impacted even worse than Olympic Medical Center.

Now in 2018, as CMS was exploring this rule, 138 bipartisan members signed a letter (Roskan/M. Thompson), urging CMS to not adopt this rule. But unfortunately, CMS ignored this request.

CMS argues that reducing these payments will increase competition with private providers. This argument is based entirely on flawed logic and faulty assumptions because it assumes that there are numerous private providers in every region and that people who go to hospital clinics would be able to get seen by them.

It misses the point that hospitals tend to care for more medically complex cases and will care for every patient, even if they cannot pay.

Private providers have no such obligation, which means that as hospitals lose money and capacity, access to healthcare will be put in serious jeopardy, especially in those areas already suffering from a lack of healthcare.

Not only is this rule bad policy, it also exceeds the authority of CMS. Section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74), affirmed that no existing off-campus hospital clinics should have their payment rates reduced.

Additionally, in 2016, Congress passed the 21st Century Cures Act (Public Law 114–255), which expanded these protections to cover clinics that were in the process of being built when the Bipartisan Budget Act of 2015 was passed.

This arbitrary rule clearly violates both laws.

It is essential that Congress act to ensure its legislative intent is upheld in law and to prevent further damage to healthcare access, especially in rural areas.

Out of concern for the damage this rule is doing to our hospitals, I have introduced the bipartisan legislation called the Protecting Local Access to Care for Everyone Act—or the PLACE Act.

The PLACE Act (HR 2552) would freeze the Site Neutral rule until December 31, 2020 and directs CMS to reimburse hospitals at the previous Medicare reimbursement rate and for the money lost under the rule since this policy went into effect.

The American Hospital Association and the Federation of American Hospitals have both endorsed this bill.

I am asking for your help because OMC is literally the only game in town in the rural regions of my district. If these hospitals and clinics close, the next option for care can be hours away—and that’s just dangerous.

Folks, this is a critical issue, not just for the constituents I represent, but for a massive part of the country—and we must work together to fix it.

I thank you for your attention to this matter and for your willingness to consider my testimony today.

Thank you.

Mr. PALLONE. Did you want to comment, Ms. Eshoo?

Ms. ESHOO. I did. Thank you, Mr. Chairman.

Thank you, Derek, for coming here today and for your testimony. To the ranking member of the subcommittee and Mr. Pallone, I met with Mr. Kilmer at his request. We have to pay attention to this. This is it is not just in his district, this is a rural hospital issue.

I believe, am I recalling this correctly, that you have even gone so far as to identify how this would be paid for, or am I confusing that with something else?

Mr. KILMER. We didn’t stipulate that in the bill but, you know.

Ms. ESHOO. But this has bipartisan cosponsorship. This really deserves the attention of our committee.

So, I want to work with you to resolve this.

Mr. KILMER. Thank you.

Ms. ESHOO. It is troubling to me that this was brought about by a reversal of policy in the Administration. And but whatever it is, we have to contend with it. And I pledge to you that I will work with you to resolve this. Because people’s lives are—you are holding all of these people in the palm of your hand. And we have a responsibility to them.

So, thank you for being here today.

Mr. KILMER. Thank you.

Ms. ESHOO. We will work with you. And let’s see what we can get going post August recess.

Mr. KILMER. Thank you.

Mr. PALLONE. Dr. Burgess.

Mr. BURGESS. I probably need to study the issue again. But in the Budget Act of 2015 the concept was that hospitals were acquiring medical practices and the reimbursement from CMS to the hospitals was three times what the individual doctors had been prior to the time their hospital—their practice was acquired by the hospital. So it was really driving consolidation.

We had a hearing on consolidation in the last Congress in the Oversight and Investigations Subcommittee. And I will have to say I don’t remember all of the, all of the moving parts there. But ones

you bring up are important. At the same I would just say to the committee there are multiple moving parts here. And just like any time you move—this would be an argument for not expanding federal footprints in healthcare delivery—but any time you move one piece in that big puzzle, a lot of other things change. So it needs to be done with some care.

I don't think it is fair to say it was all on this Administration because it was passed back in 2015. I know I heard from MD Anderson Hospital, not in my district but just outside, because they were concerned that their cancer clinics would be affected because they were more than 200 yards from the front door of their hospital, which was I think the, if I recall correctly, that was the stipulation that was in the Budget Act.

But point made. And we do need to, we do need to take it seriously. There are reasons that that was done back in 2015, probably reasons the rule was delayed, reasons that you allude to. And any time you move one piece in this, a lot of other pieces move unintentionally. And we need to be careful with it.

Thank you for bringing it to our attention.

Mr. KILMER. Thank you.

Mr. PALLONE. Mr. Peters.

Mr. PETERS. Thank you, Mr. Chairman. I would like to thank Mr. Kilmer for bringing this issue to our attention. It is a reminder, as you can see very clearly, as I don't represent a rural area, that you can see very clearly how this rule is affecting access in his district, and it is a reminder again that one size doesn't fit all. What could be a very sensible approach in a urban district where there's many providers just may not fit at all in an urban area.

So, I think we should look at this, we should take a look at your bill. And I look forward to working with you on this, Mr. Kilmer, so we can get it right.

Mr. KILMER. Thank you. Thank you, Mr. Peters.

Mr. PALLONE. Thank you, Derek.

We, you know, we have been saying over and over all the time here since 10:00 o'clock that we have to make sure that rural areas have access and affordability. And we can't neglect them, because too often that has been the case. So we are certainly going to take another look at this rule.

Thank you.

And I wanted to thank Mr. Delgado for waiting. You are next. But we are going to switch chairs here. I am going to ask our chairwoman of the Health Subcommittee to replace me.

Thank you, Anna. Mr. Delgado, you are recognized.

OPENING STATEMENT OF HON. ANTONIO DELGADO A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. DELGADO. All right. Thank you, Chairman Pallone, Chairwoman as well of the subcommittee, and Ranking Member Burgess. I appreciate the opportunity to come before the committee today to talk about an issue that is critically important to me, and one I have prioritized from the beginning of my commitment to serve New York-19, and that is healthcare.

It is unacceptable that the United States, the richest country in the world, is also the only developed one without a universal healthcare system. This is one of the top reasons why I came to Congress. And I am proud to be here today to share with you a bill I introduced to finally get us to that goal.

H.R. 2000, the Medicare-X Choice Act establishes a public option plan available for purchase on an individual and small businesses exchange. I want to thank my colleagues Representatives Higgins and Larson for working with me on this important legislation.

The folks I talk to back home want more coverage options at lower cost. Importantly, the Medicare-X Choice Act would deliver by allowing those who are happy with their employer-provided insurance to keep it, while giving another more affordable coverage option to those who need it. My bill would combine the Medicare physician networks and reimbursement rates with ACA coverage standards to create a new public option available to all Americans.

The effect of creating a public floor in the private marketplace would be to drive down premiums and deductibles for everyone.

Another critical aspect of this legislation addresses the urgent priority for New York-19 constituents, and those all across the country, and that is the cost of prescription drugs. As we all know, currently Medicare is unable to negotiate drug prices with the pharmaceutical industry—a travesty. And my bill will change this by allowing for such negotiation through Medicare Part D, and these prices would carry over to Medicare-X.

Lastly, my bill would expand access to premium tax credits to those beyond the 400 percent of the federal poverty line, the current threshold for premium assistance under the ACA. With this bill we are introducing more choice and more competition to the marketplace, starting in the places that need it most, like rural areas, without provider shortages.

Our constituents expect us to take on the big issues impacting their lives, not shy away from the hard decisions. Lowering the cost of healthcare should not be partisan. Taking on the skyrocketing costs of prescription drugs should not be a divisive issue. I am here to be a part of the solution. I encourage my colleagues to cosponsor the Medicare-X Choice Act and join me in urging consideration of this bill to achieve universal coverage.

I thank my colleagues again for the opportunity to talk about this issue that I care so deeply about; and yield back the balance of my time.

[The prepared statement of Mr. Delgado follows:]

PREPARED STATEMENT OF HON. ANTONIO DELGADO

First, thank you to Chairwoman Eshoo and Ranking Member Burgess for the opportunity to speak about a priority essential to my community.

It's unacceptable that the United States, the richest country in the world, is the only developed one without a universal healthcare system. This is one of the top reasons I came to Congress, and I'm proud to be here today to share with you all a bill I introduced to finally get us to that goal.

H.R. 2000, the Medicare-X Choice Act, establishes a public option health plan available for purchase on the individual and small business exchanges. I want to thank my colleagues Representatives Higgins and Larson for working with me on this important legislation.

The folks I talk to back home want more coverage options at lower costs. Importantly, the Medicare-X Choice Act would deliver by allowing those who are happy

with their employer-provided insurance to keep it, while giving another, more affordable coverage option to those who need it.

My bill would combine Medicare physician networks and reimbursement rates with ACA coverage standards to create a new, public option available to all Americans. The effect of creating a public floor in the private marketplace would be to drive down premiums and deductibles.

Another critical aspect of this legislation addresses an urgent priority for New York's 19th District—cost of prescription drugs.

Currently, Medicare is unable to negotiate drug prices with the pharmaceutical industry—a travesty. My bill will change this by allowing for such negotiation through Medicare Part D—and these prices would carry over to Medicare-X.

Lastly, my bill would expand access to premium tax credits to those beyond the 400% of the federal poverty line, the current threshold for premium assistance under the ACA.

With this bill, we're introducing more choice and more competition to the marketplace, starting in the places that need it most—like rural areas with provider shortages.

Our constituents expect us to take on the big issues impacting their lives—not shy away from the hard decisions.

Lowering the cost of healthcare should not be partisan. Taking on the skyrocketing cost of prescription drugs should not be a divisive issue.

I'm here to be part of the solution. I encourage my colleagues to co-sponsor the Medicare-X Choice Act and join me in urging consideration of this bill to achieve universal coverage.

I thank my colleagues again for the opportunity to talk about a topic I care so deeply about and I yield back the balance of my time.

Ms. ESHOO [presiding]. Thank you. We thank the gentleman for making time to be here today. And congratulations on your legislation. And today is all about welcoming the ideas that members have. So thank you, we will do that.

Mr. DELGADO. Thank you.

Ms. ESHOO. Your passion for the subject matter is more than self-evident.

Mr. DELGADO. Yes.

Ms. ESHOO. Dr. Burgess.

Mr. BURGESS. May I just ask a question, Mr. Delgado?

Mr. DELGADO. Absolutely.

Mr. BURGESS. What is the geographic distribution of New York-19? Where is it?

Mr. DELGADO. Oh, I am happy to talk about my district. It is nearly 8,000 square miles about two-and-a-half hours north of New York City. It includes the Hudson Valley and the Catskills.

It is the third most rural seat of any Democrat in Congress in the eighth in the entire country. It is made up of the best collection of small cities and big towns in the country. I believe the largest population center is Kingston in Ulster County, which is only about 25,000 people. So that is why it is one of the more rural seats. A land of plentiful dairy farms, fruit and vegetable farms, Delaware River, one of the best trout fisheries in the country, along with the Hudson River and the beautiful Catskill Mountains.

Come on by.

Mr. BURGESS. Maybe we ought to do a field hearing.

Ms. ESHOO. It sounds like we need to travel to your district.

Mr. DELGADO. Hey, it is God's country.

Ms. ESHOO. It is, yes. The whole country is God's country, yes.

Mr. BURGESS. You heard Ms. DeLauro talk about her issue, as I mentioned, the Medicare for All was just discussed in the rules Committee, but I believe we need to have a major hearing in this

committee and would—I am not the chairman so I can't welcome you to come back, but I will bet there would be a favorable disposition to hear your ideas and——

Mr. DELGADO. Appreciate that.

Mr. BURGESS [continuing]. Perhaps to have, to have that included in the whatever, whatever the healthcare hearing looks like when we do get around to doing that in this committee. I feel certain we shall, I just don't know when.

Thank you for bringing those ideas. Again, we would probably disagree about a number of things but, nevertheless, you deserve, it deserves to be heard. Thank you.

Mr. DELGADO. Much appreciated. Thank you.

Ms. ESHOO. Thank you, colleagues, Mr. Delgado.

Now it is a pleasure to recognize and welcome Congressman Keller from the great state of Pennsylvania. Welcome.

OPENING STATEMENT OF HON. FRED KELLER, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. KELLER. Thank you, Chairwoman. And thank you, Ranking Member. I would also like to thank the members of the committee for allowing me to testify about the importance of Pennsylvania's natural gas industry.

Pennsylvania's natural gas has far-reaching economic and geopolitical benefits, both to the Commonwealth of Pennsylvania and the United States. The record is clear, domestic natural gas production strengthens our communities and makes our country safer. Pennsylvania's natural gas industry supports more than 300,000 jobs, contributes \$45 billion to the commonwealth's economy, and saves the average household \$1,100 per year in energy costs. This means more financial security for families, making day to day life more affordable.

The success of natural gas in Pennsylvania and across the United States has completely shifted long-term thinking about American energy policy and our role in the global energy marketplace. Not long ago the United States was an energy—was energy dependent, relying on foreign adversaries to meet our energy goals. That's no longer the case.

Thanks in large part to our nation's robust supply of natural gas, paired with a strong economy, American energy production has significant implications for our national security and our relationships abroad. For the first time in six decades, the United States is a net natural gas exporter. We can now use our energy exports as leverage in our foreign policy, giving our allies flexibility while diminishing the influence of unfriendly nations.

Natural gas production is also environmentally sound. Natural gas is the cleanest and lowest carbon-emitting fossil fuel and has helped the United States to reduce carbon emissions by more than any other country. Pennsylvania has reduced carbon emissions by 30 percent in the last 10 years, mostly because of increased use of natural gas fired electric generation.

We have a great opportunity to create some good-paying jobs, lower energy costs, and expand America's role as a global economic leader. To continue with this success, we must do more at the fed-

eral level. I am committed to supporting policies that allow the natural gas industry to grow and expand into new markets. Unfortunately, some states are abusing the state environmental permitting costs to stop critical pipeline infrastructure.

Just last year, New England imported natural gas from Russia because infrastructure cannot pass through New York. It is absurd that an individual state can threaten our national security and interfere with interstate commerce. I look forward to working to stop these abuses, allow companies to transport gas to market, and strengthen our national security.

Again, I would like to thank the chairman, the ranking member, and the members of this committee for allowing me to speak about the importance of natural gas for our nation's economy, the environment, and our national security.

Thank you. I yield back.

[The prepared statement of Mr. Keller follows:]

PREPARED STATEMENT OF HON. FRED KELLER

Good afternoon and thank you for the opportunity to speak about the importance of Pennsylvania's natural gas industry.

Pennsylvania's natural gas industry has far-reaching economic and geo-political benefits, both to the Commonwealth of Pennsylvania and the United States as a whole.

The record is clear: Domestic natural gas production strengthens our communities and makes our country safer.

In Pennsylvania, the natural gas industry supports more than 300,000 jobs, contributes \$45 billion to the commonwealth's economy, and saves the average household \$1,100 every year in energy costs.

This means more financial security for families, making day-day life more affordable.

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To continue with this success, we must do more at the federal level.

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Unfortunately, some rogue states are abusing state environmental permitting processes to stop critical pipeline infrastructure.

Just last year, New England imported natural gas from Russia because infrastructure cannot pass through New York.

It is absurd that individual states can threaten our national security and interfere with interstate commerce.

I look forward to working to stop these abuses, allow companies to transport gas to market, and strengthen our national security.

Again, thank you to Chairman Pallone, Ranking Member Walden, and the members of this committee for allowing me to speak about the importance of natural gas for our nation's economy and national security.

Ms. ESHOO. Thank you, Mr. Keller, for your excellent testimony. What part of the overall energy portfolio of your state is represented by natural gas? Do you know?

Mr. KELLER. The natural gas, we actually have our energy portfolio standards. And currently right now there is probably up to 20 percent that is renewables. Up to that. That is by 2025.

Actually, in Pennsylvania I did do some legislation to help solar energy production in Pennsylvania, so that, that is one thing I worked at at the state level. Natural gas is probably I am going to say 35 percent or between 35 and probably 45 percent, just off the top of my head, as I remember it. Nuclear energy is big in Pennsylvania. We are one of the states that has—largest states for nuclear production also.

Ms. ESHOO. Thank you very much.

Dr. Burgess.

Mr. BURGESS. Thank you. And thanks for your testimony. When I first started on this committee in 2005, we had hearings about how America was running out of natural gas and the crisis that was developing because of that. So the fertilizer people were saying we don't have the feed stock to create the fertilizer that we need to have the harms to grow the corn that we need to provide the ethanol.

And then it all changed with horizontal drilling, hydraulic fracturing, as you know well. And we have now become a net energy exporter. And there are geopolitical implications. A country that used to be entirely dependent upon the former Soviet Union for their energy now have another source for that, and that would be the more friendly United States of America.

So it really has been just in the brief time that I've been on this committee the world literally has changed, and it has changed because of the ability to produce and, as you point out, move natural gas from the point of its origin to the point where it is consumed.

It is an important part of our energy infrastructure. It is an important part of our economy. And you are correct to be focused on it. And we need to maintain that focus as well.

So thank you.

Mr. KELLER. I appreciate that concern. You know, when you look at, when you look at natural gas, it lowers energy costs for families. So, families that are lower income families, it helps them.

It has also helped the Commonwealth of Pennsylvania. They had an \$800 million surplus in the past budget cycle. So it has helped the Commonwealth of Pennsylvania, and I think it can help our nation just as well as it helped the commonwealth. Thank you.

Mr. BURGESS. I think Representative DeLauro spent that on her healthcare.

Mr. KELLER. Excuse me?

Mr. BURGESS. I am just kidding. I am just kidding. I said I think she spent your surplus.

Mr. KELLER. OK. Well, I think we can spend it ourselves in Pennsylvania pretty well. Thank you.

Ms. ESHOO. Thank you. It is a pleasure to welcome and recognize our colleague from Texas, the Honorable Vicente González.

Mr. GONZÁLEZ. Thank you.

Ms. ESHOO. And who just, I just want my colleagues to know, a week ago—it was a week ago. Oh, it is almost—

Mr. GONZÁLEZ. Right.

Mr. GONZÁLEZ [continuing]. Two weeks ago now. Hosted a congressional delegation in his district in Texas. And we appreciate what you did for us.

Mr. GONZÁLEZ. Thank you.

Ms. ESHOO. It was more than an eye-opener. And your hospitality is so gracious, warm and welcoming. Thank you.

So, you are recognized.

Mr. GONZÁLEZ. It was a pleasure having you.

Ms. ESHOO. You have 5 minutes—

Mr. GONZÁLEZ. Thank you.

Ms. ESHOO [continuing]. To present your ideas to us.

Mr. GONZÁLEZ. Thank you. And I am here on a different issue. But as a Texan and as chairman of the Oil and Gas Caucus for the Democratic party, I agree with everything Congressman Keller had to say.

Ms. ESHOO. I saw you nodding.

Mr. GONZÁLEZ. It is shameful to see—

Ms. ESHOO. I noticed that you were nodding, yes.

Mr. GONZÁLEZ. It is shameful to see a Russian vessel plugged into a terminal in New England selling us Russian gas.

Ms. ESHOO. Oh my God.

**OPENING STATEMENT OF HON. VICENTE GONZÁLEZ A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GONZÁLEZ. But thank you, Chairwoman, and thank you, Ranking Member, for having us and allowing me to testify before you about the importance of including direct and indirect remuneration, or DIR fee reform in your discussion on how to best lower prescription drug prices. These price concessions are imposed on community pharmacists serving Medicare Part D patients by plan sponsors and their pharmacy benefit managers, or PBMs.

Rather than including these concessions at the point of sale, these retroactive fees are taken back from pharmacies months after the sale has taken place, exploiting patients, the government, and our community pharmacies. I can't think of any other business in the world that, that would require, would be required to sell a product to a consumer without knowing what it costs themselves.

These unpredictable fees increase patient cost sharing for drugs, pushing them into coverage gaps, better known as the donut hole, and accelerating their approach to the catastrophic phase, increasing Medicare spending at the expense of taxpayers. These fees are costing taxpayers, patients and small business money, and are, most importantly, not contributing to improved patient outcome.

I think we can all agree that without prices that make these life-saving drugs accessible, innovation for the sake of innovation is not why we were sent to Congress. I am thankful for this committee's promises to lowering prescription drug prices. I think the American people are reliant on you. I commend you all for your bipartisan consideration and the passage of H.R. 2296, the More Efficient Tools to Realize Information for Consumers Act, or the METRIC Act, which requires for price concessions to include DIR fees to be

reported to the Secretary of HHS, along with other pricing documentation.

Given your consideration of H.R. 2296, I ask that the committee consider H.R. 1034, the Fair Pricing Act of 2019, introduced by myself and Congressman Doug Collins of Georgia. Mr. Collins and I have worked with Mr. Welch, Mr. Carter, and Mr. Griffith to ensure that DIR fee reform is included in efforts to lower the costs of prescription drugs.

The Fair Pricing Act seeks to reduce prescription drug costs by—for seniors by bringing all negotiated price concessions at the point of sale. I can't think of anything that makes more sense. Ensuring savings are passed on to patients, that our community pharmacists—and that our community pharmacists are not taken advantage of through DIR fees or indirect remuneration.

The Fair Pricing Act also defines standard quality measures and sets criteria by which they are developed and applied to pharmacies. Addressing these fees would not only refocus an important part of our drug supply chain to improve patient health, but combat the financial uncertainty that these small businesses face, enabling them to continue serving Medicare beneficiaries.

I look forward to working with this committee, the Centers for Medicare and Medicaid Services, our Senate colleagues, and the President to address these fees that are hurting our seniors, our small businesses, and our taxpayers. We are seeing our community pharmacies across the country disappear.

Again, I thank you for all your leadership in lowering the costs of prescription drugs and ensuring that these policies address the role of PBMs that they are playing increasing costs of medications that our seniors are taking or that the American people are taking. I thank you for taking this issue up in such an important fashion, and I thank you for your time.

I yield back.

[The prepared statement of Mr. González follows:]

PREPARED STATEMENT OF HON. VICENTE GONZÁLEZ

Chairman Pallone, Ranking Member Walden, and members of the committee

Thank you for allowing me to testify before you about the importance of including direct and indirect remuneration, or DIR fee reform, in your discussion on how to best lower prescription drug prices.

These price concessions are imposed on community pharmacies serving Medicare Part D patients by plan sponsors and their Pharmacy Benefit Managers, or PBMs.

Rather than including these concessions at the point of sale, these retroactive fees are taken back from pharmacies months after the sale has taken place, exploiting patients, the government, and community pharmacies.

These unpredictable fees increase patient cost sharing for drugs, pushing them into the coverage gap, better known as the donut hole, and accelerating their approach to the catastrophic phase—increasing Medicare spending at the expense of taxpayers.

These fees are costing taxpayer, patients, and small businesses money and are, most importantly, not contributing to improved patient outcomes.

I think we can all agree that without prices that make these lifesaving drugs accessible, innovation for the sake of innovation is not why we were sent to Congress.

I am thankful for this committee's promise to lowering prescription drug prices.

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Mr. Collins and I have worked with Mr. Welch, Mr. Carter, and Mr. Griffith to ensure that DIR fee reform is included in efforts to lower the cost of prescription drugs.

The Phair Pricing Act seeks to reduce prescription drug costs for seniors by bring all negotiated price concessions to the point of sale—ensuring savings are passed on to patients and that our community pharmacists are not taken advantage of through Direct and Indirect Remuneration (DIR) Fees.

The Phair Pricing Act also defines standard quality measures and sets criteria by which they are developed applied to pharmacies.

Addressing these fees would not only refocus an important part of our drug supply chain to improve patient health, but combat the financial uncertainty these small businesses face, enabling them to continue serving Medicare beneficiaries.

I look forward to working with this committee, the Centers for Medicare and Medicaid Services, our Senate colleagues, and the President to address these fees that are hurting our senior citizens, small businesses, and our taxpayers.

Again, I thank you all for your leadership in lowering the cost of prescription drugs and ensuring that future policies address the role PBMs play in increasing costs.

Thank you for this time.

Ms. ESHOO. I thank the gentleman. We did, we have taken up some legislation that tracks some of the elements of your legislation relative to manufacturers, PBMs, the discounts that are negotiated. And they say that those discounts move on to the providers, and that the patients win because their premiums are lowered.

I don't think the committee really went for that, that notion. But that is really the outcome.

Mr. GONZÁLEZ OF TEXAS. I am glad they didn't.

Ms. ESHOO. And so, what you have is one of the, you know, the basic values of your legislation I think on a bipartisan basis the committee agrees with. Yours very directly goes to Part D, and that is where the money is.

Mr. GONZÁLEZ OF TEXAS. Right. Our pharmacies—

Ms. ESHOO. And so I think that—

Mr. GONZÁLEZ OF TEXAS [continuing]. Need to have certainty that whatever they are selling—

Ms. ESHOO. They do.

Mr. GONZÁLEZ OF TEXAS [continuing]. They know what it costs them themselves. And right now we don't have that.

Ms. ESHOO. And we are very fortunate, because the only pharmacist in the entire House of Representatives is the gentleman from Georgia, Mr. Carter.

Did you want to say something? Yes, you are recognized.

Mr. CARTER. Mr. González, thank you, Representative. I appreciate this very much. And you are spot on. And I just want to thank you for bringing this to the committee's attention.

And, Madam Chair, I wanted to ask, Congressman Doug Collins, who is one of the primary sponsors of the FAIR Act is unable to be here, but I wanted to ask unanimous consent to submit his letter for to be included in the record.

Ms. ESHOO. Without objection.

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

Mr. CARTER. And also, earlier this year the CMS had proposed a rule about DIR fees that, unfortunately, did not, was not finalized. And we, along with Representative González, Peter Welch and Morgan Griffith, members of our committee and, in fact, there were

20 members of the Energy and Commerce Committee as well as over 100 other Members of Congress who signed this letter to the President expressing our disappointment.

And I wanted to add that as part of the record and ask unanimous consent.

Ms. ESHOO. Without objection.

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

Mr. CARTER. Thank you. And thank you again, Representative.

Mr. GONZÁLEZ OF TEXAS. Thank you.

Ms. ESHOO. Dr. Burgess.

Mr. BURGESS. I'm smart enough to not get between Buddy Carter and DIR fees.

Mr. GONZÁLEZ OF TEXAS. It is some slippery stuff, which is part of the problem; right?

Mr. BURGESS. So, I just, and I agree with what Mr. Carter said, but I also wanted to point out I have visited your district a number of times over the years, a lovely district. And the doctors at Renaissance Hospital is certainly one of the gems of the medical delivery model in this country. So—

Mr. GONZÁLEZ OF TEXAS. They are. Thank you.

Mr. BURGESS [continuing]. H.R. 3062, which would allow for continuation and expansion of physician-held hospitals is a cause that I now carry with the retirement of Sam Johnson from our state.

Mr. GONZÁLEZ OF TEXAS. Thank you. And I support you on that.

Mr. BURGESS. It is, it is an important concept. They do a great job down there. Always enjoy it every time I get to visit their campus. And they do a lot of work on the border health problem.

Mr. GONZÁLEZ OF TEXAS. Would love to have you back.

Mr. BURGESS. Again, I am not a frequent flyer, but still I have been, I have been through McAllen Airport enough times that I know, I know where the best restaurants are.

Mr. GONZÁLEZ OF TEXAS. Yes.

Mr. BURGESS. Well, there is only one. But anyway.

Mr. GONZÁLEZ OF TEXAS. Thank you.

Mr. BURGESS. Thank you for your, for your presentation today.

Mr. GONZÁLEZ OF TEXAS. A pleasure.

Ms. ESHOO. And he hosted us at one. So, it was wonderful. I am still full.

Thank you. Thank you. We will work with you.

Now we have the pleasure of recognizing the Honorable Stacey Plaskett, the delegate from the Virgin Islands. You have 5 minutes. And this is the second time we are meeting today, the two of us.

OPENING STATEMENT OF HON. STACEY PLASKETT A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF THE VIRGIN ISLANDS

Ms. PLASKETT. Yes.

Ms. ESHOO. And I think that you are going to raise some of the issues that we spoke to. And look forward to your testimony. Welcome and thank you.

Ms. PLASKETT. Thank you, Madam Chairwoman Eshoo. And Mr. Burgess, thank you as well, and to the committee for allowing many of the members the opportunity to present brief statements

about our views on some of the areas that this committee deals with.

I would like to use this time in particular to speak about healthcare concerns on the island territories in the United States. You know that we all need significant investment in healthcare in this section. Even before the severe natural disasters of the last two years the healthcare systems in the territories were under great distress.

Specifically regarding Medicaid, the arbitrarily high local match required of territories under Medicaid impose severe and unsustainable financial demands on the territories. Each of us have tried to resolve these very differently and has had little success in doing so up until now.

Up to 30 percent of the population of my district could lose access to healthcare unless Congress takes action to eliminate the fiscal cliff that we know we are facing due to Medicaid. And Congress must act to prevent this potentially calamity before September 30th.

I am so grateful that this committee has really taken on that task and has taken action to address that cliff by moving legislation, H.R. 2328, the REACH Act, which includes the language of Mr. Soto's bill, the Territories Health Care Improvement Act, to provide an additional stream of Medicaid funds for the Virgin Islands and other territories from fiscal year 2020 to fiscal 2025.

Under this bill, for my district, the Virgin Islands, the Medicaid cap would be increased by an overall \$756 million over six years. The rate of federal matching funds for Medicaid in the Virgin Islands would also be raised temporarily at 100 percent for fiscal year 2020, 83 percent for fiscal years 2021 through 2024, and 76 percent in fiscal year 2025. Without this additional funding stream and at least another year of waiver for any local match required for Medicaid, the resulting Medicaid cuts would put healthcare delivery at risk not only for Medicaid recipients on our islands, but actually for the population at large.

Due to the large amount of individuals on Medicaid, our hospitals and other systems are solely dependent on Medicaid revenue, which help us to understand how lost Medicaid revenues would hurt healthcare providers in private practice as well.

And I have to say that I am so appreciative of this legislation. I would respectfully request, however, that the Virgin Islands have the ability to carry over any unspent funding provided in any given fiscal year to a later fiscal year in order to improve the flexibility in the way dollars are able to flow, and to better ensure that the beneficiaries will see the services they need in full, for the full entirety of the bill's 6-year period.

Lastly, I would also like to highlight healthcare needs of the territories that fall outside of the Medicaid funding cliff.

Even before the 2017 hurricane, the Virgin Islands' two hospitals, publicly owned, have been excluded from the Medicaid disproportionate share for hospitals, or DISH program, in spite of disproportionate amount of care provided to low-income patients. The exclusion of all of the territories from Medicaid DISH, and the small territories from Medicare DISH—Puerto Rico receives a Medicare DISH—had major health issues in the territories for

many years, resulting in significant uncompensated care costs, burdens on providers, hospitals, local government across the islands.

If you talk with the hospitals, this in many ways necessitated the reason why we had the type of destruction we did within our hospitals, where a hospital provides, the hospital had to make a decision are we going to pay our doctors or are we going to get a new roof put on our hospitals? We lost both of our public hospitals in the storm in 2017, and are awaiting modulars now while we are primarily doing triage care and having people medevaced out for any long-term care in the Virgin Islands.

We have two emergency rooms on each island that are operational, which is very, very precarious situation to be in.

I have sponsored legislation, joined by my colleagues from the territories, and others, to correct inequities we face under all of the federal health programs. By eliminating the Medicaid cap, providing for fair inclusion of the territories in Medicaid and Medicare, as well as other issues. It also tries to address Medicare Part D low-income subsidy programs, and address exclusion from the healthcare insurance exchange program under the Affordable Care Act.

I recognize that my time is over. That is under legislation in this session, H.R. 1354, the Territories Health Equity Act of 2019. We confront difficulty, difficult reality living in the territories. U.S. citizens have been neglected and allowed to fall behind. I trust that this committee sees the importance of this and is willing to work with us to resolve these issues.

Thank you.

[The prepared statement of Ms. Plaskett follows:]

PREPARED STATEMENT OF HON. STACEY PASKETT

Thank you to the chair and ranking member, and members of the committee, for allowing me the opportunity to present a brief statement of my views on the work of this committee in the 116th Congress. I would like to use my time to speak in particular about healthcare concerns of the island territories in the United States.

The territories will need significant investments in healthcare in this session. Even before the severe natural disasters of the last two years, the healthcare systems in the territories were under great stress.

Specifically, regarding Medicaid, the arbitrarily high local match required of U.S. territories under Medicaid imposes severe and unsustainable financial demands on the territories. Each of the territories have tried to resolve this very differently and have had little success in doing so up until now.

In addition, while overall federal Medicaid funding to the States and the District of Columbia is open-ended, Medicaid in the territories is subject to annual federal funding caps. Once the cap is reached, the territory must assume the full cost of Medicaid services.

While the capped federal funding has been supplemented by additional Affordable Care Act block grants since 2011, the Virgin Islands and all other territories face the so-called fiscal cliff on September 30th of this year when these Affordable Care Act allotments expire.

Up to 30 percent of my district could lose access to healthcare unless Congress takes action to eliminate the Medicaid fiscal cliff. Congress must act to prevent to this potential calamity before September 30th.

I am grateful that this committee has taken action to address the Medicaid cliff by moving legislation, H.R. 2328, the REACH Act, which includes the language of Mr. Soto's bill, the Territories Health Care Improvement Act, to provide an additional stream of Medicaid funds for the Virgin Islands and the other territories from fiscal year 2020 through fiscal year 2025.

Under this bill, for my district, the Virgin Islands, the Medicaid cap would be increased by an overall \$756 million over six years (\$126 million in each of fiscal years

2020 through 2025). The rate of federal matching funds for Medicaid in the Virgin Islands would also be raised, temporarily, to 100% for fiscal 2020, 83% from fiscal 2021 to 2024, and 76% in fiscal 2025.

Without this additional funding stream, and at least another year of a waiver for any local match required under Medicaid, the resulting Medicaid cuts would put healthcare delivery at risk; not only for Medicaid recipients on our islands, but also for the population at large. Due to the relatively large number of individuals on Medicaid, our hospitals and other systems depend on Medicaid revenue. Therefore, the loss of Medicaid revenue resulting from the fiscal cliff would hurt healthcare providers in private practice as well. Using 2018 data for the Virgin Islands, Medicaid funding would go from roughly \$70 million to just \$18 million. The islands cannot suffer cuts like that and continue to deliver services. Significantly more funding is needed, and at a far more equitable matching rate.

While I am very appreciative of the committee's approval of the Territories Health Care Improvement Act, I respectfully request that the Virgin Islands have the ability to carry over any unspent funds provided in any given fiscal year to a later fiscal year in order to improve flexibility in the way dollars are able to flow, and to better ensure that the beneficiaries will see the services they need for the full entirety of the bill's six-year period.

Lastly, I would like to highlight healthcare needs of the territories that fall outside of the Medicaid funding cliff.

Even before the 2017 hurricanes, the Virgin Islands' two hospitals, publicly owned, have been excluded from the disproportional share hospital (or "DSH") program, despite the disproportionate amount of care provided to low income patients. The exclusion of all of the territories from Medicaid DSH, and the small territories from Medicare DSH (Puerto Rico receives Medicare DSH), has been a major health issue in the territories for many years; resulting in significant uncompensated care cost burdens on providers, hospitals, and local government finances across all of the islands.

These uncompensated care costs, in many ways, were a major reason why the hospitals experienced the extent of their destruction in the event of disaster. For a very long time, the hospitals have been forced to make choices like whether to pay doctors and nurses or to fix a roof. The hospitals in the Virgin Islands are still waiting for modular structures to come online, while primarily doing triage care, and having people evacuated out for any long-term care. The hospital on St. Croix has only one operating room. Both hospitals remain in a very precarious situation nearly two years after the 2017 hurricanes.

I have sponsored legislation, H.R.1354, the Territories Health Equity Act of 2019, joined by my colleagues from the territories, and others, to correct the inequities faced by the territories across all of the federal health programs. The bill eliminates the Medicaid funding caps and provides for fair inclusion of the territories in Medicaid and Medicare DSH. It also improves the treatment of the territories in the Medicare Part D low income subsidy program, and addresses their exclusion from the health insurance exchange program under the Affordable Care Act.

Regarding the Affordable Care Act, I have long been dismayed that it was under-inclusive of U.S. territories. My bill would allow residents of the territories (where there are no Affordable Care Act insurance marketplaces) who lack employer-provided healthcare to access marketplace insurance plans offered to Members of Congress and congressional staff.

We must confront the difficult reality that Americans living in the territories are U.S. citizens that have been neglected and allowed to fall behind. I trust that this committee sees the importance of this and is willing to work with us to resolve these issues. Thank you.

Ms. ESHOO. Well, I thank you, Stacey, very much. I think on the first issue that you raised relative to rolling over of the funds, I already spoke to Mr. Pallone about that. And we look to be helpful to you. And I don't see any reason why funds can't be, unused funds from one fiscal year can't be rolled into another.

The DISH issue, as I said to you today earlier, is a larger one. But we appreciate what you said about the work that we have done together. I think that there is a sense of pride here on the committee on both sides of the aisle, and we saw an expansion of the commitment to the territories. We will keep working together and before the legislation goes to the full House post August recess.

So thank you, Dr. Burgess?

Ms. PLASKETT. Thank you. We love that there is an August recess.

Ms. ESHOO. Yes. Yes.

Ms. PLASKETT. We get to work on this. Thank you so much.

Ms. ESHOO. For many reasons, right. Thank you, and have a good one. And thank you for being here today. I am glad that I mentioned it to you, yes, and that you took us up on it.

The Chair requests unanimous consent to enter the following into the record: Joint testimony of Mr. Cummings and Mr. Ruppersberger of Maryland; joint testimony of Mr. Kelly of Pennsylvania and Ms. Kaptur of Ohio on behalf of the House Congressional Auto Caucus; testimony of Mr. Raskin of Maryland; testimony of Mr. Engel of New York; testimony of Mr. Gomez of California; testimony of Ms. Moore of Wisconsin; testimony of Mr. Payne, New Jersey; testimony of Mr. Briggs of Arizona; testimony of Mr. Swalwell of California; testimony of Mr. Smith of New Jersey, and; testimony of Mr. Cisneros of California.

Without objection, so ordered.

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

Ms. ESHOO. And is there anything that you would like, Dr. Burgess?

Mr. BURGESS. We will do it again real soon.

Ms. ESHOO. OK. I want to thank the Members, most especially Dr. Burgess here for the participation in today's hearing, Members Day—Member Day. I think that we learned a lot, have much to appreciate in what they brought forward, and even more work to do with the committee to help meet the needs that they have in their congressional districts. So, we are grateful to all.

And at this time, the committee is adjourned.

[Whereupon, at 3:51 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

Congress of the United States
Washington, DC 20515

February 15, 2019

The Honorable Rosa L. DeLauro
 Chairwoman
 Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
 House Committee on Appropriations
 H-305, The Capitol
 Washington, D.C. 20515

The Honorable Tom Cole
 Ranking Member
 Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
 House Committee on Appropriations
 H-305, The Capitol
 Washington, D.C. 20515

Dear Chairwoman DeLauro and Ranking Member Cole:

We are writing to express our concern about a soon-to-be proposed change in a Medicaid regulation that for the first time would allow states to eliminate Medicaid non-emergency medical transportation (NEMT) for patients that are blind, elderly, or disabled. The Medicaid rule, which is expected to be promulgated in May 2019, would repeal long-standing regulations (CFR §431.53) that have been upheld in the courts requiring State plans to include necessary transportation to and from providers.

As you may be aware, NEMT is an essential component of our nation's health care delivery system, especially in rural areas. According to a recent Kaiser study (see attached chart), over half of Medicaid transportation services are utilized by patients with the highest burden of chronic diseases, including those diagnosed with cancer, HIV, mental illness, substance abuse, and end-stage renal disease. In fact, NEMT is vital to many of our constituents who are Medicaid patients. Without this help, they could not access chemotherapy, dialysis, and other services that allow them to remain at home and out of the hospital. NEMT also helps them to travel to their pharmacists to obtain their drug prescriptions and medical supplies.

Currently, NEMT is utilized by roughly 10% of Medicaid enrollees and accounts for only 1% of total Medicaid spending. It is reserved for beneficiaries who have no other means of transportation to and from their medical appointments. State programs help to ensure the benefit is accessible only to those in need.

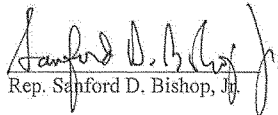
The elimination of Medicaid NEMT would have an adverse impact both on beneficiaries and state budgets. As members of the Congressional Black Caucus, we respectfully request that the Fiscal Year 2020 Labor-HHS Appropriations bill contain the following legislative language to block implementation of this unwise policy:

None of the funds appropriated in this bill or otherwise made available to the Department of Health and Human Services shall be used to publish the proposed regulation in the Fall 2018 Unified Agenda of Regulatory and Deregulatory Actions relating to the Medicaid Nonemergency Medical Transportation benefit for Medicaid beneficiaries expected to be published for comment in May 2019 and promulgated in Fall 2019 (RIN:0938-AT81).


We would be grateful if you would include this important legislative language in the FY2020 Labor-HHS Appropriations bill and join us in blocking any attempt to eliminate or undermine Medicaid NEMT. It is essential that we retain the requirement for States to offer transportation to all Medicaid patients that have no other means to access health services.

Thank you for your kind attention.

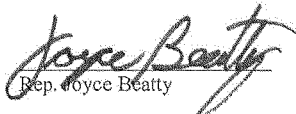
Sincerely,


Rep. Sanford D. Bishop, Jr.


Rep. Alma S. Adams


Rep. Colin Z. Allred


Rep. Karen Bass



Rep. Joyce Beatty


Rep. Lisa Blunt Rochester


Rep. Anthony G. Brown


Rep. G.K. Butterfield


Rep. André Carson


Rep. Yvette D. Clarke

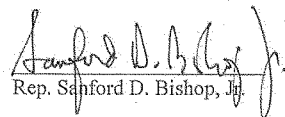
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We would be grateful if you would include this important legislative language in the FY2020 Labor-HHS Appropriations bill and join us in blocking any attempt to eliminate or undermine Medicaid NEMT. It is essential that we retain the requirement for States to offer transportation to all Medicaid patients that have no other means to access health services.

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Sincerely,


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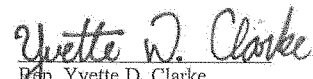

Rep. Joyce Beatty



Rep. Lisa Blunt Rochester

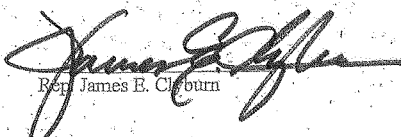

Rep. Anthony G. Brown


Rep. G.K. Butterfield


Rep. André Carson

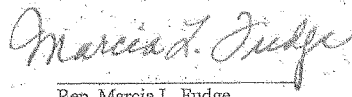

Rep. Yvette D. Clarke


Rep. William Lacy Clay

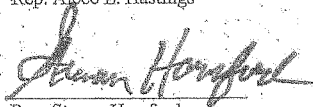

Rep. James E. Clyburn


Rep. Danny K. Davis



Rep. Val Butler Demings


Rep. Marcia L. Fudge


Rep. Alcee L. Hastings


Rep. Steven Horsford

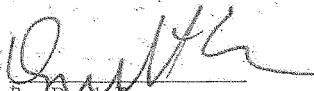

Rep. Hakeem S. Jeffries



Rep. Henry C. "Hank" Johnson, Jr.


Rep. Emanuel Cleaver


Rep. Elijah E. Cummings


Rep. Antonio Delgado

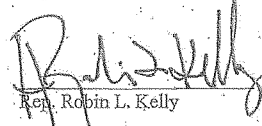

Rep. Dwight Evans



Rep. Al Green


Rep. Jahana Hayes


Rep. Sheila Jackson Lee



Rep. Eddie Bernice Johnson


Rep. Robin L. Kelly


Rep. Brenda L. Lawrence

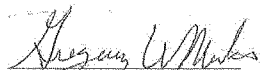

Rep. Al Lawson, Jr.


Rep. Barbara Lee

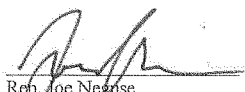

Rep. John Lewis


Rep. Lucy McBath


Rep. A. Donald McEachin


Rep. Gregory W. Meeks


Rep. Gwen Moore



Rep. Joe Neguse



Rep. Eleanor Holmes Norton

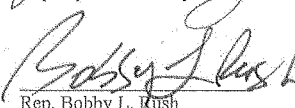

Rep. Ilhan Omar



Rep. Donald M. Payne, Jr.


Rep. Stacey E. Plaskett


Rep. Ayanna Pressley


Rep. Cedric L. Richmond



Rep. Bobby L. Rush



Rep. David Scott



Rep. Robert C. "Bobby" Scott

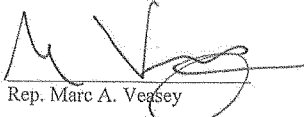

Rep. Terri A. Sewell



Rep. Lauren Underwood


Rep. Maxine Waters


Rep. Frederica S. Wilson


Rep. Bennie G. Thompson


Rep. Marc A. Veasey


Rep. Bonnie Watson Coleman

cc The Honorable Nita M. Lowey
cc The Honorable Kay Granger

SUPPORTERS OF NEMT MEDICAID FIX

REP. SANFORD BISITTO

AIDS Action Baltimore
 AIDS Alabama
 AIDS Alabama South
 AIDS Foundation of Chicago
 Allies for Independence
 American Academy of HIV Medicine
 American Association of People with Disabilities
 American Association on Health and Disability
 American Federation of County and Municipal Employees
 American Kidney Fund
 American Public Transportation Association
 American Therapeutic Recreation Association
 Amida Care
 The Arc of the United States
 Association of Programs for Rural Independent Living (APRIL)
 Autistic Self Advocacy Network
 Center for Autism and Related Disorders
 Center for Public Representation
 Children's Health Fund
 Community Catalyst
 Community Transportation Association of America
 Dialysis Patient Citizens
 Easterseals
 Epilepsy Foundation
 Equality NC
 FamiliesUSA
 First Focus
 Global Alliance for Behavioral Health and Social Justice
 Greater Wisconsin Agency on Aging
 HIV Dental Alliance
 HIV Medicine Association
 Hudson Valley Community Services
 Lakeshore Foundation
 Los Angeles LGBT Center
 Lutheran Services in America
 Medicare Rights Center
 Mental Health America
 Michael J. Fox Foundation for Parkinson's Research
 National Adult Day Services Association (NADSA)
 National Alliance on Mental Illness
 National Association for Children's Behavioral Health
 National Association of Area Agencies on Aging (N4A)
 National Association of Directors of Developmental Disabilities Services
 National Association of Nutrition and Aging Services Programs (NANASP)
 National Consumer Voice for Quality Long-Term Care
 National Council on Aging

National Healthcare for the Homeless Council
National Rural Health Association
Nevada Disability Coalition
Pennsylvania Council on Independent Living
SKIL Resource Center
The Transportation Alliance
Treatment Action Group
Treatment Communities of America
United Spinal Association
WI Association of Mobility Managers (WAMM)

Congress of the United States
Washington, DC 20515

June 18, 2019

President Donald Trump
 The White House
 1600 Pennsylvania Ave, NW
 Washington, DC 20500

Dear Mr. President,

We write today to express our disappointment that the recently finalized Centers for Medicare & Medicaid Services (CMS) rule, Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses (CMS-4180-F), failed to finalize the pharmacy direct and indirect remuneration (DIR) fee reform for plan year 2020, as included in CMS's original proposal. While we commend the administration for your goal to reduce seniors' out of pocket costs for prescription drugs, we believe that finalizing this rule without including DIR reform is a missed opportunity to deliver real cost savings to Medicare beneficiaries. Without DIR reform, another year could pass before seniors see drug prices lowered at the pharmacy counter.

As CMS itself cited in the proposed rule, DIR fees on pharmacies participating in Part D grew by 45,000 percent between 2010 and 2017. This increase is unacceptable and unsustainable, and creates uncertainty not only for community and specialty pharmacies but also for the patients who rely on Part D prescription drugs. Until pharmacy DIR fee reform occurs, seniors will continue to pay higher cost-sharing for their prescription drugs. CMS estimated that these reforms would have saved Medicare beneficiaries between \$7.1 and \$9.2 billion in cost sharing over the next ten years.

For these reasons, we continue to encourage the administration to move forward with efforts to deliver seniors real relief from rising prescription drug costs. We stand ready to work with you to determine how we can adopt this relief this year.

Sincerely,



PETER WELCH
 Member of Congress



EARL L. "BUDDY" CARTER
 Member of Congress



VICENTE GONZALEZ
 Member of Congress



H. MORGAN GRIFFITH
 Member of Congress



BRUCE WESTERMAN
Member of Congress



YVETTE D. CLARKE
Member of Congress



BRIAN BABIN
Member of Congress



MICHAEL GUEST
Member of Congress



FILEMON VELA
Member of Congress



STEVE KING
Member of Congress



ROB WITTMAN
Member of Congress



C.A. DUTCH RUPPERSBERGER
Member of Congress



BRADLEY BYRNE
Member of Congress



ROGER MARSHALL, M.D.
Member of Congress



MAC THORNBERRY
Member of Congress



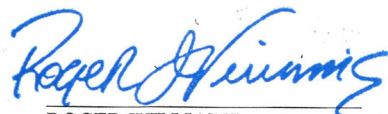
TERRI SEWELL
Member of Congress



CATHY MCMORRIS RODGERS
Member of Congress



ROBERT B. ADERSHOLT
Member of Congress



ROGER WILLIAMS
Member of Congress



FRENCH HILL
Member of Congress



GARRET GRAVES
Member of Congress



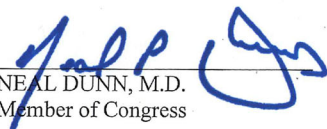
JOHN KATKO
Member of Congress



AUSTIN SCOTT
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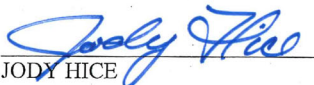
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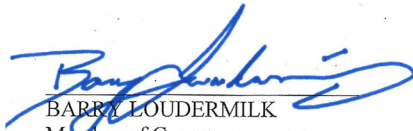
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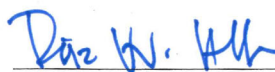
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BEN CLINE
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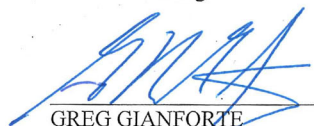
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RICK W. ALLEN
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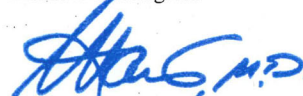
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GREG GIANFORTE
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RICK CRAWFORD
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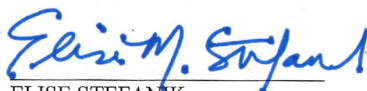
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ANTHONY BRINDISI
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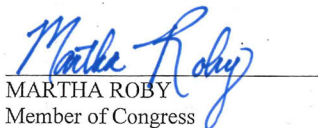
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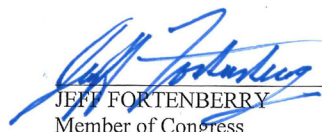
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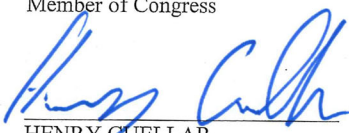
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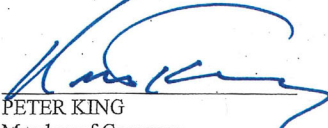


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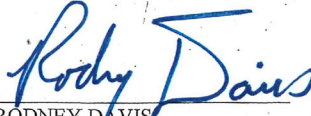

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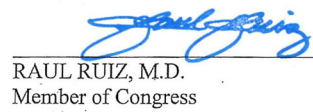

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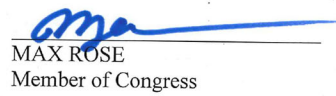

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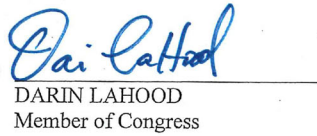

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MIKE JOHNSON
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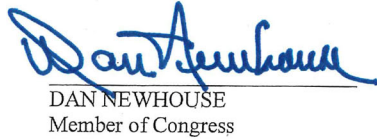

RAUL RUIZ, M.D.
Member of Congress

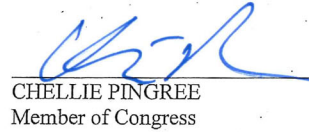

BRETT GUTHRIE
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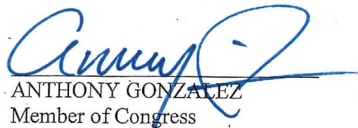

MAX ROSE
Member of Congress

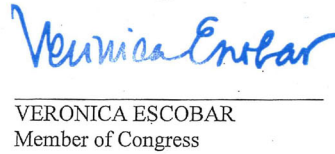

DARIN LAHOOD
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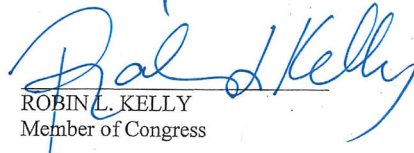

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VERONICA ESCOBAR
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LISA BLUNT ROCHESTER
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MIKE BOST
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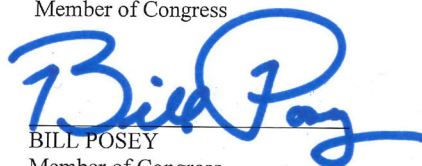

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TOM O'HALLERAN
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RON ESTES
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TRENT KELLY
Member of Congress


BILL POSEY
Member of Congress

Cc:

Mick Mulvaney, Director: Office of Management and Budget
Vice President Mike Pence
Joseph Grogan, Director: Office of Domestic Policy
Larry Kudlow, Director: National Economic Council
Alex Azar, Secretary, U.S. Department of Health and Human Services
Seema Verma, Administrator, Centers for Medicare and Medicaid Services

Congress of the United States
Washington, DC 20515

Chairman Pallone, Ranking Member Walden, and Members of the Committee:

We submit this statement today regarding H.R. 1966, the Henrietta Lacks Enhancing Cancer Research Act, legislation that honors the extraordinary life and legacy of Henrietta Lacks and takes steps to ensure that vital cancer research is inclusive of all individuals.

Henrietta Lacks, a Black woman, died of cervical cancer in 1951. During her cancer treatment, doctors took samples of her tumor, and from this the HeLa cell line was created. Without her or her family's knowledge, her cells were used in medical research and helped lead to some of medicine's most important breakthroughs, including the development of the polio vaccine, along with treatments for cancer, HIV/AIDS, leukemia, and Parkinson's disease. Her cells have made a significant contribution to the areas of global health, scientific research, quality of life, and patient rights.

Despite the progress that Lacks' cells helped to achieve, many communities still face glaring health disparities in many areas, including cancer. For example, while cancer incidence rates are highest among non-Hispanic White females, non-Hispanic Black females have the highest death rates. In addition, non-Hispanic Black males are most likely to develop prostate cancer and are roughly twice as likely to die from the disease than any other racial or ethnic group.¹

Clinical trials are a key component to advancing cancer research and treatment, and ultimately reducing disparities. The Henrietta Lacks Enhancing Cancer Research Act would direct the Government Accountability Office to study and publish a report regarding barriers to participation in federally funded cancer clinical trials by populations that have been traditionally underrepresented in such trials.

Currently, about 1 in 5 cancer clinical trials fail because of lack of patient enrollment, with racial and ethnic minorities, and older, rural, and lower-income Americans generally underrepresented in such trials. There are many factors that may lead to an individual being unable to participate in a clinical trial including lack of available local trials, transportation to trial sites, restrictive eligibility criteria, taking time off from work, and potentially increased medical and nonmedical costs. The purpose of this legislation is to ensure that Congress has the necessary information to find solutions that adequately address these barriers and help reduce health disparities.

This bill is an important step in making sure that all individuals are able to benefit from cancer research. We urge the Committee to consider this important legislation. Thank you.

ELIJAH E. CUMMINGS
Member of Congress

C.A. DUTCH RUPPERSBERGER
Member of Congress

¹ American Cancer Society Cancer Action Network, *Cancer Disparities: A Chartbook* (2018), <https://www.fightcancer.org/policy-resources/cancer-disparities-chartbook>.

**CONGRESSMAN MIKE KELLY (PA-16) & CONGRESSWOMAN MARCY
KAPTUR(OH-09)
ON BEHALF OF THE HOUSE CONGRESSIONAL AUTO CAUCUS**

**STATEMENT BEFORE THE HOUSE COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON CONSUMER PROTECTION & COMMERCE**

**MEMBER DAY HEARING
THURSDAY JULY 25, 2019
10:00 A.M.
2123 RAYBURN HOUSE OFFICE BUILDING**

We would like to begin by thanking Subcommittee Chairwoman Jan Schakowsky and Ranking Member Cathy McMorris Rogers, as well as Chairman Frank Pallone and Ranking Member Greg Walden for the opportunity to present this testimony to the House of Representatives' Energy and Commerce Committee's Consumer Protection and Commerce Subcommittee. As co-chairs of the House Congressional Auto Caucus, we relish every opportunity to talk about how important the automotive sector is to our American economy and legacy. Arguably, no other historical force has so revolutionized the way Americans work, live, and play. Given the electronic and information-age revolution afoot, special attention is due to this industry to ensure America maintains leadership and repeats the resulting benefits for years to come.

Created in 1983, the House Auto Caucus has a long history of bipartisan collaboration to promote a strong and vibrant American automotive industry. Our Caucus is supported by a diverse group of automotive associations and carries out the tradition of working with industry stakeholders to educate Capitol Hill policy makers and advance a legislative agenda that encourages an innovative, competitive, and growing automotive sector.

The greater automobile industry extends well beyond the iconic names of auto companies familiar to us all. Today, fourteen automakers are building cars and light trucks in America. The automotive industry depends on thousands of companies supplying parts, components and materials, as well as a vast retail and vehicle maintenance network of dealers. No other industry in America has such an expansive reach to every state, delivering economic benefits and creating jobs in so many different sectors.

Let's talk numbers. Represented by manufacturers, suppliers, dealers, and many auto affiliated businesses, the automotive industry employs more than 9.9 million American workers. Annually it drives more than \$953 billion into the economy through the sales, servicing of autos, and paychecks for workers throughout the sector, as well as income for auto-related small business, and government revenues. Historically, the auto industry has contributed 3-3.5% of America's total gross domestic product.¹

¹ Auto Alliance, <https://autoalliance.org/economy/> (last visited 7-20-2019).

The automobile was a key force for change in twentieth-century America. With the right support and stability, it will surely remain one in the twenty-first century. This Committee has already taken action on many of these issues, which we commend. The question before us today, is what further role can and should Congress play to facilitate cutting edge innovation, market leadership, and regulatory consistency?

We would like to discuss three primary subject areas: nontraditional automotive infrastructure, alternative energy, and automotive cyber security. None of these fit neatly into a box nor are they exclusive to the jurisdiction of this Committee. It is for these reasons we believe there is great potential with appropriate Congressional participation but also great concern if limited to a siloed approach.

Nontraditional Automotive Infrastructure

For the automobiles' first century there was significant influence with ancillary industries, particularly steel and petroleum, revolutionized by the demands of vehicle's needs. Once again, the automotive world is hand in hand with the leading sector of the day, the tech and information industry, as the technological revolution is rapidly afoot.

There is significant potential to increase mobility options and improve tragic trends in automobiles accidents with advanced technology in autonomous vehicles, but public acceptance and satisfaction with safety is key. In consumers eyes, these advances are viewed through the lenses of safety concerns. Thus far, a balanced relationship between manufacturers and the federal government have allowed incremental progress in technology to make vehicles safer, many of these advances entail semi-autonomous, advanced driver assist systems (think cruise control, parking assist, etc). Yet, anticipated leaps in current technological advancement leave much to be undetermined with how best to proceed, which is where Congress has an important role to perform.

The first two non-traditional infrastructure components we want to discuss will enable or hinder forward progress on these technological advances for automated vehicles, spectrum availability and infrastructure, and vehicle sensor connectivity, the third, advanced alternative energy infrastructure blends nicely into the following section on energy, and how infrastructure can revolutionize mobility.

Automated vehicles and eventually fully driverless vehicles need futuristic roads. This doesn't just mean the smoothest asphalt and brightest new lines. The roads of tomorrow must hold as much technological potential as the vehicles themselves. Connected vehicle technology, Vehicle to Vehicle (V2V), Vehicle to Infrastructure (V2I), and Vehicle to Pedestrian (V2P), collectively known as Vehicle to Everything (V2X) have the potential to enable Smart Cities and transportation ecosystems. Advanced sensors throughout traditional infrastructure (roads, traffic lights, signs, etc), on vehicles and wireless communications infrastructure is what enables the connectivity, and as we understand it today, the secured spectrum ensures it is safe.

In 1999, the FCC reserved 75 megahertz of spectrum in the 5.9 GHz band for automakers to develop technology to allow vehicles to communicate with each other, the technology was

Dedicated Short Range Communications (DSRC). This dedicated spectrum is essential to support V2X communications to save lives and support mobility today and into the future. Many automotive manufacturers have relied upon or planned to utilize its availability in current product development. But just last month FCC Chairman Ajit Pai called for a comprehensive review to determine whether to open this band as the Internet & Television Association has criticized its under-usage.²

Perhaps the exploration and comprehensive review are worthy pursuits, if nothing else to eliminate the regulatory uncertainty that has hindered the automotive industry for the last several years. But this regulatory review should be paralleled with Congressional oversight and analysis, and perhaps additional funding support or federal site designations to more rapidly advance V2X deployments, which could help increase the technology's efficiency and safety. There is no going back once the cat is out of the bag and unlicensed devices share the automotive sector's dedicated spectrum. The safety of connected and automated vehicles and the future of the automotive industry could pivot on this decision, as ultimately these safety concerns drive consumer confidence.

Right as the reserved spectrum debate heats-up, sensor technology is advancing rapidly in capabilities and cost. Unlike Lidar sensors mounted directly on vehicles, which perform best under 100 meters, increased usage and development on-board and of road-side V2X radios could allow vehicles to "see" activity far ahead, extending available reaction time for drivers when necessary and further increasing safety of increased autonomous vehicles. As traditional transportation infrastructure investments are made, Congress should consider and advocate for adaptations for smart city, nontraditional transportation infrastructure sensors to extend the relevance of today's federal investments.

A significant reason these road-side units have not yet taken priority is because hurdles involved in the extensive government intervention involved. Congress could easily expand designated advanced transportation zones for these purposes to support development. With expanded usage and data points to exemplify how connected and automated vehicle technology will continue to improve safety, Americans will become more comfortable with the concepts and technology. Congressional support, interest, and discussions about these technological and safety advances has a role in building consumer acceptance.

Shifting gears slightly on the non-traditional infrastructure front, is the need for additional Congressional support to expand alternative energy, refueling and recharging centers. The lack of confidence Americans have they will be able to go where they wish and access necessary refueling and recharging centers when necessary remains a top reason Americans are hesitant to purchase alternative energy vehicles. Communities and states that have adapted more expeditiously are seeing the consumer trends follow. Once again, Congress can be a more active partner with industry to help facilitate these investments on behalf of the American people and better prepare the nation for, as we will discuss in the next sections, the global automotive-revolution that is leaving America behind.

² David Shephardson, U.S. to take 'fresh look' at opening automakers' key spectrum band, Reuters, May 14, 2019, <https://www.reuters.com/article/us-usa-spectrum-fcc/u-s-to-take-fresh-look-at-opening-automakers-key-spectrum-band-idUSKCN1SK297>

Alternative Energy

Even while electric vehicle demand in the United States remains tepid, walk any of the American Auto Show circuit floors and you will see global and American auto companies alike feel differently. They continue to invest billions in research and development and retooling of manufacturing lines.

In November 2018, when General Motors announced the closure of five assembly plants, including the Lordstown plant midway between our two districts, they also announced they would double investments in electric vehicles. Shortly after the New Year we saw specifics on a plan to introduce a whole new line-up of electric vehicles, beginning with a Cadillac series.³ Last summer FCA announced a \$10 billion investment in electric vehicles⁴ including \$4.5 billion for Michigan plant development and upgrades for electric plugin models for their Jeep and Ram series.⁵ Hyundai Motor Group made a similar \$6.7 billion electric investment announcement last fall to build on its long history and leadership with electric vehicles. Their rationale? Anticipated growing global demand and increased global regulatory requirements for emission standards.⁶

Despite America's dominance as a leading consumer automotive marketplace, our electric preferences are trending behind the direction of global demand. Congressional action doesn't make or break American industry's leadership opportunities in electric vehicles, but we could do more to boost consumer confidence. Instead, we have seeded a gap for China to step up and now lead in both electric vehicle production and sales.⁷

Think back to the significance American autos played in the allied response and victory in World War I and World War II. Not only in military vehicles, but also production of essential military items.⁸ Imagine if America's elected leadership failed to facilitate and support the next revolution in automotive technology, at the same time we confront threats of near-peer competitors, such as China. It's inconceivable.

This body must do everything in our power to remove barriers to energy storage and commercial batteries, and recharging infrastructure to promote increased demand for electric vehicles. Just as DARPA first funded the futuristic driverless cars fantasy, which are becoming a reality, and

³ David Shepardson, Exclusive: GM's Cadillac will introduce EV in fight against Tesla – sources, Reuters, January 10, 2019, <https://www.reuters.com/article/us-gm-electric-exclusive/exclusive-gms-cadillac-will-introduce-ev-in-fight-against-tesla-sources-idUSKCN1P502G>

⁴ Aaron Brzozowski, FCA's Investor Day Presentation Reveals \$10.5 Billion Bet on Electrification, Fiat Chrysler Authority, June 1, 2018, <http://fcauthority.com/2018/06/fcas-investor-day-presentation-reveals-10-5-billion-bet-on-electrification/>

⁵ John Beltz Snyder, FCA to invest \$4.5 B for new Detroit plant, expanded production at current facilities, AutoBlog, February 26, 2019, <https://www.autoblog.com/2019/02/26/fca-invest-new-detroit-plant-phev-jeep/>

⁶ Emily Holbrook, Hyundai to Invest \$6.7 Billion in Electric Vehicle Production, Energy Manager Today, December 12, 2018, <https://www.energymanagertoday.com/hyundai-to-invest-6-7-billion-in-electric-vehicle-production-0180680/>

⁷ Alex Thornton, World Economic Forum, China is winning the electric vehicle race (2019), <https://www.weforum.org/agenda/2019/02/china-is-winning-the-electric-vehicle-race/>

⁸ History.Com Editors, Automobile History, History Channel, April 26, 2010, <https://www.history.com/topics/inventions/automobiles>

ARPA-E lead in energy storage leadership, particularly with batteries, this body must communicate a clear message to the American people on why clean energy technologies and energy innovation are fitting of American leadership. Congress must better assert U.S. leadership on the future of vehicle electrification policy or more broadly, alternative fuels.

Just as President Dwight D. Eisenhower understood the significance of an interstate system to connect this nation, we must show Americans they can transverse it in alternative fuel vehicles with adequate investments in refueling and recharging infrastructure. Equally important, we must modernize and improve the resiliency of our electric grid to ensure its reliability under new demand. This demand will not happen overnight. But have we adequately explored how an increase in electric vehicles might change how energy is supplied and consumed, and the shifts in demands placed on our old systems? We must look to the future here, not just at the immediate concerns.

What has always set the American automotive sector apart has been the workforce. From the individuals on the lines, to engineers developing and designing concepts beyond our wildest imaginations, the millions of Americans who rely on this industry need Congressional leadership to remain relevant and employed. New powertrain systems will have dramatic impact on the labor force. Like the threat of increased automation, mechanical and materials engineering work could be replaced with jobs requiring different skill sets, such as chemical, battery, and software engineering. Are our energy centers adequately engaged with education facilities to prepare this generation and the next?

The Auto Caucus has heard loudly the challenges industry already faces on workforce skills gaps. Although this isn't the Education and Labor Committee, as Members of Congress we each have a responsibility to think about our workforce and do all we can to smooth the transition and ease anxiety of new technology, including changes in the automotive-energy sector. We must strike an optimistic message, and support educational development in areas our nation lacks, like battery engineering, advanced manufacturing.

Perhaps what Americans and the automotive industry needs most importantly though is a consistent message. Federal and state policymakers should work together to support clear rules that encourage innovation. There is no room for deviousness towards innovation here, no matter why one believes the technology needs focus.

Automotive Cybersecurity

The transformation in technology seen in the last decade has revolutionized automotive ingenuity. Americans lead increasingly connected worlds and expect their automobile to fit seamlessly into, if not fully facilitate their connected life. With connectivity and increased automation comes the question of how to secure personal data. Cybersecurity in the automotive world is a relatively new concern, but one that needs considerable attention regarding who owns the collected data and how is it vulnerable to breaches.

Many vehicles of today already rely extensively on the collection and use of data about the driver and the vehicle's whereabouts. Data is used for safety, to improve efficient performance, for

convenience, and entertainment. Options currently available on many models include: navigation, blind spot detection, automatic emergency braking, parking assist, lane departure warnings, “infotainment” features, in-car “apps,” phone-sync with telephone contacts to enable hand-free calls and texts, and even in-vehicle internet connectivity. The collected data tells a very detailed story of each driver and vehicle.

How this data is used beyond the immediate understanding of the consumer is important. The last several years have exposed a fearsome reality of how companies believe they are operating and securing private data, when in fact their collections are incredibly vulnerable.⁹ Increased concerns within industry of who has access to this data and who does not have arisen between original equipment manufacturers (OEMs) and parts suppliers too. The control of this information is powerful and lucrative.

Most importantly though, do Americans fully understand the scope of their collected data, how it can be used, and how its collection impacts their privacy rights? Without early and adequate security, hackers could gain access to payment accounts, personal data, and possibly entire data systems (automated braking, acceleration, automated guidance systems, etc.). Consumer privacy and data ownership questions warrant ongoing Congressional attention, especially as the technology continues to evolve and becomes increasingly interconnected.

Cyber security vulnerabilities are not limited to personal data of an individual either. Automobiles are just one aspect of the growing tech-enabled transportation ecosystem. A forward-leaning approach will better ensure software security keeps pace with technology in the automotive industry, especially as we rely increasingly on artificial intelligence and develop Smart Cities with significant connectivity points.

The U.S. auto industry is already a leader in protecting consumer privacy and data, committing to the Automobile Industry Privacy Principles in 2014 and establishing the Automotive Information Sharing and Analysis Center (Auto-ISAC) in 2015.

When networks of transportation ecosystems are established, hackers and nefarious forces will seek means to manipulate them with potentially destructive consequences. This reality seemed to catch the tech industry off-guard in the promulgation of manipulative propaganda on social media and recent election interference. Too much is at stake with connected smart infrastructure and transportation to be caught off guard. These are details that are never too early to consider and deserve Congressional attention since industry cannot do it alone.

⁹ Taylor Telford and Craig Timberg, The Washington Post, Marriott discloses massive data breach affecting up to 500 million guests, November 30, 2018, https://www.washingtonpost.com/business/2018/11/30/marriott-discloses-massive-data-breach-affecting-million-guests/?utm_term=.b37c5d45c7ff; Craig Timberg, Elizabeth Dwoskin, and Brian Fung, The Washington Post, Data of 143 million Americans exposed in hack of credit reporting agency Equifax, September 17, 2017, https://www.washingtonpost.com/business/technology/equifax-hack-hits-credit-histories-of-up-to-143-million-americans/2017/09/07/a4ae6f82-941a-11e7-b9bc-b2f7903bab0d_story.html?utm_term=.c60d23c32e28; Cybersecurity Resource Center, Office of Personnel Management, <https://www.opm.gov/cybersecurity/cybersecurity-incidents/> (Last visited July 22, 2019)

Conclusion

A common frustration across all these areas confronting the future of America's automotive industry is the question of federal leadership and action, followed by appropriate regulation to streamline consistency. Alternatively, industry is left confronting a diverse and possibly even conflicting set of state and global regulatory standards.

The full Energy and Commerce Committee and its subcommittees have taken very commendable action over the past several years in holding hearings and passing legislation, to address to a degree many of the concerns we discussed, as have the relevant Senate committees. It is our hope today, to remind the Committee how important these issues are for many of us who do not have the privilege to participate in these in-depth discussions.

As leaders of a diverse Auto Caucus, we do not take a position on how best to achieve solutions to these complicated issues, but we believe strongly they all warrant Congressional oversight and exploration. With adequate attention, we know Congress can provide opportunities for the automotive industry to continue to thrive well into the next century. It is our constituents and local businesses involved in the auto sector who propel us to action. On their behalf, we thank you again for the opportunity to present policy concerns of the House Congressional Auto Caucus.

Testimony of Congressman Jamie Raskin (MD-08)
House Energy and Commerce Subcommittee on Environment & Climate Change
Member Day Hearing July 25, 2019

Chairman Paul Tonko, Ranking Member John Shimkus, and distinguished Members of the House Energy and Commerce Environment & Climate Change Subcommittee:

Thank you for holding this important hearing today and for providing me the opportunity to testify before the Subcommittee on the importance of restoring our climate.

Climate change is a civilizational emergency and is the context through which we must decide every other public policy issue facing us. The devastating dynamics of global warming are imperiling all our ecosystems. We are witnessing the compounding catastrophes of rising sea levels, vanishing glaciers, spreading drought, accelerating forest fires, proliferating floods, escalating extinction of species, dramatically expanding civil conflict and population displacement.

According to the International Panel on Climate Change (IPCC), sustained CO₂ levels above 450 parts per million (ppm) pose an existential threat to our ecosystems. Today, CO₂ levels have already exceeded 410 parts per million and are expected to rise to at least 450 parts per million by 2050 if we do not take immediate and aggressive action to confront the climate crisis.

Although I admire this Subcommittee's exemplary work to mitigate climate change and to keep global temperatures from rising more than 2° C, much more needs to be done to restore CO₂ levels to concentrations sustained for much of humanity's history. Only by removing excess CO₂ from our environment can we halt sea level rise and ensure a safe and healthy climate for future generations.

Please know that I recently introduced a [Resolution](#) that encourages scientists to research the most effective ways to restore safe CO₂ levels and declares the goal of reinstating a safe and healthy climate. I urge the Subcommittee to examine this Resolution and find ways to incorporate climate restoration principles into policy.

I look forward to working with all of you to restore our climate, and I stand ready to help in any way possible.

Thank you again, Chairman Tonko and Ranking Member Shimkus, for holding this hearing, and thank you to all the Members of this Subcommittee for your time today.

Medicare Coverage of Home Infusion Professional Services
Written Statement of Congressman Eliot L. Engel
Member Day Hearing
Thursday, July 25, 2019 - 10:00am

Thank you Chairman Pallone and Ranking Member Walden for holding today's hearing to allow Members to highlight specific legislation or issues of importance to their constituents and districts.

The issue I'd like to raise today is one that was first brought to me by a constituent more than a decade ago, and one that I have been working on with Members of this Committee ever since—Medicare's lack of coverage for home infusion therapy professional services.

For more than 30 years, home infusion providers have safely and effectively coordinated and delivered infused medications in patients' homes. A primary benefit of home infusion therapy is that it allows patients with serious conditions—including, cancer, congestive heart failure, and immune diseases—to remain at home, away from the risk of hospital acquired infections.

Beyond the issue of safety, the fact of the matter is that most seniors would *rather* receive their infusion medications in the comfort of their own homes instead of a nursing home or a clinic. Mr. Chairman, it's not hard to understand why a patient would rather sit on his couch attached to a pump rather than drive 30 minutes to an infusion center. Furthermore, treating these patients at home is more cost-effective than other care settings. Given these benefits, it's just commonsense to support home infusion therapy.

Home infusion therapy requires several important components: drugs, infusion equipment and supplies, and the accompanying professional services necessary to prepare and administer the therapy. These professional services can include therapy design, case management, medication preparation, monitoring for adverse events, coordination with the patient's other health care providers, 24/7 patient support, and other important services. Professional services are typically delivered by a multi-disciplinary team that includes a physician, a home infusion pharmacist, a nurse, and often the patient's caregiver.

Prior to 2017, Medicare reimbursed home infusion providers for the durable medical equipment (such as pumps, tubing, and vascular access devices) at a competitively-bid rate, and drug costs were reimbursed at 95 percent of the Average Wholesale Price (AWP). Nursing costs were typically covered under the home health benefit. Additional professional services necessary for the provision of infusion therapy such as pharmacy services were not reimbursable. Since infusion companies were often able to secure the drugs at a price lower than AWP, they were able to use the savings to offset the costs of the professional services. While an imprecise approach, this reimbursement framework allowed Medicare beneficiaries to access some infusion therapies in the safety and comfort of their own homes.

In the *21st Century Cures Act*, Congress reformed payment for home infusion services under Part B by transitioning drug reimbursement from the AWP benchmark to one based on the Average Sales Price (or ASP). At the same time, Congress created a new benefit for the professional services (both pharmacy and nursing professional services) associated with Part B covered infusion drugs. I was proud to work with many Members of this Committee, including my friend

from Michigan, Congressman Fred Upton, to enact this new benefit, which goes into effect in 2021. We worked together again in drafting provisions in the *Bipartisan Budget Act of 2018*, to create a transitional payment to allow home infusion providers to bridge from the AWP reimbursement system to the permanent system in 2021.

Given the significant time and effort that Congress invested in creating the home infusion professional services benefit, I was deeply disappointed when the Centers for Medicare and Medicaid Services (CMS) promulgated its rule last year that inappropriately limited home infusion reimbursement to only a “day on which home infusion therapy services are furnished by skilled professionals in the individual’s home.” This interpretation effectively reduces reimbursement to cover only nursing services—which *are* conducted in a patient’s home—and is insufficient to cover essential professional services performed remotely by a pharmacist, including therapy design, ongoing patient assessment, care coordination, and clinical monitoring.

Members of this Committee sent a letter to CMS last fall asking them to revisit their interpretation of the law and to withdraw the requirement that a nurse or other professional be physically present in the home for reimbursement to occur. We further called on CMS to develop a definition of professional services that is unique to home infusion and that captures the range of services necessary to safely and effectively deliver care. Unfortunately, these pleas fell on deaf ears and CMS moved forward with a reimbursement level that is inadequate, unsustainable and has already started to impair seniors’ access to home infusion services.

I have been working closely with Members of this Committee to find a legislative solution that will allow this new benefit to go into effect as Congress intended. I am pleased to announce that I will be introducing a resolution that would call on CMS to revise its regulation to allow for reimbursement of home infusion professional services each day that an infusion drug physically enters the patient’s body, irrespective of whether a skilled professional is in the individual’s home.

I urge my colleagues to support this resolution and help us bring quality, affordable home infusion services to all Medicare beneficiaries. Thank you again Chairman Pallone and Ranking Member Walden for allowing me to bring this important issue to the Committee’s attention.

1

Energy and Commerce Committee Members Day
Congressman Jimmy Gomez
Remarks on *Jeanette Acosta Invest in Women's Health Act* (H.R.3129)

CHAIRMAN PALLONE, RANKING MEMBER WALDEN, THANK YOU FOR HAVING ME HERE TODAY.

I AM HERE TO URGE THE COMMITTEE TO CONSIDER THE JEANETTE ACOSTA INVEST IN WOMEN'S HEALTH ACT, H.R.3129.

THE LEGISLATION HONORS A CONSTITUENT OF MINE, JEANETTE ACOSTA.

JEANETTE WAS A FIGHTER—A FORMER HILL STAFFER WHO I MET AS A WHITE HOUSE INTERN WORKING ON IMMIGRATION ISSUES, WHO TRAGICALLY LOST HER BATTLE WITH CERVICAL CANCER.

AND HER STORY SHOWS JUST HOW IMPORTANT IT IS THAT ALL WOMEN HAVE ACCESS TO PREVENTIVE, LIFE-SAVING CANCER SCREENINGS AT SAFETY NET HEALTHCARE PROVIDERS, LIKE PLANNED PARENTHOOD.

SAFETY NET PROVIDERS LIKE THESE ARE ON THE FRONT LINES, AND THEY PLAY A CRITICAL ROLE IN THE LIVES OF LOW-INCOME WOMEN AND WOMEN OF COLOR IN PARTICULAR.

THEY WERE A LIFELINE IN MY OWN FAMILY: GROWING UP WITHOUT HEALTH INSURANCE, TWO OF MY SISTERS RELIED ON OUR LOCAL PLANNED PARENTHOOD AS THEIR PRIMARY HEALTH CARE PROVIDER.

EVEN AS SOME MEMBERS OF CONGRESS ARE WORKING TO CUT MEDICAID, GUT THE AFFORDABLE CARE ACT, AND DEFUND PLANNED PARENTHOOD, WE NEED TO REDOUBLE OUR EFFORTS AND PUSH BACK.

ALL WOMEN SHOULD HAVE ACCESS TO PREVENTATIVE CANCER SCREENINGS: THEY CAN SAVE LIVES.

UNFORTUNATELY, TOO MANY BARRIERS, FROM POVERTY TO LANGUAGE ACCESS TO INADEQUATE INSURANCE, STAND IN THE WAY.

THE *JEANETTE ACOSTA INVEST IN WOMEN'S HEALTH ACT* WOULD HELP ENSURE THAT ALL WOMEN, ESPECIALLY LOW-INCOME WOMEN OF COLOR, HAVE ACCESS TO QUALITY, LIFESAVING SERVICES AT SAFETY NET PROVIDERS LIKE PLANNED PARENTHOOD.

OUR LEGISLATION WOULD CREATE NEW GRANT AND PILOT PROGRAMS TO EXPAND ACCESS TO PREVENTIVE SERVICES, BETTER TRAIN HEALTH PRACTITIONERS, AND HELP US BETTER UNDERSTAND AND ADDRESS THE HEALTH CARE NEEDS FOR ALL WOMEN.

2

THESE MEASURES WOULD REPRESENT A MASSIVE INVESTMENT IN WOMEN'S HEALTH, AND THEY ARE ESPECIALLY IMPORTANT FOR LOW-INCOME WOMEN OF COLOR, WHERE TOO MANY DISPARITIES EXIST.

BUT THEY ARE NECESSARY INVESTMENTS FOR THE LONG TERM, AND THEY SAVE LIVES.

IT'S THE RIGHT THING TO DO.

EVEN AS HER FAMILY AND FRIENDS CONTINUE TO MISS HER DEARLY, THIS IS A WAY TO HONOR JEANETTE'S LEGACY.

WE MUST ENSURE THAT ALL WOMEN—NO MATTER THEIR BACKGROUND—HAVE ACCESS TO COMPREHENSIVE, PREVENTIVE CARE.

I URGE THE COMMITTEE TO CALL A HEARING AND TAKE UP THIS LEGISLATION, AND YIELD BACK.

WRITTEN TESTIMONY OF CONGRESSWOMAN GWEN MOORE
ENERGY AND COMMERCE COMMITTEE

July 25 ,2019

Chairman Pallone, Ranking Member Walden, and Members of the Committee, thank you for the opportunity to testify about my legislative priorities for the 116th Congress that falls within the Committee's jurisdiction.

While there are many areas of concern, I want to focus my remarks today on two areas that are absolutely critical to my constituents in Milwaukee: infant and maternal mortality, challenges that affect African -Americans and Indigenous women at far higher rates.

Infant mortality remains a pressing public health concerns both nationally and in my district. According to the Wisconsin Department of Health Services, the infant death rate for African American babies in Wisconsin is the worse infant death rate in the country (15.58 per 1,000 live births compared to an overall national average for all babies of 5.87 per 1,000 live births in 2016). We can and must do better.

What can we do?

The Scarlett Sunshine H.R.2271 - Scarlett's Sunshine on Sudden Unexpected Death Act

I urge this committee to take up and pass the Scarlett's Sunshine on Sudden Unexpected Death Act, bipartisan legislation that I have introduced. I want to thank Rep. Tom Cole, Rep. Jaime Herrera-Beutler, and Rep. Cathy McMorris Rodgers, among others who have crossed the aisle to cosponsor this legislation.

Mr. Chairman I know you are well acquainted with this legislation and the problem it attempts to solve. The bill aims to strengthen efforts to save the lives of the thousands of infants and children who die suddenly and unexpectedly each year in our country causing grief for countless parents. And that grief doesn't just begin when their infant dies, but goes on for a lifetime, wondering: Was it my fault? Could I have done something? Am I a bad parent?

Sudden Unexpected Infant Death (SUID) refers to any sudden and unexpected death that occurs during infancy (from birth to age one) and includes deaths from Sudden Infant Death Syndrome (SIDS) and other ill-defined deaths. About 3,700 infants deaths are classified as SUID each year.

In my home state of Wisconsin, in 2016, 15 percent of infant deaths were classified as SUID's.

The death of a child is always a tragedy, but the unexplained nature of some of these deaths only makes it harder for grieving families, as well as public health officials and policymakers who are working to prevent them.

Sudden Unexplained Death in Children (SUDC) refers to the death of a child 12 months and older, which remains unexplained after a thorough case review is conducted. SUDC is a leading cause of death in young children.

Scarlett Lillian Pauley was one of those children. Scarlett loved her pets. She loved to smile. She loved books. Her favorite book was "Barnyard Dance" by Sandra Boynton, which her mom read to her almost every night including right before she put her to sleep on January 7, 2017. A few hours later, her mama went to check on her and Scarlett was not breathing in her crib. After being taken to the hospital, this beautiful 16-month-old baby was declared dead on January 8, 2017.

That is just one story. But it is a story that happens way too often in our nation. We can and must do something about it.

The Scarlett Sunshine Act would boost efforts to better understand SUID and SUDC, facilitate better data collection and analysis to feed prevention efforts, while also providing funds to support children and grieving families.

- The bill authorizes grants to states and local agencies to improve SUID/SUDC case reporting form completion and autopsies, training grants and materials for death scene investigators, authorizes funds so that states and localities complete comprehensive reviews of all infant and child deaths, funds outreach efforts to educate families on safer-sleep practices for infants and provides low- or reduced-cost products that meet safer sleep recommendations from experts. It also authorizes new grants to support grieving families.

By providing resources to help better examine and understand the factors that contribute to SUID/SUDC, we can help inform and strengthen prevention efforts and better support families that are at risk, especially those with fewer financial resources.

Again, this bill has bipartisan support and is bicameral. The Senate version has been introduced by Senator Bob Casey and Senator Johnny Isakson.

Just a few weeks ago, when I offered an amendment to the FY 2020 Labor-HHS funding bill in the House that would boost CDC funding to carry out some of the activities authorized in the bill to help find answers that will prevent more of these deaths, it passed by an overwhelming margin of 405-19.

Passage of that amendment was a good first step but this Committee now has the ability to help more families in every part of our country get the answers they need.

I urge you to act quickly on H.R. 2271 in the next work period and send it to the floor for consideration.

H.R. 2751—Mama’s First Act

I applaud the Committee’s continued interest in working to save the lives of mothers, including addressing the troubling racial disparities that see African American mothers die as a result of pregnancy related causes at three or four times the rate of other mothers. *In my state of Wisconsin, the rate is even higher with African American mothers dying at over five times the rate of white women.*

You all know the statistics about our nation’s maternal mortality crisis so I won’t repeat them here. In many hospital settings, women of color face systematic barriers and racial biases regarding delays in recognizing symptoms, not acknowledging the patient’s pain, not fully elaborating on treatment options, and pushing for C-sections.

This Committee has been at the forefront of efforts to address this problem and I hope it will continue to be.

My bill, the Mamas First Act (H.R. 2751), that has been referred to this Committee, would help expand access to doulas and midwives who promote patient-centered care like birthing choice and reproductive autonomy. Studies have shown that providing access to doulas and midwives reduces the need for C-sections, decreases maternal anxiety, and improve communication between pregnant women and their health care providers.

The bill would require Medicaid reimbursement for services provided by doulas and midwives. Given that almost half of the 4 million women who give birth in the U.S. annually are on Medicaid, including many who are at the highest risk, this change can significantly impact maternal and infant health outcomes and disparities.

Again, I thank you for your work on this issue and encourage you to include my bill in any maternal mortality package the Committee puts together this Congress.

**Testimony of Representative Donald M. Payne, Jr.
Before the Committee on Energy and Commerce
Members' Day Hearing
Thursday July 25, 2019, 10:00 a.m.
2123 Rayburn House Office Building**

Good Morning and thank you Chairman Pallone, Ranking Member Walden, and Members of the Committee for allowing me this opportunity to speak with you today.

As some of you may know, my father, Congressman Donald Payne, Sr., died of colorectal cancer. Colorectal cancer is the second leading cause of cancer deaths in the United States among men and women combined. Though it *is* a preventable disease, my father did not get screened. Sadly, his case is not unique – one out of every four Americans between the ages of 50 to 75 are not screened for this deadly disease.

I am here today to encourage the Committee on Energy and Commerce to consider HR 1570, the Removing Barriers to Colorectal Cancer Screening Act. This bill, which I introduced along with Reps. Rodney Davis, Donald McEachin, and David McKinley, has 285 bipartisan cosponsors and is an important step in increasing colorectal cancer screening rates in the United States. Ensuring that people can get their recommended screenings for colorectal cancer can help individuals detect cancer earlier when it's more treatable, or even prevent cancer altogether.

Under current law, Medicare covers a screening colonoscopy for beneficiaries without any cost-sharing. However, Medicare requires seniors to pay 20 percent coinsurance if polyps are found and removed during the screening. Removing precancerous polyps during a colonoscopy can prevent cancer, making colonoscopies a unique preventive service, but there is no way to know if you have polyps until after the colonoscopy is completed. This coinsurance requirement can cause seniors to wake up to a surprise bill of as much as \$350, which can act as a serious deterrent to this

lifesaving cancer screening. More importantly, those who have private insurance do not face this same cost barrier.

The Removing Barriers to Colorectal Cancer Screening Act would fix this glitch, waiving patient cost-sharing requirements for colonoscopies and removing a potential barrier for seniors to get screened for colorectal cancer. It is critically important that Medicare-eligible seniors be screened for colorectal cancer because approximately 60 percent of cases and 70 percent of deaths due to colorectal cancer occur in those aged 65 years and older.

I believe the administration has the legal authority to make this policy change, and they are currently considering what policy changes to include in this year's proposed Medicare physician fee schedule rule. Earlier this year, I worked with colleagues on both sides of the aisle to lead a letter sent by 83 members of the House asking the administration to make this policy change. We strongly encourage CMS to take action to waive this cost sharing.

However, if the administration does not make this policy change, I respectfully request the Committee take action on this legislation to ensure that seniors do not have a barrier to colorectal cancer screening.

Mr. Chairman, thank you, and I yield back.

The Honorable Andy Biggs

Energy and Commerce Member Day Testimony

Subcommittee on Communications & Technology

July 25, 2019

2123 Rayburn House Office Building

Chairman Pallone, Ranking Member Walden, Subcommittee Chairman Doyle, and Ranking Member Latta, thank you for the opportunity to testify at today's House Energy and Commerce Committee Member Day.

Today, I want to highlight the importance of opening up the 5.9 gigahertz band to the free market.

And I appreciate Federal Communications Commission (FCC) Chairman Pai's commitment to finding solutions to make this happen.

The FCC's efforts to increase the availability of unlicensed spectrum will bring positive benefits to consumers, innovators, and the economy.

In fact, a recent economic study by RAND Corporation found that the 5.9 gigahertz band's annual potential contribution to the United States' growth domestic product ranges from \$59.8 billion to \$105.8 billion, and opening the band for unlicensed spectrum like, WiFi, could provide gains of \$82.2 billion to \$189.9 billion.

The FCC originally reserved the band specifically for Dedicated Short-Range Communications (DSRC) in hopes that exclusive spectrum access would spur innovation in auto safety technologies; however, the DSRC has proven to be a market failure. In the twenty years since the DSRC allocation, only one car on the road today uses this technology.

Maintaining free and exclusive spectrum access for particular auto technologies is a tremendous subsidy that puts a thumb on the scale for certain companies, while depriving American consumers and businesses of much needed unlicensed spectrum to support Gigabit WiFi, 5G, and hundreds of billions of dollars in economic growth.

I commend the FCC for responding to the shifting auto technology trends by expanding vehicular radar spectrum from 76-77 gigahertz up to 81 gigahertz to promote continued innovation in new and existing commercial and safety vehicle technologies. I hope the FCC will take a similar approach to meet the accelerating demand for unlicensed spectrum such as WiFi by expanding unlicensed spectrum operations into the 5.9 gigahertz band.

It's time to correct a flawed FCC decision from an era long past, and make sure to not repeat the same mistake of betting on particular technologies in an era of constant innovation.



CONGRESSMAN
ERIC SWALWELL
Fifteenth District of California

Committee on Energy and Commerce
 Subcommittee on Health
 Member Day
 July 25, 2019; 10 a.m.

Thank you, Madam Chair.

In 2015, when I was the head of Future Forum, a group of young Democratic Members of the House of Representatives who are focused on issues and opportunities for millennial Americans, I had the honor of meeting Dr. J Craig Venter, a key figure in the Human Genome Project. Dr. Venter has dedicated his life to genomics research and is known for leading the first draft sequence of the human genome. After meeting with several stakeholders passionate about genomics, I gained a greater appreciation of how critical these technologies can be in diagnosing and preventing severe diseases. I decided that legislative action was needed to promote access to genetic and genomic testing.

Genetic testing has the potential to further the emerging field of precision medicine. Today, there are currently 75,000 different genetic tests that represent approximately 10,000 unique test types and cover more than 4,600 disorders. Precision medicine is healthcare based on the individual variability in medical history, genes, environment, and lifestyle for each person. This tailored treatment can cut healthcare costs by facilitating better diagnosis and the consideration of certain preventive measures.

However, many of these tests are not covered by insurance providers and the Centers for Medicare and Medicaid Services (CMS) has not made coverage determinations for many genetic tests. Instead, CMS allows Medical Administrative Contractors (MACs) and state Medicaid agencies to make their own coverage determinations. Many believe genetic testing will help realize a brighter future of healthcare, especially for children and younger Americans, but the realization of this future will be limited without increasing access to testing through insurance coverage.

Since genetic tests are considered an optional benefit through the Medicaid program, state Medicaid agencies can choose whether or not to cover them with requirements varying from

state to state. For example, 35 states cover BRCA testing, which can help determine a patient's risk for developing breast and ovarian cancer, for qualifying individuals based on their personal and family history of cancer. Even if a patient's state Medicaid agency covers such a test, barriers like pre-approval and a lack of access to genetic counseling still prevent many from receiving and understanding their own genetic testing results.

Last Congress, I introduced the *Advancing Access to Precision Medicine Act*, along with 22 members of Congress, both Democrats and Republicans. This bill would address some of the problems I just mentioned by directing the Department of Health and Human Services to enter into an agreement with the National Academy of Medicine to develop recommendations on how the federal government may reduce barriers to the utilization of genetic and genomic testing. The bill would also allow states to apply for an exception to the federal medical assistance percentage rate (FMAP), thereby providing them with more money, to provide whole genome sequencing clinical services for certain children on Medicaid who have an unresolved disease that is suspected to have a genetic cause. The purpose is to provide data regarding whether such services help settle a child's diagnostic odyssey, improve clinical outcomes, and ultimately reduce program expenditures. I believe that these actions will help support the transformation of our health care system to better focus on the uniqueness of each and every patient in the future.

I am currently working on a revised version of this bill to better encourage coverage of genetic testing. I look forward to re-introducing this bill in the coming weeks with my fellow colleagues and working with the Energy and Commerce Committee on it.

Thank you for allowing me to speak to you today and I would be happy to answer any questions you may have.

Rep. Chris Smith (NJ-04)
Addressing the Urgent Need for Federal Action on Cord Blood and Lyme and other Tick-Borne Diseases

I thank the Chairman and ask the Committee to consider two bills that were original ideas of mine 20 years ago – first, the Umbilical Cord Blood and Stem Cell Therapeutic and Research Act (HR 3520), which I introduced in 2001 after 5 long years of hard work, was enacted in 2005 and is up for reauthorization next year. The second bill, the TICK Act (HR 3073), is my 19th bill since 1998 to combat Lyme and other tick-borne diseases.

STEM CELL AND UMBILICAL CORD BLOOD

The umbilical cord blood and Stem Cell Therapeutic and Research Act, which will expire at the end of fiscal year 2020. HR 3520 provides for the continuation of two lifesaving programs, the National Cord Blood Inventory (NCBI) and C.W. Bill Young Cell Transplantation Program (the Program) through 2024.

Umbilical cord blood stem cells, obtained after the birth of a child, have proved highly efficacious in treating 80 diseases, including sickle-cell disease, lymphoma, and leukemia. And scientists are continuing to study and better understand the regenerative effects of cord blood cell therapies for other diseases and conditions. Bone marrow donations provide lifesaving transplants to treat diseases like blood cancer, sickle cell anemia, or inherited metabolic or immune system disorders.

The National Cord Blood Inventory (NCBI) provides funding to public cord blood banks participating in the program to allow them to expand the national inventory of cord blood units available for transplant. These units are then listed on the registry by the “Be the Match” Program. The funds appropriated thus far have led to an important increase in the overall number

of high-quality cord blood units available through the national registry, including 104,000 NCBI units.

The Program registry allows patients and physicians to locate matching cord blood units, as well as adult donors for marrow and peripheral blood stem cells, when a family donor is not available. The Program is the world's largest, most diverse donor registry, with more than 20 million volunteers and more than 295,000 public cord blood units. To date, the National Marrow Donor Program/Be The Match (NMDP), through its operation of the Program, has facilitated more than 92,000 transplants. According to Be the Match, more than 25,000 patients having received cord blood transplants.

The success of bone marrow transplants and cord blood stem cell therapies in treating diseases and alleviating suffering highlights the urgent, compelling case for reauthorizing this program. I urge the committee to quickly taken up and support HR 3520.

THE TICK ACT

The TICK Act – cosponsored by the Chairman of the Agriculture Committee, Collin Peterson, with 39 total cosponsors – would address the ongoing challenges posed by Lyme and tick-borne diseases. The federal Tick-Borne Disease Working Group, established by language within the *21st Century Cures Act (now Public Law 114-255)*, released its inaugural report to Congress late last year. In its comprehensive study, the Working Group was loud and clear.

They stated that:

- “Tick Borne Diseases have rapidly become a serious and growing threat to public health in the United States,” with an estimated 300,000 to 437,000 new cases each year.

- Chronic Lyme—10 to 20 percent of these patients suffer from persistent symptoms which can be chronic and disabling.
- Diagnosis of tick-borne diseases, including Lyme, are often inaccurate and complex to interpret.

The Working Group also stated that:

- “Americans need help, yet progress has been hampered by a lack of attention at the Federal level and by divisions within the field.”

Mr. Chairman, Lyme disease is one of the deadliest tick-borne diseases. We must do more to mitigate and over time eradicate this catastrophic disease. As such, I, along with my colleague and co-chair of the House Lyme Disease Caucus, Collin Peterson, introduced the *TICK Act* (Ticks: Identify, Control, Knockout Act) this Congress. The *TICK Act* is comprehensive, multiyear legislation (H.R. 3073) which creates a new national strategy to aggressively fight Lyme disease and other vector-borne diseases, expand research, and improve testing, treatment affordability and public awareness. The bill also targets \$180 million through CDC grants to state health departments and Regional Centers of Excellence to boost funding for research, prevention, and treatment programs.

These five Centers of Excellence are:

- located at universities in New York, California, Florida, Texas, and Wisconsin.
- specifically: Cornell University, the University of California (Davis and Riverside), the University of Florida, the University of Texas Medical Branch in Galveston, and the University of Wisconsin, Madison.

H.R. 3073 and the companion bill, introduced by Senators Susan Collins and Tina Smith are supported by more than 25 organizations dedicated to combatting Lyme including the

Entomological Society of America, the National Association of Vector-Borne Disease Control Officials, the National Association of County and City Health Officials, the Northeast Regional Center for Excellence in Vector Borne Diseases, and the LivLyme Foundation. Once enacted, the *TICK Act* will enable additional federal agencies to step up their effort in the fight against Lyme.

Through its whole-of-government approach, this legislation will bring greater support to the overwhelming number of patients currently suffering from Lyme disease; the more than 300,000 Americans who will be diagnosed with Lyme just this year alone; and the hundreds of thousands who are unknowingly suffering from Lyme due to misdiagnosis or lack of clear symptoms.

We cannot shortchange our federal responsibility. We owe it to the countless patients suffering from tick-borne diseases and their families. I have included for the record a list of my previous legislation on Lyme disease, and urge support for this bill. We must act now.

Legislation Introduced by Rep. Chris Smith on Lyme Disease:

- 1) [H.R. 3116](#) - an amendment to the *Department of Defense Appropriations Act, 1994*, which appropriated \$1 million to establish a Lyme Disease research program through the Environmental Hygiene Agency of the U.S. Department of the Army. It passed and became law.
- 2) [H.R. 3795](#) – the *Lyme Disease Initiative Act of 1998*, to establish a program to provide for a reduction in the incidence and prevalence of Lyme disease, with the goal of ensuring that patients, advocates, and scientists with diverse viewpoints would be fairly represented in public health policy decisions affecting Lyme. The bill also called for establishing a Lyme Disease Task Force to provide advice to the Secretaries on achieving the goals. The bill authorized \$45 million over five years, from 1999 through 2003.
- 3) [H.R. 2790](#) - the *Lyme Disease Initiative of 1999*, which directed the Secretaries of Health and Human Services, of Agriculture, of the Interior, and of Defense to: (1) establish a specified detection test, improved surveillance and reporting system, and prevention goals to provide for a reduction in the incidence and prevalence of Lyme disease and related tick borne infectious diseases; and (2) establish a five-year plan of activities toward achieving those goals, and carry them out. It also established the Lyme Disease Taskforce to advise the Secretaries with respect to achieving such goals. The bill authorized \$40 million over five years, from 2000 through 2004.
- 4) [H.R. 1254](#) - the *Lyme Disease Initiative of 2001*, which established a program to help reduce the incidence and prevalence of Lyme disease, with the goal of ensuring that patients, advocates, and scientists with diverse viewpoints would be fairly represented in public health policy decisions affecting Lyme. The bill also called for establishing a Lyme Disease Task Force, authorized \$40 million over five years, from 2002 through 2006.
- 5) [H.R. 2877](#) - the *Act for Lyme Education and Research and Tick-Borne Diseases*, which focused on establishing a five-year plan providing for Lyme and studying chronic Lyme. The plan authorized \$500,000 over two years—2006 and 2007.
- 6) [H.R. 3427](#) - the *Lyme and Tick-borne Disease Prevention, Education, and Research Act of 2005*, which authorized \$1 million over five years— from 2006 through 2009. H.R. 3427 also required the Secretary of Health and Human Services (HHS) to establish a Tick-Borne Diseases Advisory Committee.
- 7) [H.R. 741](#) - the *Lyme and Tick-Borne Disease Prevention, Education, and Research Act of 2007*, which authorized \$1 million over five years— from 2008 through 2011. H.R. 741 also required the Secretary of Health and Human Services (HHS) to establish a Tick-Borne Diseases Advisory Committee.

- 8) [H.Res. 337](#) - *Supporting the goals and ideals of a Lyme Disease Awareness Month*. Education and public awareness are key in the fight against disease, particularly for Lyme disease. H.Res.337 sought to build on this principle by increasing awareness for Lyme disease through a nationally-recognized Lyme Disease Awareness Month.
- 9) [H.R. 1179](#) - the *Lyme and Tick-Borne Diseases Prevention, Education, and Research Act of 2009*, which authorized \$1.2 million over five years— from 2010 through 2014. H.R. 1179 also required the Secretary of Health and Human Services (HHS) to establish the Tick-Borne Diseases Advisory Committee.
- 10) [H.R. 2557](#) - introduced in 2011 to establish a Tick-Borne Diseases Advisory Committee and which authorized \$1.2 million over five years— from 2012 through 2016.
- 11) [H.R. 611](#) - the *Lyme and Tick-Borne Diseases Prevention, Education, and Research Act of 2013*, which required the Secretary of Health and Human Services (HHS) to establish the Tick-Borne Diseases Advisory Committee and authorized \$1.2 million over five years— from 2014 through 2018. The Committee would advise the HHS Secretary regarding: (1) interagency coordination on efforts to address tick-borne diseases, (2) opportunities to coordinate efforts with other federal agencies and private organizations addressing such diseases, (3) interagency coordination and communication with constituency groups, (4) ensuring that a broad spectrum of scientific viewpoints is represented in public health policy decisions and that information disseminated to the public and physicians is balanced, and (5) advising relevant federal agencies on priorities related to Lyme and tick-borne diseases.
- 12) [H.R. 610](#) - introduced in 2013 to establish a Tick-Borne Diseases Advisory Committee and which authorized \$1.2 million over five years— from 2013 through 2017.
- 13) [P.L. 114-255](#) - the *21st Century Cures Act (P.L. 114-255)*, to establish an Interagency Lyme and Tick-Borne Disease Working Group in order to further facilitate research, development, and collaboration on Lyme disease. Under the *21st Century Cures Act*— which became law in December 2016—the HHS Secretary established a Tick-Borne Disease Working Group comprised of federal and public members with diverse disciplines and views pertaining to tick-borne diseases.
- 14) [H.R. 2029](#) - secured in the *Consolidated Appropriations Act of 2016*—for the first time ever—**\$5 million in funding for Lyme and other tick-borne diseases research** through the DOD’s Congressionally Directed Medical Research Program (CDMRP).
- 15) [H.R. 665](#) - introduced in 2015 to establish a Tick-Borne Diseases Advisory Committee and which authorized \$1.2 million over five years— from 2015 through 2019.
- 16) [H.R. 1625](#) - secured in the *Consolidated Appropriations Act of 2018* a necessary increase—\$353.6 million— in funding for the National Institutes of Allergy and Infectious Diseases (which funds Lyme disease research and other infectious diseases), bringing total funding for these institutes to \$5.26 billion.

- 17) [H.R. 5900](#) - the *National Lyme and Tick-Borne Diseases Control and Accountability Act of 2018*, to establish the Office of Oversight and Coordination for Tick-Borne Diseases (TBD Office) to oversee the creation and implementation of a national strategy.
- 18) [H.R. 220](#) - the *National Lyme and Tick-Borne Diseases Control and Accountability Act of 2019*, to establish the Office of Oversight and Coordination for Tick-Borne Diseases (TBD Office). This office will oversee the much-needed creation and implementation of a national strategy to help combat the threat of Lyme disease.
- 19) [H.R. 3073](#) - the *TICK Act (Ticks: Identify, Control, Knockout Act)* to create a new national strategy to aggressively fight Lyme disease and target an additional \$180 million to boost funding for research, prevention and treatment programs.



**MEMBER DAY TESTIMONY BEFORE THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE**

July 25, 2019

Chairwoman Eshoo, Ranking Member Burgess, and members of the House Energy and Commerce Subcommittee on Health, thank you for allowing me this opportunity to provide testimony on the health issues affecting constituents in my district. I hope the information I share today will help inform your work as you examine policies to advance access to quality and affordable healthcare for all Americans.

Access to affordable healthcare is a top priority for my constituents. Just last weekend, I hosted an Open House for my constituents in my District Office and nearly every person who attended raised healthcare access and affordability. Whether it is fear that the current administration will undermine protections for pre-existing conditions, concern that healthcare premiums and prescription drug costs will skyrocket, or pleas from patients with deadly diseases and their families for increased investments in medical research, my constituents are looking to us for leadership.

I am sincerely grateful for the actions this Committee has taken to date to help address some of these concerns. I was immensely proud to cosponsor and cast my vote in favor of H.R. 987, the Strengthening Health Care and Lowering Prescription Drug Costs Act, earlier this year to ensure those with pre-existing conditions are not discriminated against, prevent the administration's recent actions undermining the Affordable Care Act, and we must urgently address the rising cost of prescription drugs by ending "pay for delay" practices that prevent affordable generic prescription drugs from being brought to market.

More needs to be done to make healthcare premiums truly affordable, however, particularly for those approaching Medicare age. I support legislation introduced by Rep. Higgins, H.R. 1346, the Medicare Buy-In and Health Care Stabilization Act of 2019, to address age ratings that inflate monthly costs. By giving Americans who are approaching retirement age the option to buy into the health insurance program with the highest satisfaction rate, we can ensure older Americans have access to a wider provider network with lower administrative costs.

In parallel, we must protect patients against unexpected emergency room costs, and I appreciate this Committee's action to date to closely examine this issue. Patients who are treated by an out-of-network provider, through no fault of their own, should be protected by law from paying bills more than what would be expected when in-network. I look forward to continued work on this issue on the House floor when we return from the August work period.

When it comes to prescription drugs, I believe more aggressive action is necessary. I support legislation introduced by Rep. Doggett, H.R. 1046, the Medicare Negotiation and Competitive Licensing Act, to allow the Secretary of Health and Human Services to negotiate directly with Pharmaceutical companies on prescription drug prices, just as we do for prescription drugs under the Veterans Health Administration. With Americans dying because they are rationing lifesaving drugs like insulin due to prices, we must act with deliberate speed.

I want to express my gratitude to the Committee for your action to date to prevent an expiration of the Community Health Center (CHC) fund. There are 14 CHCs in my district and provide many of my constituents with the accessible care they need. I had the immense privilege to tour the St. Jude Neighborhood Health Center in Fullerton earlier this year and saw firsthand the excellent care they provide to underserved populations, from primary care services to dental and mental healthcare. It is absolutely critical that we extend the CHC fund to ensure it does not expire.

While I am grateful this Committee approved H.R. 2328, the Community Health Investment, Modernization, and Excellence (CHIME) Act of 2019, earlier this month, I am concerned that it reduces the reauthorization length from five to four years and that it does not contain annual inflationary adjustments to account for rising costs of healthcare. Your Senate counterpart has approved legislation to provide for a five-year extension which will provide more certainty for CHCs to make long-term plans and explore innovative solutions to support their community. I support Rep. Clyburn's legislation, H.R. 1943, the Community Health Center and Primary Care Workforce Expansion Act of 2019, which would extend the CHC fund and National Health Service Corps (NHSC) for five years with annual growth rates and includes additional funding for health center capital funding.

Finally, I would like to take this opportunity to ask that you take steps to support our brothers and sisters who live with disabilities. I support legislation introduced by Rep. Sensenbrenner, H.R. 555, the Disability Integration Act of 2019, which will help ensure Americans with disabilities have a right to stay in their homes to receive services. Those living with disabilities must be afforded the choice to stay in their communities rather than an institutional setting, and we have a duty to ensure their voice is not lost in Congress.

I thank you again for your efforts to date and for your judicious work to help Americans afford and access healthcare services. I look forward to continuing to work with you on behalf of my constituents in California's 39th Congressional District.

E&C Member Day
Thursday, July 25, 2019
Written Testimony: Rep. Harley Rouda (CA-48)
H.R. 1317 – The Coastal Communities Adaptation Act

First, I would like to thank Chairman Tonko, Ranking Member Shimkus for providing this opportunity to come and testify today to highlight an important piece of legislation within the Committee's jurisdiction.

As you and the members of this committee already know, climate change is not only real – it is already happening.

That's why, earlier this year, I introduced H.R. 1317, The Coastal Communities Adaptation Act. This piece of legislation is important to the district I represent and coastal districts across the country and has earned the support of 32 cosponsors.

For far too many coastal districts like the one I represent, climate change has already increased the frequency of coastal flooding, including what we would consider "regular" tidal floods. The combination of water expansion as the ocean has warmed and the melting of land ice into the oceans has driven sea level up about seven inches since 1990, and this rise is accelerating.

Earlier this summer, the Los Angeles Times reported that, "In the last 100 years, the sea rose less than 9 inches in California. By the end of this century, the surge could be greater than 9 feet."

My bill would jumpstart research and grant funding by the National Science Foundation (NSF) and the National Institute for Standards and Technology (NIST) into improved buildings and structures to account for extreme weather, create a prize competition to stimulate innovation for new techniques into natural shoreline risk reduction measures, direct the Department of Housing and Urban Development (HUD) to promote the adoption of windstorm preparedness and mitigation measures for HUD-code housing units, and order new research by National Oceanic and Atmospheric Administration (NOAA) into the use and effectiveness of nature-based and nonstructural approaches to reduce flood risk.

Higher sea levels mean that deadly and destructive storm surges push farther inland and bring more frequent flooding to coastal communities. With sea levels expected to continue to rise, many vulnerable coastal populations will be further impacted. What was once a niche planning effort to limit seasonal storm damage is now a broad effort to integrate hazard planning and water management into all aspects of local comprehensive plans and related development codes.

We must consider high and extreme sea levels when making decisions that directly impact people and critical resources in coastal California and in the other 29 coastal states (including Great Lake states) across the country.

Coastal communities recognize the necessity of integrating climate change considerations into their planning – resiliency planning is a fundamental part of how communities plan, grow, and prosper. This is not a one-size-fits-all solution to a diverse and multi-faceted challenge. The financing tools provided by my bill will help communities large and small turn their unique resiliency plans into a safer reality.

The shorelines of Louisiana, Virginia, and Texas are shrinking. Beaches in North and South Carolina are disappearing. Places like Florida, Hawaii, and Guam are already drowning. And, California's coast is eroding more and more with each storm surge.

Our coastal lands are treasured natural resources, and they are also something else – they are places that many Americans call home. This is about more than sandy beaches, surf breaks, and boardwalks – this is about our lives, our businesses, and critical infrastructure.

Thank you again, Mr. Chairman, for the opportunity to testify today, and I urge the Committee to consider this legislation because we need to address the reality of climate change if we want to maintain the same quality of life – our planet's oceans will not wait until we're ready – sea levels will continue to rise, whether we are prepared or not.

Testimony of Congressman Doug Collins
Energy and Commerce Member Day Hearing
July 25, 2019

Chairman Pallone and Ranking Member Walden, thank you for holding this hearing today. I appreciate the opportunity to appear before you and discuss the importance of addressing the impacts of direct and indirect (DIR) fees on Medicare Part D patients and pharmacies across the country.

Currently, three pharmacy benefit managers (PBMs)—middlemen between pharmacies and insurers—own over 80% of the pharmaceutical insurance market, allowing them to steer patients to their own pharmacies and operate with little transparency, even in dealings with the federal government. In recent years, these PBMs have begun to purchase or merge with some of the largest health insurers in order to increase their market share and block competition from access to the marketplace.

Under Medicare Part D, PBMs extract price concessions from pharmacies that they should be passing on to patients. They claim that they pass along 90% or more of these savings to the Part D program. But according to the Centers for Medicare and Medicaid Services (CMS), PBMs and PDP sponsors often use these pharmacy rebates and price concessions to pad their profits instead of lowering the price patients pay for medications. In fact, in its proposed rule, “Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses,” CMS notes that the documented increase of retroactive pharmacy fees has translated into higher cost-sharing for beneficiaries, pushing them more quickly into the “donut hole,” or coverage gap of their Part D benefit. CMS chose not to finalize the rule at this time but stated that due to the volume of comments, it will need additional time to review all of the input from stakeholders.

These fees make it increasingly difficult for community pharmacies to care for patients and operate their businesses as the fees are unpredictable and can be clawed back months after the medications are dispensed. CMS stated that under current rules, PBMs may have weak incentives—and in some cases even no incentive—to lower prices at the point of sale or to choose lower net cost alternatives.

On February 7, 2019, I reintroduced the Phair Pricing Act of 2018 (H.R. 1034) with Congressman Vicente Gonzalez (D-TX), Congressman Peter Welch (D-VT), Congressman Buddy Carter (R-GA) and Congressman Morgan Griffith (R-VA) to address the gap between reality and the claims that PBMs and prescription drug plan (PDP) sponsors negotiate with pharmacies on behalf of patients. The Phair Pricing Act will guarantee patients at the pharmacy counter directly benefit from lower costs allegedly negotiated on their behalf by directing all

price concessions between pharmacies and PDP sponsors or PBMs to be included at the point of sale.

The Phair Pricing Act will also bring much-needed transparency to a notoriously complex industry. CMS' proposed rule stated that passing through pharmacy price concessions at the point-of-sale would save beneficiaries \$9.2 billion over 10 years at the pharmacy counter. It would also address how PBMs and PDP sponsors use pharmacy rebates and price concessions to pad their profits instead of lowering the price patients pay for medications, which is the stated purpose of the rebates and price concessions.

Additionally, the current system allows PBMs to create quality metrics that favor pharmacies they own rather than rewarding the highest quality of care. H.R. 1034 seeks to remedy this by directing the Secretary of Health and Human Services to determine the quality measures that apply to pharmacy operations. Under the bill, the Secretary will also be required to consult with members of the pharmacy supply chain and appropriate standard-setting bodies to design measures that improve patient health outcomes..

As the Committee considers legislation to lower drug costs for Americans and improve health care transparency, I encourage you to consider the Phair Pricing Act to decrease the costs of prescription drugs and protect pharmacies from anti-competitive behaviors.

Doug Collins

Thank you Chairman Pallone and Ranking Member Walden for holding this Member hearing,

I would like to take some time to highlight the importance of opening up the 5.9 gigahertz band to the free market.

And I appreciate Chairman Pai's commitment to finding solutions to make this happen.

The FCC's efforts to increase the availability of unlicensed spectrum will bring a positive benefits consumer, innovators, and the economy.

In fact, a recent economic study by RAND Corporation found that the 5.9 gigahertz band's annual potential contribution to U.S. gross domestic product ranges from \$59.8 billion to \$105.8 billion, and opening the band for unlicensed spectrum like WiFi could provide gains of \$82.2 billion to \$189.9 billion.

The FCC originally reserved the band specifically for Dedicated Short-Range Communications (DSRC) in hopes that exclusive spectrum access would spur innovation in auto safety technologies; however, the DSRC has proven to be a market failure. In the twenty years since the DSRC allocation, only one car on the road today uses the technology – a high-end GM Cadillac ITS, with the next not expected until 2023.

Maintaining a free and exclusive spectrum access for particular auto technologies is a tremendous subsidy that puts a thumb on the scale for certain companies while depriving American consumers and businesses of much needed unlicensed spectrum to support Gigabit WiFi, 5G, and hundreds of billions of dollars in economic growth.

I commend the FCC for responding to the shifting auto technology trends by expanding vehicular radar spectrum from 76-77 gigahertz up to 81 gigahertz to promote continued innovation in new and existing commercial and safety vehicle technologies. I hope the FCC will take a similar approach to meet accelerating demand for unlicensed spectrum such as WiFi by expanding unlicensed spectrum operations into the 5.9 gigahertz band.

It's time to correct a flawed FCC decision from an era long past, and make sure to not repeat the same mistake of betting n particular technologies in an era of constant innovation.

ANDY BIGGS
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HOUSE JUDICIARY COMMITTEE

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COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY

Congress of the United States
House of Representatives
Washington, DC 20515-0305

December 20, 2018

The Honorable Ajit Pai
Chairman
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Dear Chairman Pai,

We applaud your leadership and service at the Federal Communications Commission (FCC). We appreciate your commitment to finding solutions that are best for consumers, innovators, and the economy. The Commission's efforts to increase the availability of spectrum – in this instance unlicensed spectrum – so that American innovators and entrepreneurs can continue to provide services to consumers and grow the economy has come to our attention.

In 1999 the FCC made a flawed decision that has resulted in the underutilization of a broad swath of valuable mid-range spectrum for nearly twenty years – adopting a technology-specific allocation of the 5.9 GHz band in favor of “Dedicated Short-Range Communications” (or “DSRC”). The assessment of future market needs by the then-Commission did not produce the expected results for consumers. This left a valuable band of spectrum fallow while other more effective and efficient automotive safety technologies sped past the government's costly bet on DSRC and our economy's reliance on unlicensed spectrum increased. As such, and given the current evolution of automotive safety solutions, we respectfully ask the Commission to accelerate its work by moving forward with the 5.9 GHz proceeding to permit unlicensed operations in the 5.9 GHz band.

The 5.9 GHz band is the best near-term opportunity to fill the accelerating need for unlicensed spectrum and represents an essential step to advance to 5G and the next generation of broadband. It is positioned directly adjacent to the existing unlicensed 5 GHz band and could be brought online quickly to meet the growing spectrum needs of American consumers and businesses. In fact, a recent economic study by RAND Corporation found that the 5.9 GHz band's annual potential contribution to U.S. gross domestic product ranges from \$59.8 billion to \$105.8 billion, and opening the band for unlicensed spectrum like WiFi could provide gains of \$82.2 billion to \$189.9 billion.

The 5.9 GHz band is largely unused today. The Commission originally reserved the band specifically for DSRC in hopes that exclusive spectrum access would spur innovation in auto safety technologies; however, DSRC has proven to be a market failure. In the twenty years since the DSRC allocation, only one car on the road today uses the technology (a high-end GM Cadillac ITS, with the next not expected until 2023).

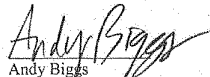
While the restrictions on the 5.9 GHz band have endured, innovation in alternative vehicle safety technologies has flourished outside the 5.9 GHz band, some not using spectrum at all. Automatic braking, blind-spot detection, drowsiness detection, and others, using more sophisticated crash avoidance radars, lasers, cameras and sensors (all of which do not use DSRC or 5.9 GHz spectrum), are almost standard-issue in cars today, demonstrating that the marketplace has moved beyond DSRC, and that technology-specific spectrum policy does not work. In short, the market worked while the government's spectrum carve did not.


Finally, maintaining free and exclusive spectrum access for particular auto technologies is a tremendous subsidy that puts a thumb on the scale for certain companies while depriving American consumers and businesses of much needed unlicensed spectrum to support Gigabit WiFi, 5G, and hundreds of billions of dollars in economic growth. We believe such a subsidy distorts broader communications technology markets that already support automotive safety and commercial products and will again lead to underutilized spectrum and stifled innovation.

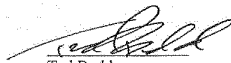
We commend the Commission for responding to the shifting auto technology trends by expanding vehicular radar spectrum from 76-77 GHz up to 81 GHz to promote continued innovation in new and existing commercial and safety vehicle technologies. We hope the Commission will take a similar approach to meet accelerating demand for unlicensed spectrum such as WiFi by expanding unlicensed spectrum operations into the 5.9 GHz band.


We can no longer afford to let 75 MHz of spectrum sit unused. It's time to correct a flawed FCC decision from an era long past, and make sure to not repeat the same mistake of betting on particular technologies in an era of constant innovation. Accordingly, we urge the Commission to move forward with its 5.9 GHz proceeding and enable access to unlicensed technologies.

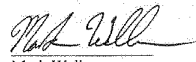
Sincerely,


Andy Biggs
Member of Congress


Brian Babin
Member of Congress


Ted Budd
Member of Congress


Tom Emmer
Member of Congress


Mark Walker
Member of Congress