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EXAMINING THE POLICIES AND PRIORITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, JUNE 13, 2023

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C O N T E N T S

Page

Hearing held on June 13, 2023 1

OPENING STATEMENTS

Foxx, Hon. Virginia, Chairwoman, Committee on Education and the Workforce 1
Prepared statement of 4
Scott, Robert C. "Bobby", Ranking Member, Committee on Education and the Workforce 7
Prepared statement of 9

WITNESSES

Becerra, Xavier, Secretary, U.S. Department of Health and Human Services 12
Prepared statement of 15

ADDITIONAL SUBMISSIONS

Ranking Member Scott:
Letter from Centers for Medicare and Medicaid Services dated May 4, 2023 84
Article from The Tennessean dated October 31, 2022 120
Letter requesting to schedule a child labor hearing dated June 6, 2023 124
Article from Scientific American dated May 12, 2022 127
Brochure from Education and Labor dated September 2022 134
Letter from Kristen Clarke, Assistant Attorney General, Civil Rights Division, U.S. Department of Justice dated March 31, 2022 143
Article from NPR.org dated August 26, 2022 147
Article from American College of Cardiology (ACC) dated October 14, 2022 166
Blog from American Academy of Pediatrics dated August 10, 2022 168
Grothman, Hon. Glenn, a Representative in Congress from the State of Wisconsin:
Field Guidance #10 dated March 22, 2021 from the Administration for Children & Families 28
Field Guidance #11 dated March 31, 2021 from the Administration for Children & Families 32
Manning, Hon. Kathy, a Representative in Congress from the State of North Carolina:
Governor child care sign on letter dated June 13, 2023 89

Page

Miller, Hon. Mary, a Representative in Congress from the State of Illinois:
FDA Warning from the Food and Drug Administration dated July 1, 2022 57
Stefanik, Hon. Elise M., a Representative in Congress from the State of New York:
Article from The New York Times dated April 17, 2023 92
Article from The New York Times dated February 25, 2023 103

QUESTIONS FOR THE RECORD

Response to questions submitted for the record by:
Secretary Xavier Becerra 172

EXAMINING THE POLICIES AND PRIORITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tuesday, June 13, 2023

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND THE WORKFORCE,
Washington, DC.

The committee met, pursuant to notice, at 10:17 a.m., House Rayburn Office Building, Room 2175, Hon. Virginia Foxx, [Chairwoman of the Committee] presiding.

Present: Representatives Foxx, Thompson, Walberg, Grothman, Stefanik, Allen, Banks, Comer, Owens, Good, McClain, Miller, Kiley, Bean, Burlison, Moran, James, Chavez-DeRemer, Williams, Houchin, Scott, Courtney, Sablan, Wilson, Bonamici, Takano, Adams, DeSaulnier, Norcross, Jayapal, Wild, McBath, Hayes, Omar, Stevens, Leger Fernandez, and Manning.

Staff present: Cyrus Artz, Staff Director; Mindy Barry, General Counsel; Jackson Berryman, Speechwriter; Michael Davis, Legislative Assistant; Cate Dillon, Director of Operations; Isabel Foster, Press Assistant; Daniel Fuenzalida, Staff Assistant; Sheila Havenner, Director of Information Technology; Taylor Hittle, Professional Staff Member; Claire Houchin, Intern; Amy Raaf Jones, Director of Education and Human Resources Policy; Alex Knorr, Legislative Assistant; John Martin, Deputy Director of Workforce Policy/Counsel; Hannah Matesic, Director of Member Services and Coalitions; Audra McGeorge, Communications Director; Rebecca Powell, Staff Assistant; Ian Prince, Professional Staff Member; Kent Talbert, Investigative Counsel; Heather Wadyka, Professional Staff Member; Seth Waugh, Director of Workforce Policy; Joe Wheeler, Professional Staff Member; Jeanne Wilson, Retirement Counsel; CJ Mahler, Professional Staff Member; Meghan Heckelman, Intern; Andre Lindsay, Minority Professional Staff; Banyon Vassar, Minority IT Administrator, Bob Shull, Minority Senior Labor Policy Counsel; Brittany Alston, Minority Operations Assistant; Carrie Hughes, Minority Director of Health & Human Services Policy; Daniel Foster, Minority Senior Health and Labor Counsel; Dhrtvan Sherman, Minority Staff Assistant; Ilana Brunner, Minority General Counsel; Jessica Schieder, Minority Economic Policy Advisor; Kota Mizutani, Minority Deputy Communications Director; Nekea Brown, Minority Director of Operations; Raiyana Malone, Minority Press Secretary; Stephanie Lalle, Minority Communications Director; Theresa Tilling-Thompson, Minority

Professional Staff; Veronique Pluviose, Minority Staff Director; and Angela Lopez—Albarran, Minority Intern.

Chairwoman FOXX. The Committee on Education and the Workforce will come to order. I note that a quorum is present. Without objection, the Chair is authorized to call a recess at any time. Welcome, Secretary Becerra. Let me start by reviewing the OMB guidelines which govern your appearance before the Committee today.

When testifying, OMB Circular A 11, Section 22 states, "Witnesses will give frank and complete answers to all questions." Frank and complete. I emphasize this point because Acting Secretary of Labor Su and your fellow cabinet official Secretary of Education Cardona have failed to be either frank or complete in appearances before the Committee so far this Congress.

I watched earlier this year when you were unable to provide frank or complete answers to the Ranking Member of the Senate HELP Committee, Dr. Bill Cassidy, regarding questions about the Department of Health and Human Services, HHS telework policy. I hope you come prepared with more adequate responses today.

Being forthcoming in your testimony and in answering the Committee's questions is not only important to our duty to conduct oversight, but also because the HHS budget is the largest in the executive branch. The President's Fiscal Year 202024 budget request calls for a massive 144.3 billion in discretionary spending, and 1.7 trillion in mandatory spending.

My colleagues know I hate those two words as being distinguished, but that is the way they are dealt with in our system. For context, one in every four dollars taken from taxpayers by the Federal Government is routed through HHS. It was not until the last 10 years or so that the word trillion became a part of everyday budget parlance. It is a worrisome trend.

Budgets calling for more money and reckless spending are crushing everyday Americans. We have seen the inflationary effect of this administration's 5 trillion dollars of deficient spending reflected in four dollars for a dozen eggs and four dollars for a gallon of gas. Each dollar matters when wallets are stretched thin.

The enormous HHS budget requires a critical eye. Our oversight duties can be summed up in three rhetorical questions. One, are you being a good steward of taxpayer money? No, Mr. Secretary, this administration has drastically increased the burden on taxpayers by quietly, but steadily moving enrollees from the small group market to Obamacare exchanges in Medicaid.

The budget calls for the permanent expansion of Obamacare's advanced premium tax credits, which would lead to 1.6 million employees losing employer sponsored coverage, and costing 247.9 billion over a 10 year span. The all-out assault on employer sponsored insurance is costly, but it is also the Trojan horse for Medicare for all.

While most workers like their employer sponsored insurance, these plans are dwindling under the Biden regulatory scheme. Now, employee sponsored coverage represents under half of all plans, and fully socialist healthcare is all but certain as Medicare and Medicaid enrollees reach critical mass.

Second, your regulatory scheme is hurting the taxpayer, but are your policies promoting a healthier America? Again, the answer is no. At the southern border, HHS has endangered countless minors through unaccompanied children programs, then covered it up through whistleblower intimidation.

This means HHS knowingly transferred these children to the possession of others who were not their parents without ensuring that the child was healthy, or that the transfer was necessary. Ultimately, this negligence may have contributed to the deaths of at least two migrant children in the past few months, which the Committee learned about by reporting by Fox News and CNN.

It is troubling that HHS did not think this tragedy warranted a phone call. Last, your policies are not promoting a healthier America, but are you committed to upholding the Constitutional rights of all Americans? Strike three. At least not with the respect to the First Amendment, which protects Americans' free exercise of religion.

From the beginning, Secretary Becerra, your record has shown hostility toward faith-based groups. In fact, the only healthcare experience you had before assuming office was litigating an appellate court case in which you attempted to strong arm Catholic nuns into paying for others' contraceptives.

You have carried the very same disposition toward religious liberty into your role as Secretary. Tooth and nail you fought religious groups by threatening them. St. Francis Health Systems knows you threatened to remove its Medicare accreditation if it did not extinguish the living flame in its chapel.

That is not to say that HHS serves no religion, rather antagonizing faith-based organizations is merely an attempt to smuggle your department's pseudo religion through the back door. Mr. Secretary, HHS serves the civil religion of progressivism and radical gender ideology.

Minors are undergoing irreversible sex change operations in this country, operations that you encouraged with your rhetoric and funding. Radical gender ideology is not a marker of a healthy country. On every axis, anxiety, depression, suicidality, self-harm, you name it, these children are unhealthy and in desperate need of a society-wide fix, not individual genital mutilation. In 1787, Thomas Jefferson wrote, "Without health, there is no happiness, and attention to health then, should take the place of every other object." In the spirit of Jefferson, let us recognize and remedy our national mental health sickness.

It seems to me that it is the worst, where and when radical gender ideology is most pervasive. Maybe, Mr. Secretary, you should start there. With that, the Committee looks forward to your direct, frank, and complete answers, and I yield to the Ranking Member for his opening statement.

[The prepared statement of Chairwoman Foxx follows:]

COMMITTEE ON EDUCATION & THE WORKFORCE

COMMITTEE STATEMENT

Opening Statement of Rep. Virginia Foxx (R-NC), Chairwoman
Committee on Education and the Workforce Hearing:
"Examining the Policies and Priorities of the Department of Health and Human Services"
June 13, 2023

(As prepared for delivery)

Secretary Becerra, let me start by reviewing the OMB guidelines which govern your appearance before the Committee today. When testifying, OMB Circular A-11, Section 22, states, "Witnesses will give frank and complete answers to all questions."

"Frank and complete" – I emphasize this point because Acting Secretary of Labor Su and your fellow cabinet official, Secretary of Education Cardona, have failed to be either "frank" or "complete" in appearances before the Committee so far this Congress.

I watched earlier this year when you were unable to provide frank or complete answers to the Ranking Member of the Senate HELP Committee, Dr. Bill Cassidy, regarding questions about the Department of Health and Human Services' (HHS) telework policy. I hope you have come prepared with more adequate responses today.

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It wasn't until the last ten years or so that the word "trillion" became a part of everyday budget parlance. It's a worrisome trend. Budgets calling for more money

and reckless spending are crushing everyday Americans. We've seen the inflationary effect of this administration's five trillion dollars of deficit spending reflected in $4 for a dozen eggs and $4 for a gallon of gas.

Each dollar matters when wallets are stretched thin, so the enormous HHS budget requires a critical eye. Our oversight duties can be summed up in three rhetorical questions.

One, are you being a good steward of taxpayer money?

No, Mr. Secretary. This administration has drastically increased the burden on taxpayers by quietly but steadily moving enrollees from the small group market to Obamacare exchanges and Medicaid. The budget calls for the permanent expansion of Obamacare's advanced premium tax credits, which would lead to 1.6 million employees losing employer-sponsored coverage and costing $247.9 billion over a ten-year span.

The all-out-assault on employer-sponsored insurance is costly, but it's also the trojan horse for Medicare-for-All. Though most workers like their employer-sponsored insurance, these plans are dwindling under the Biden regulatory scheme. Now, employee-sponsored coverage represents under half of all health plans, and fully socialist health care is all but certain if Medicare and Medicaid enrollees reach critical mass.

Second, your regulatory scheme is hurting the taxpayer, but are your policies promoting a healthier America?

Again, the answer is no. At the southern border, HHS has endangered countless minors through its Unaccompanied Children Program, then covered it up through whistleblower intimidation.

This means HHS knowingly transferred these children to the possession of others who were not their parents without ensuring that the child was healthy or that the transfer was necessary. Ultimately, this negligence may have contributed to the deaths of at least two migrant children in the past few months, which the Committee learned about through reporting by Fox News and CNN. It's troubling that HHS did

not think that this tragedy warranted a phone call.

And lastly, your policies are not promoting a healthier America, but are you committed to upholding the constitutional rights of all Americans?

Strike three. At least not with respect to the First Amendment, which protects Americans' free exercise of religion.

From the beginning, Secretary Becerra, your record has shown hostility towards faith-based groups. In fact, the only health care experience you had before assuming office was litigating an appellate court case in which you attempted to strong-arm Catholic nuns into paying for others' contraceptives.

You have carried the very same disposition toward religious liberty into your role as Secretary. Tooth and nail, you have fought religious groups by threatening them. Saint Francis Health System knows. You threatened to remove its Medicare accreditation if it did not extinguish the living flame in its chapel.

That is not to say that HHS serves no religion. Rather, antagonizing faith-based organizations is merely an attempt to smuggle your department's pseudo-religion through the backdoor.

Mr. Secretary, HHS serves the civil religion of progressivism and radical gender ideology. Minors are undergoing irreversible sex change operations in this country – operations that you encourage with your rhetoric and funding.

Radical gender ideology is not a marker of a healthy country. On every axis—anxiety, depression, suicidality, self-harm, you name it—these children are unhealthy and in desperate need of a society-wide fix, not individual genital mutilation. In 1787, Thomas Jefferson wrote that "Without health there is no happiness. An attention to health, then, should take the place of every other object."

So, in the spirit of Jefferson, let's recognize and remedy our national mental health sickness. It seems to me that it's the worst where and when radical gender ideology is most pervasive. Maybe, Mr. Secretary, we should start there.

With that, the Committee looks forward to your direct, frank, and complete answers, and I yield to the ranking member for his opening statement.

SCOTT. Thank you, Dr. Foxx. Secretary Becerra, good morning. Thank you for being with us today. It is always a pleasure to welcome you back to the Committee. You are familiar with this room. You and I began our congressional careers in this room 30 years ago, and it is a pleasure to see you back.

A pleasure to see you discuss your work as you protect our Nation's well-being. One of the enduring lessons reaffirmed in the COVID–19 pandemic is that when we invest in the health of our communities, we provide people with the tools and resources to care for themselves and their loved ones.

Under your leadership, the Department of Health and Human Services made historic investments to help every worker and family get quality, affordable healthcare. Last Congress, we passed the American Rescue Plan Act, which you had a lot to do with. It enhanced premium tax credits, and lowered monthly costs for Americans, especially by eliminating the subsidy cliff, so more individuals could get affordable coverage.

We also passed the Inflation Reduction Act to extend these tax credit enhancements, cap the cost of insulin for people on Medicare, and for the first time ever, direct the Federal Government to negotiate lower prices for prescriptive drugs covered by Medicare. These decisive actions have yielded results.

Last August, we brought the portion of Americans without health insurance down to the lowest level ever. In the most recent open enrollment period, a record 16.3 million people signed up for marketplace coverage. You also know that protecting our Nation's health goes beyond improving access to health insurance, and that is why last Congress we also secured House passage of legislation to prevent child abuse, addressed domestic violence, and lift people out of poverty.

Unfortunately, while my colleagues on the other side speak frequently about their commitment to our Nation's health and safety, they have not backed up their words with actions. For example, my colleagues may talk about child labor today. However, the reality is that they sought to hold our Nation's full faith and credit hostage, and threaten severe cuts in Federal resources that protect children, and prevent abuses from happening.

The Republican State legislatures all over the country are working to reverse child worker protection laws, and despite our letter requesting a hearing on this persistent and growing problem, the majority has yet to schedule a hearing or advance legislation to address child labor violations.

Instead, we have seen Republican politicians continue to attempt to sabotage quality healthcare coverage, and undermine access to services that our constituents need. The nation is witnessing the harsh restrictions and criminalization of women's access to abortions, jeopardizing the health of women and families across the country.

We are all bearing witness to the baseless villainization of unnecessary care that supports transgender individuals, and you heard some of that just a moment ago. Earlier this year the Federal judge

of the Fifth Circuit who previously tried to eliminate the Affordable Care Act before it was upheld by the Supreme Court, ruled to strip millions of Americans of access to preventive healthcare, and thankfully that ruling has been temporarily suspended.

Just last week, the Committee majority voted to report out two bills that increase healthcare cost for vulnerable Americans by expanding association health plans, and blocking State and Federal consumer protections with stop loss insurance. In contrast, Committee Democrats and congressional Democrats, and this administration will continue working to lower prescriptive drug prices, strengthen the ACA, and approve transparency for healthcare consumers.

Committee Democrats remain focused on how this administration can help build on our progress to ensure equal access to care for our most vulnerable communities, meet the changing healthcare needs of families, and lower the costs of quality healthcare and community support.

The administration's proposed investments underscore your commitment to protect the health and well-being of every American. I thank you, Secretary Becerra, for your work and for joining us today, and I look forward to our discussion. Thank you, Madam Chair, and I yield back.

[The prepared statement of Ranking Member Scott follows:]

Opening Statement of Ranking Member Scott (VA-03)
Full Committee Hearing
Examining the Policies and Priorities of the U.S. Department of Health and Human Services
2175 RHOB
Tuesday, June 13, 2023 | 10:15 a.m.

Secretary Becerra, good morning and thank you for being with us today. It is always a pleasure to welcome you back to the Committee.

You are familiar with this room. You and I began our congressional careers in this room 30 years ago, and it is a pleasure to see you back. It is also a pleasure to see you discuss your work to protect our nation's well-being.

One of the enduring lessons reaffirmed during the COVID-19 pandemic is that, when we invest in the health of our communities, we provide people with the tools and resources to care for themselves and their loves ones.

Under your leadership, the Department of Health and Human Services has made historic investments to help every worker and family get quality, affordable care.

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These decisive actions have yielded results. Last August, we brought the portion of Americans without health insurance down to the *lowest level ever*. During the most recent Open Enrollment Period, a record 16.3 million people signed up for Marketplace coverage.

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a hearing on this persistent and growing problem, the Majority has yet to schedule a hearing or advance legislation to address child labor violations.

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In contrast, Congressional Democrats and this administration will continue working to lower prescription drug prices, strengthen the ACA, and improve transparency for health care consumers.

Committee Democrats remain focused on how this administration can help build on our progress to:

- Ensure equal access to care for our most vulnerable communities,
- Meet the changing health care needs of families, and,
- Lower the cost of quality health care and community support.

The Administration's proposed investments underscore your commitment to protecting the health and well-being of every American.

So, thank you, Secretary Becerra, for all your work and for joining us today. I look forward to our discussion.

Chairwoman FOXX. Thank you, Mr. Scott. Pursuant to Committee Rule 8(c), all members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically in Microsoft Word format by 5 p.m., 14 days after the date of the hearing, which is June 27, 2023.

Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

I now turn to the introduction of our distinguished witness. We have before us today Hon. Xavier Becerra, the Secretary of the U.S. Department of Health and Human Services, and as Mr. Scott mentioned, a former member of this Committee. We thank you for being here today and look forward to your testimony.

I remind the witness that we have read your written statement, and it will appear in full in the hearing record. Pursuant to Committee Rule 8(d) and Committee practices, I ask that you limit your oral presentation to a 5-minute summary of your written statement.

I would also like to remind the witness to be aware of his responsibility to provide accurate information to the Committee. With that Mr. Secretary, I recognize you for 5 minutes.

STATEMENT OF HON. XAVIER BECERRA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary BECERRA. Chairwoman Foxx, Ranking Member Scott, and members, thank you very much for this opportunity to testify. I understand that CDC Director Dr. Rochelle Walensky is also testifying at an oversight hearing this morning. Dr. Walensky helped lead our unprecedented whole of government response during this historic pandemic.

We are living our lives again, and the American people are safer now because of her leadership. Under her direction, we began the critically important work of modernizing our public health infrastructure. She leaves the CDC better positioned to respond to future threats. Working alongside Dr. Walensky as a partner and friend has been an immense honor. As she prepares to leave later

this month, I wish to publicly thank her for restoring, in no small measure, the health of America.

Now, let me offer a few data points as we prepare to discuss the President's 2024 budget and investments. Today, under the President's watch, more Americans have access to a doctor or a hospital through their own insurance than ever before. More than 300 million. 16 million, another all-time high, have it through the Affordable Care Act.

The President's new lower cost prescription drug law is already working. Today insulin costs only $35.00 per month, and preventative vaccines like those for the flu, COVID and shingles are free under Medicare. Soon, we will finally begin to negotiate to lower prescription drug costs. We have effectively implemented the largest adult vaccination program in U.S. history, achieving close to 700 million shots in arms to tackle COVID.

Finally, HHS has successfully launched and expanded 988, the three-digit suicide and mental health crisis lifeline. We have added text and chat capabilities, lines that are dedicated for our veterans. We have added language support options. Millions of Americans have since reached out for life-saving help using 988.

Our aim is to build a healthier America by moving the Nation from an illness care system to a wellness care system. An illness care system leaves our most vulnerable families behind. A wellness care system invests in providing the full spectrum of healthcare to all Americans.

Illness care allows the price of prescription drugs to skyrocket. Wellness care would seek to negotiate for the best price for prescription drugs and treat nutritious foods as medicine. Illness care requires you to get a referral to a specialist from your own family physician in order to secure mental health support.

Wellness care lets you get that support the minute you walk through the door of your family physician's office. Illness care, well it forces hardworking Americans to deplete their life savings in their later years in order to afford the long-term care and support they need.

Wellness care advances long-term care, and invests in in-home care, so older adults and Americans with disabilities can thrive at home in their communities. The President's Fiscal Year 202024 budget builds on our successes and moves us closer to a wellness care model. The budget invests in better preparing America to tackle the next public health crisis and keeps us in a ready position to confront a COVID resurgence.

On mental health and substance abuse, we build support for crisis care services. We invest in growing the behavioral health workforce, and we dedicate resources to combat fentanyl and opioid addiction. The President's budget strengthens Medicare for the next generation. We also take care of our family members in this budget by investing in childcare and preschool programs, and by strengthening Medicaid home and community-based services.

Americans will appreciate that the President drives forward funding for the cancer moonshot, and ARPA-H's investments in cutting edge medical innovation. His budget protects and bolsters Title X family planning programs so essential to so many of our families, and it honors our responsibilities to Indian country.

Through his Fiscal Year 202024 budget, President Biden once again delivers on his promise to the American people to lower healthcare costs for more Americans with better benefits. I am very much looking forward to working with every member of this Committee, and I look forward to your questions today. Thank you.

[The prepared statement of Secretary Becerra follows:]

TESTIMONY OF SECRETARY XAVIER BECERRA BEFORE THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE
June 13, 2023

Chairwoman Foxx, Ranking Member Scott, and Members of the Committee, thank you for the opportunity to discuss the President's Fiscal Year (FY) 2024 budget for the Department of Health and Human Services (HHS). I am pleased to appear before you today, and I look forward to continuing to work with you to serve the American people.

It is my great pleasure to serve as the head of the Department of Health and Human Services – a department full of dedicated civil servants who work tirelessly to meet our mission of enhancing the health and well-being of the American people. We know this goal is also shared by all of you, and we are excited about working with you to fund key initiatives that will enable us to continue to meet that mission.

The FY 2024 budget proposes $144 billion dollars in discretionary funding and $1.7 trillion dollars in mandatory funding to continue the work of the Department and make major investments in several critical areas. Our country faces numerous health care challenges – and HHS is at the center of addressing many of these issues – including the need to transform behavioral healthcare; prepare for future public health threats; support unaccompanied children and refugees; protect the health of all Americans; meet the health needs of Indian Country; expand the health care workforce; expand coverage and access to care, including high-quality early childhood education; improve the health and well-being of children, families, seniors, and people with disabilities; advance science to improve health; end cancer as we know it; and promote effective and efficient management and stewardship.

Transforming Behavioral Healthcare

In response to the current behavioral health crisis, HHS makes substantial investments in services to provide more Americans with access to the care they need when they need it. The 9-8-8 National Suicide Prevention Lifeline operates 24/7 to provide access to trained counselors to people in crisis. In the FY 2024 budget, the Substance Abuse and Mental Health Services Administration (SAMHSA) will dedicate an additional $334 million to the 9-8-8 program to meet an expected volume of 9 million contacts. Investing in the crisis response continuum more broadly is critical to ensuring that the system is responsive at any time and in any place. The budget builds on previous investments to provide $100 million for mobile crisis response to expand partnerships with 9-8-8 local crisis centers, community providers, 9-11 centers, and first responders to promote health-first responses to mental health, suicidal, and substance use crisis events.

One in 4 adults in the United States had a mental illness and 46 million Americans had a substance use disorder in the past year.[1] To address these challenges, the budget continues to

[1] "Facts about Suicide", Centers for Disease Control and Prevention

invest in the nation's mental health infrastructure and to further integrate behavioral health care into health care, social services, and early childhood systems. The FY 2024 budget proposes to increase the Community Mental Health Services Block Grant by $645 million and proposes to increase the Substance Use Prevention, Treatment, and Recovery Services Block Grant by $700 million. The budget converts the Certified Community Behavioral Health Clinics demonstration to a permanent program to further ensure access to comprehensive behavioral health care for all who need it.

Additionally, to help build the behavioral health workforce needed to provide such care and services, the FY 2024 budget expands Medicare coverage of, and payment for, additional behavioral health professional services including those furnished by clinical social workers, peer support workers, and certified addiction counselors.

To develop new approaches to addressing mental health and substance use disorders, the FY 2024 budget includes an additional $200 million for the National Institutes of Health (NIH) to prioritize innovative mental health research and treatment, with the agency allocating a portion of these resources to launch a new precision psychiatric initiative. NIH will also continue to invest over $1.8 billion in research on opioid misuse, addiction, and pain disorders, including the Helping to End Addiction Long-term (HEAL) initiative. HEAL aims to develop innovative treatments for opioid addiction and chronic pain and associated health disparities. The budget also includes proposals to modernize and expand Medicare's mental health benefits and improve behavioral health for the private insurance market, with an emphasis on improving access, promoting equity, and fostering innovation.

Preparing for Future Public Health Threats

On February 11th, HHS renewed the COVID-19 Public Health Emergency (PHE) for what we expect will be the final time. The nation has made tremendous progress: the Administration effectively implemented the largest adult vaccination program in U.S. history, with nearly 270 million Americans receiving at least one shot of the COVID-19 vaccine. Second, we made available to the American public 1.16 billion COVID tests at no cost. And we were able to provide over 23 million therapeutic courses of treatment to Americans. According to the Commonwealth Fund, two years of COVID vaccinations saved over 3 million lives, in addition to preventing more than 18.5 million hospitalizations.

The FY 2024 budget prioritizes preparedness for the next health crisis. The budget includes $20 billion in mandatory funding, available over 5 years, across the Administration for Strategic Preparedness and Response (ASPR), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and NIH to support the President's plan to transform the Nation's capabilities to prepare for, and respond rapidly and effectively to, future pandemics and other biological threats. This includes investments in enhancing early detection and warning systems, advancing, and securing safe and effective supplies and medical countermeasures, and strengthening public health systems and core capabilities. For ASPR, the budget includes $1 billion in discretionary funding for the Biomedical Advanced Research and Development Authority (BARDA) to develop innovative medical countermeasures, $995 million for the Strategic National Stockpile, and $400 million to bolster the medical supply chain and create

medical countermeasures that address key preparedness gaps. The FY 2024 budget includes $10.5 billion in discretionary funding for the CDC to protect health, safety, and security at home and abroad. Additional strategic investments, including at the FDA and NIH, are proposed to bolster our national preparedness posture as we ready ourselves for the next public health threat – no matter its origin. These funding proposals are paired with a suite of legislative proposals that would provide HHS with authorities to enable HHS to respond to future threats nimbly and effectively.

Supporting Unaccompanied Children and Refugees

Children presenting at the border without a parent or guardian, and refugees arriving in our nation, must be cared for in a safe and humanitarian manner. At HHS, we will continue to do our part to protect the safety and wellbeing of unaccompanied children by providing them appropriate child-centered care while they are in our custody; placing them in the custody of parents, relatives, and other appropriate sponsors after thorough vetting; and providing post-release services including safety and wellbeing calls. HHS already provides post-release services to more than 40 percent of children released from our care, nearly double the percentage receiving services when the Biden Administration took office, and is on track to provide services to nearly 60 percent of children by the end of this fiscal year, and all children within the next two years.

The FY 2024 budget provides $5.5 billion for unaccompanied children and $1.7 billion for refugees and other new arrivals eligible for benefits. In addition, to address the inherent uncertainties in budgeting for these populations, the budget includes a discretionary contingency fund, which would provide additional resources if either population exceeded certain levels and is estimated to provide $2.8 billion in FY 2024. The fund expands on the unaccompanied children contingency fund that Congress enacted in FY 2023. These services and resources are critical to our country, and I would like to thank Congress for your continued dedicated support.

Protecting the Health of All Americans

The Administration aims to reduce maternal mortality and morbidity, through proposals such as the "Birthing-Friendly" hospital designation, which drives improvements in maternal health outcomes. The budget includes $1.9 billion for the Health Resources and Services Administration (HRSA) Maternal and Child Health programs, an increase of $205 million, directing $276 million toward reducing maternal mortality and morbidity and $185 million to the Healthy Start program to reduce racial disparities in maternal and infant health outcomes. The budget also provides $30 million for NIH to continue the Implementing a Maternal health and PREgnancy Outcomes Vision for Everyone (IMPROVE) initiative to support research focused on interventions for preventable maternal mortality and morbidity and associated risk factors that contribute to health disparities in maternal care. The budget further includes $3 million for NIH's continued research on the effects of COVID-19 on individuals during pregnancy, lactation, and the postpartum period. The budget also requires states to provide 12 months of postpartum coverage through Medicaid and the Children's Health Insurance Program.

HHS is also committed to protecting and strengthening access to reproductive healthcare. The budget provides $512 million to the Title X family planning program to address the increased need for family planning services for approximately 4.5 million individuals, with 90% having family incomes at or below 250% of the federal poverty level. Title X is the only federal grant program solely dedicated to providing individuals with comprehensive family planning and related preventive health services in communities across the United States.

In 2022, HHS released the Viral Hepatitis National Strategic Plan, which provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030. The Viral Hepatitis Plan focuses on hepatitis A, hepatitis B, and hepatitis C—the three most common hepatitis viruses that have the most impact on the health of the nation. The Viral Hepatitis National Strategic Plan is the first to aim for elimination of viral hepatitis as a public health threat in the United States. Building on this work, the FY 2024 budget includes $11.3 billion for a new HHS-wide proposal to establish a five-year national program to significantly expand screening, testing, treatment, prevention, and monitoring for hepatitis C infections. This program would increase access to tests and curative medicines and expand public health efforts, with a net cost of $5.1 billion over ten years once accounting for health improvements and reduced health care spending. Continuing this work is vital to protecting and improving the lives of Americans who are impacted by this serious disease.

Health Centers provide healthcare services to underserved populations across the country, including low-income patients, ethnic minorities, rural communities, and persons experiencing homelessness. The budget proposes a pathway to doubling the program's funding with a critical three-year down payment on this goal. The FY 2024 budget provides $7.1 billion for Health Centers, which includes $5.2 billion in proposed mandatory resources, an increase of $1.3 billion above FY 2023 enacted. At this funding level, the Health Center Program will provide care for approximately 33.5 million patients.

The FY 2024 budget also makes critical investments to establish Vaccines for Adults program within CDC, as a complement to the successful Vaccines for Children program. The Vaccines for Adults program will begin expanding access to routine and outbreak response vaccines recommended by the Advisory Committee on Immunization Practices for uninsured adults at no cost.

Meeting the Health Needs of Indian Country

HHS is committed to upholding the United States' responsibility to tribal nations by addressing the historic underfunding of the Indian Health Service (IHS). Building on the historic passage of advance appropriations for the IHS in FY 2023, the FY 2024 budget proposes $8.1 billion in discretionary funding for the IHS Services and Facilities accounts, an increase of $2.2 billion above FY 2023 enacted. This funding will expand access to healthcare services for 2.8 million American Indians and Alaska Natives, address key operational capacity needs, and modernize outdated facilities and information technology systems. The budget also includes $1.6 billion in proposed mandatory funding in FY 2024 for Contract Support Costs, payments for Section 105(*l*) tribal leases, and the Special Diabetes Program for Indians.

Beginning in FY 2025, the budget proposes all IHS resources as mandatory. The budget would automatically grow IHS funding each year to account for inflationary factors, population growth, key programmatic needs, and existing backlogs in both healthcare services and infrastructure needs. The mandatory funding approach would ensure that the IHS budget grows sufficiently to both address historic underinvestment and expand capacity for increased service provision. It also includes new funding streams to address key gaps, including the lack of dedicated funding for public health infrastructure in Indian Country. HHS firmly believes that mandatory funding is the most appropriate long-term solution to address chronic underinvestment in IHS. The Department will continue consultation with Tribes and working in partnership with Congress to see this important goal realized. While this work is underway, it is critical that Congress continues to provide discretionary advance appropriations to ensure that the critical advancements achieved through enactment of advance appropriations in the FY 2023 Omnibus are not reversed.

Expanding and Retaining the Health Workforce

The health workforce plays a vital role in responding to public health needs. As the demand for healthcare workers increases, HHS remains committed to strengthening, expanding, and retaining the workforce. The FY 2024 budget provides $2.7 billion for HRSA workforce programs, including $947 million in mandatory resources, to expand workforce capacity across the country. The discretionary budget includes $28 million for a new program to support innovative approaches to address health care workforce shortages and strengthen retention efforts. The budget also provides $25 million for a program to support the adoption of workplace wellness in health care facilities including hospitals, rural health clinics, community health centers, and medical professional associations. The budget includes $106 million within CDC to support public health training and fellowship programs to strengthen the existing workforce as well as support a pipeline of personnel ready and able to address public health threats. In addition to these investments, HHS prioritizes the importance of diversifying the health care workforce to better serve all communities and build a more equitable health care system.

Expanding Coverage and Access to Care

It is ever more crucial to promote the health, safety, and dignity of older adults and people with disabilities, particularly as America's older population increases. The FY 2024 budget makes essential investments to strengthen our nation's long-term care system and invests $150 billion over 10 years to improve Medicaid home and community-based services, to ensure that more people who are aging and those with disabilities can receive care in their home or community and to strengthen the home care workforce. President Biden also issued a call to action to improve the quality of America's nursing homes, and HHS continues to take action to ensure that older adult nursing home residents receive the highest quality care. The FY 2024 budget includes multiple provisions to strengthen nursing home oversight, transparency, and enforcement, including $566 million for surveying and inspections. The provisions protect older adult residents by identifying and penalizing nursing homes that commit fraud, endanger patient safety, and/or prescribe unnecessary drugs.

Since the passage and subsequent expansions of the Affordable Care Act, tens of millions of Americans have gained access to quality health insurance through the marketplace. To build on this success, the FY 2024 budget invests in making private insurance even more affordable. This includes new proposals to build on historic progress made in Congress, including a permanent extension of the enhanced premium tax credits in P.L. 117-169, commonly known as the Inflation Reduction Act. The budget proposes to extend protections from the No Surprises Act to ground ambulances. The FY 2024 budget also provides Medicaid-like coverage to low-income individuals in states that have not expanded Medicaid under the Affordable Care Act, paired with financial incentives to ensure states maintain their existing expansions.

Improving the Well-Being of Children, Families, Seniors, and People with Disabilities

Early childhood programs have a return of up to $9 for every $1 spent due to the positive long-term health, educational, and social impacts on vulnerable children. The budget includes $13 billion for Head Start, an increase of $1.1 billion, to provide comprehensive early learning and development services to roughly 760,156 slots for eligible children and pregnant women. Within this total, $440 million is included for a cost-of-living adjustment for Head Start workers, and $575 million is included to further improve compensation. Collectively, these investments ensure that families have access to high-quality services by retaining and supporting the workforce. In addition, the budget includes a legislative proposal to expand tribal, migrant, and seasonal Head Start eligibility.

The budget likewise invests in child care, critical to both working parents, and particularly to mothers and children. For the discretionary Child Care and Development Block Grant, the budget provides for an investment of $9 billion, an increase of nearly $1 billion over the FY 2023 enacted funding level. In addition, the budget includes a mandatory proposal to invest $400 billion over 10 years in high-quality child care, and $200 billion over 10 years in universal preschool.

The $400 billion in mandatory funding over 10 years for high-quality child care includes funding for states to serve children ages zero to five for families earning up to $200,000. It provides higher federal matching funds for child care providers serving low- and middle-income families and allows those families to pay the lowest co-pays – with a goal of ensuring that the lowest income families pay nothing and that most families pay no more than $10 a day per child, meaning that a median-income family with young children saves about $400 per month while accessing higher-quality care. The Administration's proposal enables states to expand access to affordable, high-quality child care to more than 16 million children. This reflects an expectation that all states will choose to adopt the program but, if some states do not, the Administration is committed to serving low-income children through a federal alternative.

The $200 billion in mandatory funding over 10 years for universal preschool supports free preschool in the setting of a parent's choice – from public schools to child care providers to Head Start – to support healthy child development and ensure that children enter kindergarten ready to succeed. The proposal provides funding through a federal-state partnership to expand high-quality preschool education to all 4-year-old children, with the flexibility for states to expand preschool to 3-year-olds once high-quality preschool is fully available to 4-year-old children.

The proposal also includes funding to provide access to preschool to children in underserved communities in states that do not choose to participate in the new preschool program, so that families in every state have access to high-quality preschool.

To further protect and enhance child well-being, the budget also includes $4.9 billion in mandatory funding over 10 years for prevention services and kinship navigator programs, $1.3 billion in mandatory funding over 10 years to give states an incentive to place children with kin, and $1 billion in mandatory funding over 10 years for support for youth who experienced foster care in transitioning to adulthood.

The COVID-19 pandemic revealed that millions of children, families, seniors, and people with disabilities are living with food insecurity. The increased need for nutrition programs has not abated, and the FY 2024 budget supports the Administration's National Strategy on Hunger, Nutrition, and Health by including $137 million across HHS to reduce hunger, food insecurity, and malnutrition. Within the $137 million, the budget includes $12 million at the Administration for Community Living (ACL) for nutrition services for older adults and people with disabilities and $72 million to expand CDC's State Physical Activity and Nutrition program, which implements evidence-based strategies to reduce chronic disease. In addition, the budget proposes to increase funding at NIH for nutrition research. The budget also expands Medicare coverage for nutrition and obesity counseling, and includes a new pilot project on medically tailored meals.

HHS is committed to ensuring that seniors and people with disabilities have the essential resources and services they need. The FY 2024 budget also makes key investments in the Elder Justice Adult Protective Services program. And, to help more older adults and those with disabilities receive care in their home or community. As noted above, the budget also includes a $150 billion mandatory investment over 10 years in improving and strengthening Medicaid home and community-based services and provisions to improve safety and quality in our nation's nursing homes.

The budget extends the solvency of the Medicare Hospital Insurance Trust Fund by at least 25 years without cutting benefits. The budget builds on efforts in the Inflation Reduction Act to lower prescription drug prices. It also invests $8 billion to enhance Medicare benefits, such as preventing diabetes, expanding access to behavioral health services and community health workers, improving the quality and safety of long-term care services, expanding coverage for nutrition and obesity counseling, eliminating hepatitis C, and advancing equity. Additionally, the budget aligns income and asset determination processes for Medicare low-income assistance programs, easing administrative burdens for states and removing enrollment barriers for individuals.

Advancing Science to Improve Health

As President Biden has said, "cancer does not care if you're a Republican or a Democrat," which is why the President and First Lady reignited the Cancer Moonshot one year ago. HHS is committed to leading the public sector in pursuit of cutting the cancer death rate by 50 percent

over the next 25 years and supporting families, their caregivers and family members, living with and surviving cancer.

NIH will continue to build on the Cancer Moonshot's momentum by supporting projects that will deliver important insights into preventing, detecting, and treating cancer. The FY 2024 budget includes $716 million in discretionary resources for dedicated Cancer Moonshot activities at NIH. In addition to the FY 2024 resources, the budget also proposes to reauthorize the 21st Century Cures Act Cancer Moonshot through 2026 and provide $2.9 billion in mandatory funding in 2025 and 2026, $1.45 billion each year. To support the goals of the Cancer Moonshot, the FY 2024 budget includes an additional $183 million for a total of $839 million to support cancer prevention and control programs across CDC, including screening programs, tobacco prevention, Human Papillomavirus (HPV) prevention and analysis of cancer clusters, and laboratory and environmental health activities. An additional investment of $20 million for HRSA is also provided, to expand partnerships between federally funded health centers and NCI-Designated Cancer Centers to facilitate access to lifesaving cancer screenings and early detection services for medically underserved populations. The budget also includes $108 million within IHS to address specialized cancer care needs in tribal communities. The budget also proposes to create a new Cancer Care Quality Reporting Program for all Medicare providers furnishing cancer care services. This unified program would enable the Centers for Medicare & Medicaid Services (CMS) to assess and compare cancer care delivered through multiple provider types, drive improvements in the quality of cancer care, and standardize data collection to identify and address potential inequities in care.

The FY 2024 budget includes several investments for FDA to support food programs including $20 million for the Emerging Chemicals and Toxicology Issues program to streamline regulatory frameworks for food products that may pose chronic risks to human health. Funds support post-market reassessment of previously approved food chemicals and develop approaches to inform and modernize safety assessments using science and risk-based approaches. An additional investment of $5 million is provided for the 21 Forward food supply chain continuity system, which enables the agency to develop accurate models for situational awareness and forecast the impact of a pandemic, product shortages, or other high-risk threats on the food supply chain. Within medical product safety, the budget dedicates a total of $59 million to continue efforts that strengthen public health supply chains and promote the availability of medical devices by proactively monitoring, assessing, and communicating risks and vulnerability.

The budget will prioritize innovative mental health research and treatment and the NIH climate change initiative. NIH will continue to invest funds to address the opioid crisis, end HIV, and advance other research areas, such as improving health disparities and inequities research, as well as continuing the agency's progress towards a universal influenza vaccine. NIH's budget also continues support for the *All of Us* and Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) initiatives, both started with the 21st Century Cures Act.

The budget also invests in high-impact research advances that drive innovation through the Advanced Research Projects Agency for Health (ARPA-H). As an independent research entity, ARPA-H will be able to accelerate health breakthroughs with the potential to transform important areas of health and medicine. The budget provides $2.5 billion for the agency's

approach to prevent, detect, and treat cancer and other diseases such as diabetes and dementia. ARPA-H will advance high-potential, high-impact biomedical and health research that cannot be readily accomplished through and other existing research or commercial activity.

In keeping with the Agency for Healthcare Research and Quality's (AHRQ) mission to provide evidence-based research, data, and tools to improve healthcare quality, the FY 2024 budget includes $564 million to support AHRQ's research on quality, health costs, and outcomes to make healthcare safer, more accessible, equitable, and affordable for all Americans. Included are additional resources to further Long COVID care, primary care, and diagnostic safety research.

Promoting Effective and Efficient Management and Stewardship

As federal stewards, it is our duty to ensure that taxpayer dollars are spent appropriately through the delivery of high-quality services, through necessary security, and through strong action to prevent fraud and abuse. To protect against information technology threats, the budget provides an increase of $88 million above FY 2023 enacted for cybersecurity initiatives in the Office of the Chief Information Officer (OCIO). Due to the increasing frequency of cyber-attacks that impede the delivery of healthcare and leak private patient health information, the ASPR and OCIO budgets have been increased to understand, mitigate, and identify Healthcare and Public Health (MPH) Sector cybersecurity risks, as well as, to prevent, detect, respond, and recover from HPH cyber-attacks.

The budget makes robust investments in the Health Care Fraud and Abuse Control funding to provide oversight of CMS health programs, strengthen the HHS Office of Inspector General investigations, and protect beneficiaries against healthcare fraud. Our comprehensive program integrity legislative package and allocation adjustment yields $19.7 billion in net savings over 10 years. The Office of Civil Rights would receive significant additional funding to address a sharp rise in its caseload, from 45,000 cases in 2020 to a projected 80,000 in 2024. Finally, the budget includes much-needed investment in core infrastructure, oversight, and operations, including in the Nonrecurring Expenses Fund, General Departmental Management, CMS Program Management, and ACL.

Conclusion

I want to thank the Committee for inviting me to discuss the President's FY 2024 budget for HHS. The budget represents the continued investment in the health, growth, protection, and vitality of the American people. With adequate funding in these critical areas, we can support the forward mobility of our country and continue to make stride towards a brighter future. Thank you for your dedication and partnership in our shared goal to improve the health, safety, and well-being of our nation.

Chairwoman FOXX. Thank you, Mr. Becerra. Under Committee Rule 9, we will now question the witness under the 5-minute rule, and I recognize myself for 5 minutes. Change of plans. I recognize Mr. Walberg for 5 minutes.

Mr. WALBERG. Madam Chairman, thank you for that opportunity. Secretary, welcome back to the Committee room. We had the opportunity to serve together on this Committee and appreciate you coming back. However, before I go on to my main questions, I would be remiss in not at least letting you know my concern as the position you are in, given that position by the President, confirmed to be in the position.

I would have to say that what is going on with our children, regardless of the adults, what is going on with our children right now, I would believe contrary to science, and we have been told for the past several years to the science, follow the science, follow the science on many things.

What is being foisted on our kids these days, relative to things we would not have countenanced just three, four, 5 years ago. Suggestions about their sexuality, and gender, et cetera is gravely concerning to me, and we probably can talk about that some other day.

It is a great concern. A great concern to many parents, and adults who care about kids. Their lives now, and for the future, and so your position has much to do with that in making sure a generation moves to what will be productive, healthy for the future, and living according to science and nature itself.

Mr. Secretary, in April the New York Times published an article detailing the horrifying reality that unaccompanied migrant children were being released from HHS custody to sponsors who are exploiting them. The lack of coordination between the Department of Labor, the Department of Health and Human Services, and Department of Homeland Security described in the New York Times piece is alarming.

It is the responsibility of HHS to ensure that these children are placed with responsible caregivers after they leave HHS, yet it appears as though many of these children were placed with human traffickers, and were forced to work in dangerous jobs. Did the Department of Labor warn HHS that these children were at risk for human labor trafficking at any point in 2021 and 2022?

Secretary BECERRA. Congressman, first on your earlier remarks, I appreciate the way you posed that, and at some point, perhaps we will have opportunity to discuss that type of care that Americans are receiving and need.

On this particular question, let me again thank you for the way you posed the question. First, to point out that we are working closely with the Department of Labor to try to coordinate where we can. We do not have jurisdiction over the kids that are in the hands of sponsors. What we can do is work with Labor if they find that there are some markers, signs that perhaps there are certain employers or companies that are violating child labor laws.

What we do is we try to work with them, but this is not one of those cases where we are able to monitor a child who has been placed with a sponsor.

Mr. WALBERG. Do you think—I understand it is your responsibility to vet sponsors. Do you think they were properly vetted?

These unaccompanied minors who were eventually found to be exploited by human traffickers.

Secretary BECERRA. Congressman, yes. Let me tell you why the answer is affirmative. Virtually all of these—well, the vast majority of these children are placed with either the parent or a close family relative. They all go through background checks. We continue to do the checks that you would expect to make sure that if you are going to place a child in a particular home, that they will be safe.

Mr. WALBERG. How did this happen then? If that is the policy. How did this happen that they ended up being human trafficked?

Secretary BECERRA. Yes. What I would tell you is that what I think the evidence points to is that we have unfortunately unscrupulous employers and companies that are willing to take advantage of some of these kids. Not all of them are migrant kids by the way, there are some U.S. citizen kids. Clearly, migrant children are more vulnerable, and what we see is that they are being taken advantage of by some of these employers.

I hope that we all work together to try to get to the bottom of this.

Mr. WALBERG. Well, I would hope so, because it appears that you had the opportunity to return these children to immediate relative, or an original sponsor, and ultimately the vetting was not done, and they ended up being human trafficked. That was under your watch.

Secretary BECERRA. Congressman, we did the vetting that showed that whether it was a parent, or an older brother or sister, or an aunt or an uncle, if we cannot place them with a close relative like that, then it would be very, very difficult. There are far fewer a number who are assigned to someone who is not an immediate or close relative.

Mr. WALBERG. They ended up being human trafficked. That is my concern, and we are expecting you, your agency, to make sure that that does not happen. This was the New York Times bringing out this issue, so please, please help us on that one.

Secretary BECERRA. We will look forward to working with you.

Mr. WALBERG. I yield back.

Chairwoman FOXX. I want to ask members to not start questions in the last few seconds or to continue speaking. If the witness is speaking, I am tolerant of that. I do not think members should keep speaking, so we can get through the hearing as quickly as possible. Mr. Courtney, you are recognized for 5 minutes.

Mr. COURTNEY. Thank you, Madam Chair. Mr. Secretary, good to see you here again today, and you know, I would just begin by just saying that you know, for all the talk that our friends on the other side, in the majority, about you know, the problem of inflation, which is real, for the American people over the last five and a half months, in the majority they have actually contributed absolutely nothing in terms of real policy that could make a difference.

Just a few minutes ago, the Bureau of Labor Statistics just announced their latest inflation numbers. It shows that inflation dropped to 4 percent. That is the lowest number in 2 years, 11 straight months. Again, we have got more work to do, and one thing that this Congress could do is to follow on the work of the Inflation Reduction Act regarding prescription drugs.

As we all know, starting on January 1, because of the Inflation Reduction Act, the cost of insulin was cut by two thirds for people on Medicare, which was authorized by that law. What is not maybe as well known is that just a week ago you announced more savings with the provision in the law requiring drug manufacturers to pay rebates to Medicare if the price of the product rises faster than inflation in part B and part D.

HHS last week released a list of drugs in the Medicare Part B system for which drug manufacturers increased prices against the law, and that means that those drug companies have to pay rebates, which according to your statement could mean, for patients and seniors, up to $449.00 per dose of savings for 43 drugs.

Now, if we wanted to do something about inflation in this Committee, we could extend the benefits of those price negotiation rebates and insulin reductions to employer-based health plans, which we passed in the House when the Inflation Reduction Act came out of the House. Unfortunately, that was stripped from the Senate.

Could you talk a little bit about the rebate savings, and again about there is a golden opportunity for us to extend those savings to working age Americans through their employer sponsored health plans.

Secretary BECERRA. Congressman, absolutely. Everyone is now familiar with the $35.00 for a month's supply of insulin. Great news. Great news. By the way, I hear more from seniors about the shingles vaccine, that is now free, than about anything else because the shingles vaccine could cost you 200 or 300 hundred dollars. For a lot of seniors on fixed income, that is not doable.

Worry about getting shingles because it is not fun. It is very painful, and so it is great that it is zero cost. What we just announced is that we found that there were 43 drugs that pharmaceutical companies were putting out there where these companies had actually increased the new price more than the rate of inflation, and because of the new law that you all passed, we now have the ability to go back and say you cannot do that.

If you try to increase the price beyond the rate of inflation, we get to pull back the excess, and put it back into Medicare so it provides savings to those Medicare beneficiaries.

Mr. COURTNEY. Again, to the point about our ERISA jurisdiction in this Committee. I mean there is nothing that really justifies not extending that same benefit to people who are not in Medicare. Is that correct?

Secretary BECERRA. That is right. In fact, we saw that companies because the President pressured them said you should be able to do $35.00 insulin not just for those on Medicare, but for every American and today that is what we are seeing.

Mr. COURTNEY. I am glad you mentioned that because you are right. A couple of the large drug manufacturers who produce insulin were almost shamed into again, matching the $35.00 cost for seniors under Medicare. Again, this was a drug that had been off patent for over 100 years, and there was no justification for the overpricing that took place.

Again, I hope again, as the fruits of this law begins to again become more and more apparent to my colleagues, that we will revisit this issue of again extending this benefit, so that again, pri-

vate health plans that provide insurance for people of working age, in employer sponsored settings, will again also benefit from lower costs helping reduce inflation, in a really critical area, which people depend on for life saving medications.

I want to congratulate the Department for their successful and swift, implementation of the Inflation Reduction Act rebate program, and with that, I yield back.

Chairwoman FOXX. Thank you, Mr. Courtney. Mr. Grothman, you are recognized for 5 minutes.

Mr. GROTHMAN. First thing I would like to submit for the record Administration for Children and Families, or Field Guidance Number 10, and Field Guidance Number 11.

Chairwoman FOXX. Without objection.

[The information of Mr. Grothman follows:]

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/programs/orr

FIELD GUIDANCE – March 22, 2021

RE: ORR Field Guidance #10, Expedited Release for Eligible Category 1 Cases

GUIDANCE

The Office of Refugee Resettlement (ORR) prioritizes the placement of unaccompanied children (UC) with parents and legal guardians available to provide custody in the United States. To that end, ORR is instituting a revised policy of Expedited Release for Eligible Category 1 Cases. Under this revised policy, certain children will be released to their parents or legal guardians using specialized procedures that modify standard release requirements under ORR Policy Guide, section 2 and accompanying instruments. Due to the novel nature of this policy, and in recognition of operational flexibilities that may require additional follow up, these instructions may be further modified by ORR.

Expedited Release

As a preliminary step, a child may only be released to their parental or legal guardian sponsor under processes for Expedited Release for Eligible Category 1 Cases if the following three conditions for Expedited Release for Eligible Category 1 Cases are met:

- If the child is screened and determined to not be especially vulnerable;
- If the child is not be otherwise subject to a mandatory TVPRA home study; and
- If there are no other red flags present in the case, including red flags relating to abuse or neglect.

In the event any of these conditions apply, the case will follow standard sponsor assessment and release procedures, including completion of the Initial Medical Exam (IME).

Once the basic conditions listed above are met, care providers can release a Category 1 case provided the following steps are taken (further details on these processes are provided in the "INSTRUCTIONS" section below):

(1) Completion of a Modified *UC Assessment* for Expedited Release Cases

(2) Completion of Interviews with the Child and the Parent

(3) Completion of a Modified *Family Reunification Application*

(4) Establishment of Proof of Relationship and Identity

(5) Completion of Sponsor Background Check (no household member checks) with a valid *Authorization for Release of Information*.

(6) Completion of a Modified *Sponsor Assessment*

After completion of these requirements the Case Manager makes a release recommendation that is transmitted directly to the ORR Federal Field Specialist. No third-party Case Coordinator review of the case is required for Expedited Release for Eligible Category 1 Cases.

Transfer of Custody

After completion of the requirements above, and so long as no concerns relating to abuse or neglect exist, the child may be released directly to the sponsor's care.

In cases where Expedited Release for Eligible Category 1 Cases is appropriate, ORR authorizes care providers to pay for the sponsor's travel to the ORR care provider facility to pick up their child and complete paperwork at the facility (if allowed). ORR also authorizes care providers to pay other transport fees for return travel or allow for the child's transport to the sponsor's location following traditional transfer of physical custody policies under ORR Policy Guide 2.8.2, including ORR paying for such travel (including for escorts). Travel arrangements should be made as soon as it appears that the child's release is viable.

INSTRUCTIONS

The following section provides the care providers with instructions regarding the steps listed above that must be followed any time the Expedited Release for Eligible Category 1 Cases process is used.

In all Expedited Release for Eligible Category 1 Cases, the care provider is responsible for the following:

(1) Completion of a Modified *UC Assessment* for Expedited Release Cases

(a) Care provider staff completes a modified *UC Assessment* for Category 1 cases. If the case is later determined to require completion of a standard release, the care provider will make efforts to update the standard *UC Assessment* for the child.

(b) The Case Manager will upload the modified *UC Assessment* into the ORR database.

(2) Completion of Interviews with the Child and the Parent

The Case Manager interviews the child and parent separately to determine if there are any concerns related to trafficking or abuse. See ORR Policy Guide 2.2.1 and UC MAP 2.2.1.

(3) Completion of a Modified *Family Reunification Application*

(a) ORR plans to create a modified *Family Reunification Application* in the near future. Until a new form is created Case Managers working on the sponsors behalf will fill out the

standard *Family Reunification Application* (FRP-3 or FRP-3S), questions 1-11, and 15. The responses to the application questions are made during the sponsor interview.

(b) The Case Manager will read the contents of the *Sponsor Care Agreement* to the sponsor and ensure the sponsor agrees to those conditions of release.

(c) The Case Manager will read the attestation regarding perjury to the sponsor on page 7 of the *Family Reunification Application*. Additionally, the Case Manager will attest in the Release Request that they had the interview with the sponsor and obtained the sponsor's attestation.

(d) The Case Manager will upload the application into the ORR database.

(e) The Case Manager will then mail the *Family Reunification Packet* documents to the sponsor after the child's release, including the partially completed *Family Reunification Application* completed on the sponsor's behalf. Any discrepancies can be reconciled after the release. See ORR Policy Guide 2.2.3

(f) Importantly, Know Your Rights (KYRs) are not a requirement for release, but if a child has not received a KYR, release information may be shared with a Legal Service Provider (LSP) to facilitate legal services after the child's release.

(4) Establishment of Proof of Relationship and Identity

(a) The care provider will establish proof of the child's identity.

(b) The care provider will establish proof of the sponsor's identity and relationship to the child. This will be accomplished using supporting documentation such as birth certificates for the child and the sponsor, or other documents used to verify the sponsor's identity and prove the parent-child relationship (or legal adoption). Copies or photos of documents are allowed, including those taken on phones and texted or emailed to the care provider.

(c) **ALTERNATE PROCESS:** *DNA Collection and Results*

Alternatively, and where available, sponsors and children can prove biological parentage through DNA. Use of DNA is only used for purposes of establishing biological relationships for purposes of sponsorship and is not submitted to law enforcement personnel or run against law enforcement databases.

Submission of DNA by the parent is voluntary. Competent unaccompanied children aged 14 or over must voluntarily consent to DNA submissions. ORR will presume consent for children under the age of 14 for purposes of DNA submissions to establish relationship. In any event, ORR will provide advanced notice to a child's attorney of record that a DNA test will be conducted.

ORR will ensure that DNA results are destroyed within 15 business days following confirmation of the results by ORR or ORR contractors or grantees. Following confirmation of results, ORR will share results with the potential sponsor and may share results with the child after making a determination that sharing the results is in the child's best interest.

References to results of DNA tests are maintained in the ORR database but are considered confidential information and may only be disclosed as required by law.

DNA may be collected at a care provider site using rapid test results or through the use of an external laboratory.

(5) Completion of Sponsor Background Check using *Authorization for Release of Information*.

(a) The Case Manager will conduct a sponsor background check according to the following requirements:

(i) A parental sponsor undergoes a public records check following standard procedures. Please mail or have the sponsor fill out and submit any authorization forms (*Authorization for Release of Information*) required by the public records check vendor. The care provider may accept a photograph of a signed form for purposes of the public records check. Additionally, for purposes of Expedited Release for Eligible Category 1 Cases, no other background checks are required for other household members (alternate care givers need not be identified).

(ii) If the results of the sponsor's public records check come back with derogatory information that may lead to a denial of release under ORR Policy Guide 2.7.4, the case is no longer eligible for Expedited Release for Eligible Category 1 Cases and instead follows standard procedures. Please note only case review results that may lead to denial under section 2.7.4 are cases that are no longer eligible for release (e.g. DUIs are not an example of criminal history that would lead to a denial of sponsorship to a parent).

(6) Completion of a Modified *Sponsor Assessment*

The Case Manager completes a modified *Sponsor Assessment* and uploads the results to the ORR Database.

Recommendation and Decision Making

In all cases involving Expedited Release for Eligible Category 1 Cases, the Case Manager makes a release recommendation using only the information described in the preceding sections following procedures for straight release, without sending the case for a third party review by a Case Coordinator. The recommendation is then sent directly to the ORR Federal Field Specialist who makes a final release decision.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/programs/orr

FIELD GUIDANCE – March 31, 2021

RE: ORR Field Guidance #11, Temporary Waivers of Background Check Requirements for Category 2 Adult Household Members and Adult Caregivers

GUIDANCE

Effective immediately, background check requirements (as well as requirements for obtaining identification) for adult household members and alternate adult caregivers identified in a sponsor care plan are not required as a condition of release for any Category 2 case, unless:

- the child is especially vulnerable;
- the child is subject to a mandatory TVPRA home study; or
- there are red flags present in the case, including red flags relating to abuse or neglect.

If a child falls under one of the excluded cases listed above, please continue to perform background checks according to ORR Policy Guide, section 2.5.1.

ORR continues to require that sponsors identify adults in the household and an alternate adult caregiver as part of the application and assessment process.

Waivers of background check requirements for this group of cases will be reevaluated within 60 days.

INSTRUCTIONS

(1) Case managers update the *Release Request* to note which Category 2 cases are eligible for the exemption.

(2) Case managers continue to check adult household members or adult caregiver names in the ORR Database that are reported in the *Family Reunification Application* and/or during the sponsor assessment to determine whether those individuals sponsored, or had previously attempted to sponsor, an unaccompanied child.

If you have any questions regarding this waiver, please contact your Federal Field Specialist.

Mr. GROTHMAN. Thank you. Last week I met with a young gal 15 years old who unfortunately, let herself get tied up with what is quickly becoming the medical establishment. She had been on testosterone and puberty blockers, and wound up getting her breasts cutoff at age 15.

Now she just feels horrible about that to a degree she feels she has made fundamental changes in her life, and she is never going to be able to live a normal life. I have also read a book When Harry Became Sally, by a guy of the name Ryan Anderson, which talks about the horrific long-term effects of these type of gender, what I guess you guys would refer to, as gender affirming healthcare.

Mr. Secretary, what are puberty blockers?

Secretary BECERRA. I am sorry, Congressman?

Mr. GROTHMAN. What are puberty blockers?

Secretary BECERRA. Congressman, there are a number of medical treatments and services that are provided to Americans to fulfill their healthcare needs.

Mr. GROTHMAN. Yes. What do they—what effect do they have on brain development? Do we know that?

Secretary BECERRA. Well based on the recommendations of a physician, an individual would be recommended for these types of medicine.

Mr. GROTHMAN. Yes. I know. Have we done, like, studies over a period of 20 or 30 years, so we know the long-term effects of puberty blockers on kids? It seems to me a very significant thing that I would never allow anybody who was asking for my advice ever to take. What is the long-term effect of 20 or 30 years?

Secretary BECERRA. Well, there is scientific and medical evidence regarding the practice of some of these medicines. These are treatments.

Mr. GROTHMAN. Where is that evidence?

Secretary BECERRA. There are a number of medical journals that we could cite you to. There are a number of physicians who have been providing gender affirming care for quite some time. Most every major national medical association supports gender affirming care, and so it is not new. It has been around.

Mr. GROTHMAN. Is it true that on some of this stuff, Scandinavian countries, Dutch countries, at one time recommended this, and they do not recommend it anymore?

Secretary BECERRA. I am sorry. Who did not?

Mr. GROTHMAN. Scandinavian countries and the Dutch.

Secretary BECERRA. Congressman, I could tell you about America. I would be out of my lane if I tried to tell you about Scandinavia.

Mr. GROTHMAN. Does it bother you that European countries at one time used these and now are backing off?

Secretary BECERRA. I think we have some of the best medical professionals in the world. We do some of the best research. I trust the medical judgment of those who are experts in this field.

Mr. GROTHMAN. I guess I would ask you to familiarize yourself with what is going on in other countries and see why they are backing off this sort of treatment. Next, are you familiar with studies that show increased levels of suicide, depression going with peo-

ple who take these puberty blockers, and much less people who have surgeries when they are 15 years old?

Secretary BECERRA. Congressman, we could talk about a lot of the research and the data. I will tell you that what we know at HHS is that many of the transgender youth that are having very difficult, traumatic times find that getting gender affirming care has been helpful in stabilizing their lives.

Mr. GROTHMAN. You stand behind the idea of a 15-year-old girl having her organs removed? You think that is under any circumstance appropriate? 15?

Secretary BECERRA. Congressman, you are asking questions that are issues that are made or judgments that are made by that individual patient with that patient's physician, a medical expert, not a politician.

Mr. GROTHMAN. She is 15. I know she is making the decision, and she was 15. Does that mean anything to you? Do you think this is appropriate for a 15-year-old?

Secretary BECERRA. It means a lot to me that a medical professional is the one guiding that patient's decisions, not a politician, not a bureaucrat.

Mr. GROTHMAN. Okay. I want to switch really quickly to ORR, and the type of people who are becoming sponsors. Do you—frequently these people are becoming sponsors, claim to be relatives of some nature. Do you ever do DNA tests on these people to assure that they are related? If they claim they are related?

Secretary BECERRA. We do a number of background checks. We include fingerprinting.

Mr. GROTHMAN. Do you do DNA tests?

Secretary BECERRA. We do background checks, and we do them——

Mr. GROTHMAN. That means no?

Secretary BECERRA. I could tell you what we do.

Mr. GROTHMAN. That is what I want to know. Do you do DNA tests?

Secretary BECERRA. We do background checks that include fingerprinting. We check——

Mr. GROTHMAN. It is a yes or no question. Okay? I know that at the southern border, the border patrol does DNA tests sometimes when somebody says. I gave you a yes or no question. You have the capability of doing DNA tests. Do you do them or not?

Chairwoman FOXX. Mr. Grothman, I think the witness answered your question.

Mr. GROTHMAN. He did not answer the question.

Chairwoman FOXX. He did. He did not answer it, so he answered it. Ms. Wilson, you are recognized for 5 minutes.

Ms. WILSON. Thank you. Thank you, Chair Foxx, and Ranking Member Scott for today's hearing. Secretary Becerra, my friend, we miss you, but it is great to see you today. Congressional Democrats, with the help of HHS, have been working to expand access to quality and affordable healthcare. Florida led the Nation in Obamacare enrollment for 2023.

More recently, I have successfully fought and gotten resources to build new clinics, and expand access to primary care and dental care for children in my district. I have proposed legislation that

places a registered nurse in every school, and provide additional resources for HIV and AIDS patients in Florida.

These actions all demonstrate Democrats' dedication to accessible healthcare. I look forward to working with you, Mr. Secretary, to working to address health disparities, a woman's right to choose, the nurse shortage, COVID services to our underserved minority communities, and I want to extend an invitation to you to come visit Miami, so that we can work closely together.

I would love to have you, so that is on the record. With that, I have a few questions. I have so many questions that I am going to ask them all, and let you answer.

Secretary BECERRA. Okay.

Ms. WILSON. Okay, so how about that. How are you working to protect 340 B programs to ensure community health centers can continue to serve our communities with the end of the COVID funding? Medicaid redetermination, can you work with our State to improve the process and address the Floridians who lost coverage because of their redetermination?

COVID funding. We have a group in Miami led by Dr. Dwight Reynolds, it is called Centers for Health Promotion. How can HHS help this coalition continue their work to provide COVID–19 vaccinations, treatment, and education to the African American community in South Florida?

Gun violence. Gun violence has been the No. 1 killer of black men and boys between the ages of 15 and 44. In 2006, gun violence became the No. 1 killer of black children, and now gun violence is the No. 1 killer of all children. What is HHS doing to address gun violence and health disparities in black men?

What is HHS doing to address these preventable health issues of black men, heart disease, stroke, and other preventable illnesses? Also, in 1978, there were 1,410 black men in medical school. Now there are 690. Has your agency worked with the American Medical Association and NMA to address this disparity? Thank you. I have some more, but I will run out.

Secretary BECERRA. Congresswoman, let me do the best I can to try to respond to as many of those questions as possible. First, I will respond to your comment, and I publicly can say to you I look forward to being in your district, and meeting with folks who are desperate to make sure that we continue to offer them affordable healthcare quality, and affordable healthcare, so I look forward to the invitation to come visit in your congressional district.

340 B, as you know, it is a critical discount, drug discount program for safety net providers. Without the 340 B program, a lot of those community health centers that offer tremendous services would not be able to make reasonably priced pharmaceutical drugs available to so many people, and so we understand the importance of it.

It is a big tug of war right now. I know you know this. We are going to do everything we can to enhance transparency in the way those middlemen operate. We want to make sure that those who are operating these 340 B programs and determining which health centers are able to get access to the 340 B program, are doing so in a way that complies with current law.

We also want to make sure that any of the savings that are being generated by the drug discount program, are actually going back to the American people. Through lower priced drugs, and so there is a lot of work we need to do there, but as you know many of those who operate in this space use the courts to try to protect themselves from full disclosure and transparency.

We are going to do what we can. The president's budget does propose an increase, 17 million dollars, so about a 5 million dollar increase, to be able to actually strengthen the program's operation.

Redeterminations on Medicaid, I hope we can all work—every member in here can work with us. We just sent out a letter to every Governor in this country saying we need to work on redeterminations.

Chairwoman FOXX. Thank you, Mr. Secretary. Thank you, Mr. Secretary, and thank you, Ms. Wilson. Mr. Allen, you are recognized for 5 minutes.

Mr. ALLEN. Thank you, Madam Chairwoman, and thank you Mr. Secretary, for being here this morning. I have got a lot to get through here. Right now, private health insurance in this country is virtually non-existent, as the government is currently driving all healthcare decisions, as a large part because Democrats have been working for years to move Americans from the small group market to the Obamacare exchanges.

Even though according to Congressional Budget Office estimates, Obamacare plans, per enrollee, are three times more expensive for taxpayers than employer sponsored insurance. In fact, in a reported article in Forbes December 22, 2013, the Obama administration provided special carveouts for labor unions when they realized the increased cost provisions like, you know, like the reinsurance tax.

How is HHS working to help remove barriers of access to employer sponsored markets for Americans?

Secretary BECERRA. Congressman, we work closely with all those stakeholders in the insurance market for healthcare. We try to compliment what is being done by employer health insurance providers. For example, on Medicaid redetermination as some individuals who are currently on Medicaid in your State, may end up losing coverage through Medicaid, we work with the employer sponsored insurance companies.

Mr. ALLEN. Why would you give waivers to employee sponsored plans, so that they could go out into the private markets without the assistance of the government? In other words, have a system where we can actually compare costs in the private sector, versus this government run system?

Secretary BECERRA. Well, Congressman, remember the——

Mr. ALLEN. I mean why would you give those waivers? Yes, or no? I mean.

Secretary BECERRA. The marketplace plans that people receive under Obamacare are private sector plans. They are not government run plans.

Mr. ALLEN. No, sir. That is not correct. The private insurers have to, I mean, they have to abide by the providers have to abide by all of the requirements in Obamacare.

Secretary BECERRA. Well, of course, you want to have minimum standards.

Mr. ALLEN. It is not in private plans. That is wrong. That is wrong.

Secretary BECERRA. If you want to have minimum standards.

Mr. ALLEN. Do you believe Americans from government sponsored plans under Obamacare to the private employer sponsored market would be beneficial? Do you believe we could save money in the Federal Government if we allow these folks to go totally private? The association plans?

Secretary BECERRA. We would love to continue to work with anyone who can come up with a lower cost prescription drug plan, or any kind of plan for healthcare.

Mr. ALLEN. Well, I guarantee you if you will give them the waivers, they will do it. Mr. Secretary, prescription drug middlemen like pharmacy benefit managers are raking in profits while evading congressional scrutiny. An executive for one of the big PBMs recently told investors to not worry about Congress, that it would find ways to maintain its level of profit if those reforms to things like drug rebates went into effect.

Earlier this Congress, I joined my colleagues from Georgia, my colleague from Georgia, Buddy Carter, who is a pharmacist, in introducing the Drug Price Transparency and Medicaid Act to establish oversight and accountability for PBM's taking part in the spread of price practices in Medicaid programs that often leads to low reimbursement rates for pharmacies, and artificially raises healthcare costs.

What other actions can Congress take to increase oversight and accountability on PBMs?

Secretary BECERRA. Congressman, great question, because we know that PBM's should get more scrutiny. We hope that you will engage with your colleagues to change some of the statutory rules because we think we need to get more transparency in that system. I would agree with you.

Mr. ALLEN. Good.

Secretary BECERRA. The PBMs are raking in more money than they should.

Mr. ALLEN. Thank you very much. Mr. Secretary, as you are aware this Nation was founded on religious freedom when it was adopted as the First Amendment to the Constitution, that is why the Center for Medicare/Medicaid Services framework for health equity declares each person CMS serves should receive care that was responsive to their cultural health benefits and practiced traditions, and other communication needs.

In light of that, why does CMS reject an appeal from St. Francis Hospital in Oklahoma, which was threatened with termination from Medicare for having a lit candle behind two layers of glass, in the hospital chapel?

Secretary BECERRA. Congressman, I am not familiar with that case.

Mr. ALLEN. Yes. If you will get back with me on that. How did this threat ensure Medicaid/Medicare beneficiaries are receiving care that is responsive to them?

Secretary BECERRA. Congressman, I could try to get back to you, but I would tell you that we do everything we can to protect religious conscience. We have rights in this country. We want to make sure no one is discriminated against, and so if someone believes that they are being discriminated against because of their religious beliefs, we would want to know that because we would try to protect those rights.

Mr. ALLEN. That is interesting, because CMS finally agreed to a compromise, which incidentally coincided with the story hitting the media. You might better abide by the Constitution before you put out these rules, or deny the reimbursement. Thank you, and I yield back.

Chairwoman FOXX. Thank you, Mr. Allen. Ms. Bonamici, you are recognized for 5 minutes.

Ms. BONAMICI. Thank you. Secretary Becerra, welcome to the Committee, and thank you for your leadership. It has been nearly a year since extremist justices on the Supreme Court overturned 50 years of precedent that protected reproductive healthcare in this country.

Since then, we have seen the devastating, and really wide ranging effects of this decision, especially on the approximately 22 million people of reproductive age, who now live in states where abortion access is restrictive or banned, and it also affects their families as well. Many have made harrowing journeys to another State to receive needed medical care.

I just heard about a young woman who was experiencing an ectopic pregnancy, which as you know, can be life threatening if not treated. She was denied care because of the State law. She had to travel to another State. I am sure this is not the only case like that. I have heard from doctors.

Some doctors have had to watch their patients' health deteriorate significantly before providing care because of life of the mother exceptions, putting those doctors at risk. Stories of people being turned away, the sort of, leave until you are closer to death approach, which is incredibly dangerous and concerning.

Even before the Dobbs decision, maternal death rates in 2020 were 62 percent higher in states that ban or restrict abortion, than in states where abortion is accessible. With the kind of restrictions that many of these Republican-controlled states are imposing, do you expect maternal mortality rates to increase or decrease in this country?

Secretary BECERRA. Congresswoman, the signs are pretty clear that we would expect to see mortality increase as a result of what is now in place under the Dobbs decision.

Ms. BONAMICI. Well, that is serious. That is very concerning, my Republican colleagues like to call themselves pro-life, Mr. Secretary. Does enacting laws that increase maternal mortality rates sound pro-life to you?

Secretary BECERRA. All I can tell you, Congresswoman, is that pregnant women in states with abortion bans are nearly three times more likely to die during the process of bringing a child into their family.

Ms. BONAMICI. Well, we have some work to do, and I thank you for your leadership on this issue. I want to talk about childcare.

Your budget reflects that you understand, and the administration understands fortunately, the importance of childcare for families, children for the economy. As you noted in your testimony, we get a return of up to $9.00 for every dollar we spend on early childhood education.

I fought hard for the nearly 40 billion dollars in childcare stabilization grants that help providers keep their doors open during the pandemic. Providers across the country are now facing a sort of fiscal cliff when the American Rescue Plan's stabilization grants end.

How can we work together to prevent a wave of childcare provider closures in September, and for the budget request we are discussing today is fully funded, which I submit should happen, will that fully close the childcare gap, or where there still be childcare deserts?

Then also, in response to that, will you talk a little bit about the workforce? There is a tremendous need, as you know, to grow the workforce, and I know you have a workforce center designed to attract approximately 100,000 childcare workers lost during the pandemic.

What more can we do to meet these workforce needs and care?

Secretary BECERRA. Congresswoman, the president's budget outlines a great proposal to try to move us forward on childcare. We know that we do not have a large enough workforce. We are never going to get it to be where we need to be, so long as you can go flip burgers at a hamburger shop, and probably make more money than caring for our children in childcare programs. We need to try to expand services.

The president's budget proposal actually works with states to increase and expand access to childcare services. The president has been trying to get through a robust proposal for childcare programs, and Head Start, and we look forward to support there.

Ms. BONAMICI. Absolutely. It is such a good investment in our children. I am going to go back to reproductive healthcare because I have been concerned for years since my time at the State legislature, about so-called crisis pregnancy centers. Many of these centers regularly provide inaccurate, incomplete, and injurious information to people who are seeking guidance, and actually fact based reproductive healthcare.

Recently, I reintroduced my Stop Anti-Abortion Disinformation Act to direct the Federal Trade Commission to prohibit unfair or deceptive advertising of abortion services. What dangers do crisis pregnancy centers pose for patients, and what is the Department doing to help regular the spread of reproductive health misinformation?

Secretary BECERRA. Congresswoman, every American deserves to get accurate, complete information about healthcare because when you make very important healthcare decisions, you need to make sure that you are making the right decision. We are going to do everything we can to make sure that if you are out there providing services, that you give to every American the information that they are entitled to when it comes to the services that they are about to take.

Ms. BONAMICI. Accurate healthcare information.

Secretary BECERRA. Absolutely.

Ms. BONAMICI. Is what is needed. Well, I am proud to be from a State that respects the right of people to make their own reproductive healthcare decisions, and thank you for visiting Oregon, where we talked about the 988 service that is being provided out there, especially for our youth. It was a great visit, and I appreciate that. I yield back my time. Thank you, Madam Chair.

Chairwoman FOXX. Thank you, Ms. Bonamici. Mr. Banks, you are recognized for 5 minutes.

Mr. BANKS. Mr. Secretary, when you were the Attorney General in California your State expanded its ban on 18 to 20-year-olds owning hand-guns, including rifles, and shotguns as well, and I am just curious. What do you think—why do you think that 18 to 20-year-olds cannot be trusted with a firearm?

Secretary BECERRA. Congressman, let me try to take you back a little bit when I was Attorney General in California, by first by saying for us here at HHS, gun violence is a healthcare crisis in this country, and we have to do everything we can. I am proud that my State has tried to undertake measures that would try to keep individuals from using, especially assault weapons, for purposes that never should be deployed in a civilian society, and so.

Mr. BANKS. You supported these policy changes. I am just curious, what was it about 18 to 20-year-old's that you focused on to take away their gun rights to own rifles, or hunting shotguns, and other firearms? What was it about that age 18 to 20-year-old?

Secretary BECERRA. Yes. We could go back to the legislative record. I was not the legislator—a legislator who voted for that legislation, but I was the AG who defended our state's laws.

Mr. BANKS. You did not believe that an 18-year-old should be allowed to own a hunting rifle. Is that—I mean that is what you supported then? Do you still believe that today?

Secretary BECERRA. My job as the Attorney General was to defend the laws that the State of California has enacted.

Mr. BANKS. You do think that an 18-year-old should be allowed to own a hunting rifle?

Secretary BECERRA. Congressman, when you are the Attorney General, you have an obligation to support and defend the laws of your State. I happened to believe in many of those laws that help us not only protect Americans from gun violence, but also keep weapons of destruction out of the hands of Americans when it is not necessary.

Mr. BANKS. Okay. An interesting way to dodge the question. I mean back then, you clearly defended and supported changes in the law to stop 18 to 20-year-olds from being able to own a firearm. I just want to ask this question. Why do you think that children much, much younger than 18 years old, 9, 10, 11-year-old's are mature enough to make a decision to have a sex reassignment surgery because you support those policies too, so can you defend that for the Committee?

Why do you believe that a 9, 10, or 11-year-old should be allowed to change their sex?

Secretary BECERRA. Let me be clear. My position, my views, have not changed with regard to gun violence, and what we should do to try to control that mass killing that is occurring. Whatever my

views were when I was Attorney General on those issues, are still probably the views that I have now.

Again, I am not the Attorney General of California anymore. With regard to the healthcare of any——

Mr. BANKS. Let me just be really clear, then you believed that an 18-year-old should not be allowed to own a hunting rifle. Today you believe that a 9, 10 or 11-year-old should be able to change their sex, and have an irreversible surgery to do that. Just help us explain the logic.

Secretary BECERRA. Yes. Congressman, I would appreciate it if you let me characterize what I believe, and we can have a good conversation, rather than you characterize what I believe. What I would say to you is, with regard to gun violence, I think it is important that we take actions to protect our communities and our neighborhoods. With regard to——

Mr. BANKS. I do not think you want to explain it, because you realize how crazy it is, and that is why you are dodging the question.

Secretary BECERRA. No. That is not the case.

Mr. BANKS. Let me move on.

Secretary BECERRA. No. That is not the case.

Mr. BANKS. This spring, HHS released a 112-page report claiming that gender affirmation, including social transition, changing one's name pronoun, and/or appearance, is appropriate and beneficial for gender minority children and adolescents, according to this report.

The report recommends cutting Federal funds from states with "policies that stigmatize transgender children, including by denying them access to medically necessary healthcare." Mr. Secretary, does this mean that HHS is seriously threatening to withhold hospital grants from states like my own if they refuse to go along with surgeries, or puberty blockers for kids?

Secretary BECERR. Congressman, we are going to protect the rights of any American to get the healthcare they are entitled to, and if someone tries to stop them from that, that is a violation of the law.

Mr. BANKS. You would withhold hospital grants from states like mine that ban transgender sex reassignment surgeries for minors? I mean that is what the report says clearly.

Secretary BECERRA. We will protect the rights of any individual to receive the healthcare that they are entitled to, and we will take action against anyone who tries to discriminate against that person.

Mr. BANKS. That is a yes. I want to ask you the same question that I asked Secretary Cardona the other week. Do you support pulling Federal funds, Federal school lunch benefits, from schools that refuse to comply with your definition of gender identity? Withholding school lunches from kids in schools that will not recognize the definitions that you do?

Secretary BECERRA. Congressman, I would not hold anyone to the standard of having to uphold my definitions. I would hold them to a standard that protects what the rights of Americans are under the law.

Mr. BANKS. It is pretty clear what you believe. The report says so. Madam Chair, I hope and pray 1 day that the history books look back and realize just how crazy the policies of this administration are, and Mr. Secretary, your photo with the President is going to be in those history books, as history will not look back fondly on your policies. I yield back.

Chairwoman FOXX. Thank you. Mr. Takano, you are recognized for 5 minutes.

Mr. TAKANO. Thank you, Madam Chair. Mr. Secretary, my colleagues on the other side of the aisle want to create some sort of moral panic over gender affirming surgeries. I have heard from the transgender community that I do not know if any—that surgeries for minor children are hardly ever, if ever, performed in this country. Is that your understanding of the current State of affairs?

Secretary BECERRA. I am sorry, ask the question again, Congressman?

Mr. TAKANO. My question is gender affirming surgeries for minor children, those below 18 years old, are hardly ever, if ever performed in our country.

Secretary BECERRA. That is right. It is very rare, and it is always done through the consultation with the medical experts.

Mr. TAKANO. It is extremely rare, and so this moral panic being created by this line of questioning, and I think is meant to inflame Americans' sensibilities about transgender people and stigmatize them. That is my sense of it.

I want to turn to your role, Mr. Secretary, as you have responsibility over the Office of Refugee Resettlement and the Administration for Children and Families, correct?

Secretary BECERRA. Correct.

Mr. TAKANO. The responsibility of vetting sponsors to host unaccompanied minors falls within ORR. That is right?

Secretary BECERRA. To have custody, temporary custody, yes.

Mr. TAKANO. Temporary custody?

Secretary BECERRA. Yes.

Mr. TAKANO. When you took office in March 2021, there was a surge of unaccompanied minors presenting themselves in the United States. Is that right?

Secretary BECERRA. That is correct.

Mr. TAKANO. It was a significant surge, above what had been occurring the year prior?

Secretary BECERRA. Yes.

Mr. TAKANO. I imagine your concern was to keep these children safe. Is that correct?

Secretary BECERRA. That is the primary concern.

Mr. TAKANO. The previous administration was criticized, rightfully so, for keeping children locked up in cages, and was it your intention to avoid this scenario repeating itself?

Secretary BECERRA. Absolutely.

Mr. TAKANO. I imagine you were looking to respond to the situation differently than was handled by the administration before. I am looking at a recent audit conducted by your department, which revealed that the Office of ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children, with a vetted sponsor.

Mr. Secretary, do you believe that the current statutory requirements provide you with enough authority to protect our unaccompanied minors effectively?

Secretary BECERRA. Congressman, the authority is sufficient for the work of protecting these children while they are in our custody. The moment we are able to place them with a vetted sponsor we lose custody. What happens after that? Well we have seen some of these reports, New York Times and others, that show in some cases, some of these kids have been exploited by employers and companies.

That is where I think we have to really focus. We do not have that jurisdiction. Not even the Department of Labor has sufficient jurisdiction, but if we want to have a better sight of what is going on with kids after they leave our care, I would urge Congress to consider that.

Mr. TAKANO. Thank you. Thank you. You see a room for whether it is giving you more authority, Labor more authority, or some entity more authority. Would you say that our current Federal—so the current Federal statutory environment, whether in regard to Department of Labor, or your department, or how you relate to State and local agencies that there are definitely holes of authority, and kids are falling—these unaccompanied minors are falling through the gaps in terms of protection.

Secretary BECERRA. Without a doubt. I suspect that the Department of Labor has come and testified how they lack the number of inspectors they need to do the oversight of violators of child labor laws, employers, and companies. Certainly, there is a gap when it comes to how we protect children, make sure they are going to school, versus going to the workplace.

Those are the kinds of authorities that we do not have existing right now.

Mr. TAKANO. You do not have the authority, nor say the funding, or the staffing to do case management after you have placed these children, because you have temporary custody. You have handed the custody over to these vetted sponsors, but as far as monitoring what goes on with those families, monitoring whether or not they are adhering to sending those kids to school, as required by law, you do not have the resources or authority to deal with that, do you?

Secretary BECERRA. You struck the—you hit the nail on the money because what you have pointed out is that unlike foster care in America, where a foster child may go to a home, but the foster care agency still has custody over that child. We do not maintain custody once that child is placed with a vetted sponsor.

Mr. TAKANO. You do not have any—there are no resources going to that host family, like in a foster family.

Secretary BECERRA. That is correct.

Mr. TAKANO. They are given some money to take care of that kid.

Secretary BECERRA. That is correct.

Mr. TAKANO. There is no ability for you to do case management post?

Secretary BECERRA. The link is not there.

Mr. TAKANO. Thank you. I yield back, Mr. Chairman.

Chairwoman FOXX. Thank you, Mr. Takano. Mr. Comer, you are recognized for 5 minutes.

Mr. COMER. Thank you, Madam Chair. Mr. Secretary, thank you for being here today. During your testimony before the Senate Appropriations Committee on the Department's Fiscal Year 2024 budget request, you were asked about the role of pharmacy benefit managers they play in rising drug costs.

I know those questions have been addressed earlier, but this is something that the House Oversight Committee is taking a lead on and investigating. You responded, and I quote, "I think we know that there are some folks who are very clever and creative in how they do this work.

Middlemen have always skimmed money off the top, and it is a matter of how we can try to keep the resources where they are most needed, with consumers, not with the middleman."

Now, we have recently seen this idea stated directly from the Chief Financial Officer of CVS Caremark, AETNA, who was quoted on May 31st at an industry conference when asked about the potential reforms proposed in Congress saying and I quote, "There's other ways in the economic model that we can adjust if one of those things changes," and advises his peers not to worry about Congress.

Now this blatant admission by PBM's of behind the scenes control of cost to patients and pharmacies, allude to the factors in evidence that have led the House Oversight Committee to examine how these middlemen weaponize their access to patient information at the expense of those they were intended to benefit.

Today, every major PBM is owned by a major health insurer, and owns or is owned by specialty, mail order, or retail pharmacy, or all three. Mr. Secretary, PBM's were found to have overcharged State Medicaid programs millions of dollars by claiming they paid competing pharmacies higher reimbursements than they actually did.

Kentucky, my home State for example, was overcharged 123 and a half million dollars. Are you familiar with these instances?

Secretary BECERRA. I am familiar with the general proposition that you are stating, yes.

Mr. COMER. Would you say that PBM's engage in self-serving practices at the expense of patients and taxpayers?

Secretary BECERRA. Clearly, something is going on where consumers are not benefiting the way they should, and many providers are paying more than they should.

Mr. COMER. Do you believe this is evidence of vertical and horizontal manipulation of the pharmaceutical market?

Secretary BECERRA. Mr. Chairman, you are going to where I used to be when I was Attorney General in California, but I will tell you that we need to look closely at these programs, because PBM's should not be able to game the system.

Mr. COMER. I agree. My criticism of the whole PBM saga is that Congress has been looking at it for a long time. It is well past time for Congress to do something.

Secretary BECERRA. I agree.

Mr. COMER. We want, you know, the question I have for you is there anything as Secretary, you would advise Congress to do to

cut out this unnecessary middleman that is costing consumers, and it is costing Medicare and Medicaid a fortune?

Secretary BECERRA. Yes. Congressman, transparency. As they say sunshine is the best disinfectant. We need to go behind the curtains to see what they are doing. No one is saying that we do not need someone who can make sure that from the pharmaceutical company to the consumer, the medicine gets to them.

It is just how it is getting there. Are these middlemen taking advantage? We need to be able to get behind the curtain, so whatever you can do to help us have the transparency.

Mr. COMER. Well, let me ask you this, Mr. Secretary, would you be supportive of reforms or limitations to the pharmacy benefit manager model, including preventing PBM's from owning the pharmacies, insurers, and clinics for which they are expected to negotiate?

Secretary BECERRA. Yes. Very interested in exploring all those ideas with you because we do need to make some progress, and we do need Congress to act.

Mr. COMER. If you keep up with much that the House Oversight Committee, which I am honored to serve with our distinguished Chairwoman, Ms. Foxx, very, very active member on the House Oversight Committee. We do not agree on a lot in that Committee. When I say we, the Republicans and Democrats. There is 100 percent agreement, and 100 percent bipartisan support to act on these PBM's and do more than requiring them to be transparent.

That is a political talking point. That does not do anything. One of the suggestions, and there are bills. I know we mentioned a couple of the bills in Energy and Commerce, but I think there is support on that Oversight Committee, bipartisan support, and I know Representative Porter, Representative Ocasio-Cortez, Raja Krishnamoorthi, there are many Democrats that agree with my school of thought, that we should break these PBMs up.

Because you cannot be vertically integrated. I mean, what the PBM's were created to do, and by all accounts there needs to be someone negotiating these drug prices. What they were created to do and what they are doing is they have gone so far off the reservation. I am a Republican. I am all about making money, but this is ridiculous what they are doing.

This is costing consumers and taxpayers, so if we are going to have a serious conversation about reducing drug costs in America, and we do not mention the PBM, then no one is serious about reducing drug costs. We have to do it with the PBM's, and we have to do more than require transparency.

Secretary BECERRA. Our team is ready to work with you, Mr. Comer.

Chairwoman FOXX. Thank you, Mr. Comer.

Mr. COMER. I yield back.

Chairwoman FOXX. Dr. Adams, you are recognized for 5 minutes.

Ms. ADAMS. Thank you, Madam Chair, and thank you, Secretary Becerra, for coming to the Committee, it is good to see you again, and I appreciate you coming into my district, and all the great things that you are doing. Thank you for your leadership. I have to agree with Mr. Courtney, who talked about the $35.00, and I

agree that certainly you should not have to be old, as I am, or some of the others, to get that benefit.

We have young children who also have diabetes and so forth, but anyway, thank you for doing that.

There have been a series of reports, and I think one was referred to earlier, in terms of a—and I will just say there was a video that was leaked, and as a result, talking about the children, and migrant children and processing them.

I wanted to just give you an opportunity to speak to that, but you have also—HHS announced some initiatives to address some of those problems, and if you could just speak to a couple of those, I would appreciate that.

Secretary BECERRA. Congresswoman, thank you very much, and I look forward to a visit again when it is accommodating for you. Our foremost priority is the health and safety of these children while they are temporarily in our custody. We have then an obligation to find a more appropriate setting for them while they are awaiting their immigration proceedings to conclude.

Rather than stay in a Federal congregate care setting, with a lot of other kids where they are not getting that more individualized care, we seek to find sponsors who will protect them, will take care of them. Typically, that means a parent, or a very close relative for most of these children.

We go through the process of providing them while they are temporarily in our custody, with healthcare, medical checks, mental health services, in some cases educational services. We try to provide everything that a licensed care facility for someone, for example, who is a foster youth might get.

We do it temporarily. Typically, a child will stay with us from 3 weeks to four or 5 weeks. Some stay longer, some stay less. What we try to do is make sure we work efficiently, because some of these kids have come with a lot of trauma. It is all the medical experts, all the child welfare experts will tell you, all the migrant children, advocates will tell you, it is best to try to get that child with someone that child knows and loves and is a close family relative.

That is our goal. It is tough because in 2021 we had a large number of these kids, today it is much more manageable, but we continue to try to make improvements as we go along.

Ms. ADAMS. Thank you. Let me ask you a question about the whistleblowers issue, and that has been in the news a lot, and retaliation against whistleblowers. There was an article in the New York Times that you were aware that staff in the agency were raising concerns about the safety of unaccompanied migrant children who were being placed with unrelated adults.

To the best of your knowledge, did the Department demote, transfer, or terminate staff because they raised concerns about the safety of children in the care of the Office of Refugee Resettlement?

Secretary BECERRA. Absolutely not. ORR did not demote anyone because they raised concerns. In fact, we encourage our ORR staff, Office of Refugee Resettlement staff, to report, and we urge the contractors that we work with to provide care to report. In fact, they are obligated to report any instance of abuse of a child.

Ms. ADAMS. Okay. Let me ask you, I have been very involved with the issue around domestic violence, and I know that you have been concerned about this issue as well. Could you just speak to the importance of reauthorization, and how delaying the reauthorization of when the House passed the Family Violence Prevention and Services Improvement Act, can you speak to how delaying the reauthorization would hinder the efforts to prevent intimate partner violence, and support the victims?

Secretary BECERRA. Congresswoman, first let me just say I hope you and your colleagues have success in getting us to reauthorize the Family Violence Protection and Services Act because it is indispensable. We know for example, that during COVID, when people were in their homes and afraid to come out, that there was a rise of domestic violence.

We know that Americans are being injured, in some cases killed, because we're not there to provide the services. Whether it is the victim who needs the services, or the perpetrator who might need the services. We are hopeful that we could continue to make the investments that let us reach people before the violence occurs, because most of the time, as you know, it is violence between people who know each other very well.

Ms. ADAMS. Right. Proactivity is what we need. Thank you very much, Mr. Secretary. Madam Chair.

Chairwoman FOXX. Thank you, Dr. Adams. Mr. Good, you are recognized for 5 minutes.

Mr. GOOD. Thank you, Madam Chairman. Thank you, Mr. Secretary, for being with us once again. There is a story that just came out today that Open-the-Books.com, as you know, a watchdog group who tracks governments reports, of payment reports I should say, and is reporting that the Federal Government made nearly three trillion improper payments over the last 20 years.

We reached a record level last year, with about 250 billion dollars in bogus payments. It cited HHS as being No. 1. I guess it is great to be first, or No. 1 in something maybe, but HHS was the worst agency of all, and it reported that Medicaid had about 80 billion in improper payments, and Medicare had about 46 billion, so combined together it was right at 127 billion dollars.

Can you just share some thoughts on that?

Secretary BECERRA. I have not seen those reports, but I will tell you that we know that there are people who are always trying to game the system. Medicaid and Medicare, some of the largest programs in the country certainly are ripe for that. That is why our budget calls for more money for program integrity, so we can go after those fraudsters.

We know that for every dollar——

Mr. GOOD. Why would we give more money to manage something when we have got 127 billion dollars in bogus payments last year? Why would the answer be to spend more money?

Secretary BECERRA. Well the Inspector General, our oversight and law enforcement agencies would need to do oversight in order to recoup some of that money from fraudsters.

Mr. GOOD. 127 billion dollars in improper payments, and your solution is to spend more money. Let me ask about the border.

Secretary BECERRA. It is to make sure we do the oversight.

Mr. GOOD. Let me ask about the border sir, I am reclaiming my time. Do you think the United States has operational control of the border?

Secretary BECERRA. Youn are asking me a question that is outside of HHS's jurisdiction.

Mr. GOOD. Do you believe the United States has operational control of the border?

Secretary BECERRA. I think the U.S. Government has done a yeoman's work of trying to make sure that we can protect Americans.

Mr. GOOD. Do you think that the United States has operational control of the border?

Secretary BECERRA. I think the Federal Government is proving that we can manage a border.

Mr. GOOD. What would a loss of operational control of the border look like?

Secretary BECERRA. I am sorry?

Mr. GOOD. What would a loss of operational control at the border look like? How would you define a loss of control if this is control?

Secretary BECERRA. If we are leaning to something relating to the jurisdiction in my department, HHS, I am more than willing to try to answer, otherwise I think you are more appropriately——

Mr. GOOD. Well, HHS is more involved with the border than they ever have been under this administration, so what would a loss of operational control of the border look like if this is control of the border?

Secretary BECERRA. Again Congressman, I could talk to you about my personal views, but if you wish to know what the Federal Government should be doing with regard to the border, I would urge you to continue to ask questions of the Department of Homeland Security.

Mr. GOOD. The ORR, or Office of Refugee Resettlement, has lost contact with more than 85,000 migrant children in the last 2 years.

Secretary BECERRA. That is not true sir. That is not true.

Mr. GOOD. Well, what is accurate?

Secretary BECERRA. We have not lost contact with kids. Once we place those children, we lose jurisdiction over those kids, and so we cannolt lose people we do not have jurisdiction over.

Mr. GOOD. Well, so what percentage of the 85,000 would you say that your department has followed up with in the last 2 years?

Secretary BECERRA. We try to followup with every child that we have placed in the custody of a vetted sponsor. Whether the child or the sponsor choose to reply, or respond to our efforts to reach them, is another matter because Congress did not give us the authority to make them respond to us. We reach out to every child.

We try to contact the child. We try to contact the sponsor. It is no guarantee that we are going to get that child or sponsor to respond to our overtures.

Mr. GOOD. There are reports that migrant children have been found working in slaughter houses, operating machinery, doing other hard labor jobs.

Secretary BECERRA. Yes.

Mr. GOOD. Do you believe your department is adequately screening UACs?

Secretary BECERRA. I do not believe that these children are receiving the oversight protections when an employer, a company, is violating their labor rights, but we do not have jurisdiction to try to enforce against violations of child labor laws. That is not within our jurisdiction. Even the Department of Labor will tell you they do not have enough resources and personnel to go out there and inspect all these work sites the way they should.

Mr. GOOD. In a recent Oversight Committee hearing, the ORR Director admitted that only a third, or 37 percent of UACs ended up with a parent. Do you agree with that assessment?

Secretary BECERRA. I think that number is pretty accurate. About a third of the kids that we place are placed directly with the parent. If those kids are not placed with the parent, the chances are they will be placed with a close relative of that child.

Mr. GOOD. Biden plans to rescind the Trump rule exempting individuals and entities from the contraception mandate on moral convictions. Given that the District Court of the District of Columbia decision in March for Life vs. Burrell, how does your department's proposed rescission not violate the Constitution of religious liberties?

Secretary BECERRA. I am sorry, can you State the question again?

Mr. GOOD. I am out of time. I will yield back, Chairman.

Chairwoman FOXX. The gentleman can submit his question, and we could ask for a response in writing from the Secretary. Ms. McBath, you are recognized for 5 minutes.

Mrs. MCBATH. Thank you.

Secretary BECERRA. Your microphone is not on.

Mrs. MCBATH. Thank you, Secretary Becerra, and Chairwoman Foxx, Ranking Member Scott, and to all the staff that have put together today's hearing. I am a two-time breast cancer survivor, and the daughter of two healthcare professionals, so healthcare is very, very personal to me.

I am so excited to finally see a budget that truly puts working families, and their healthcare needs first. As I said, I am a two-time breast cancer survivor, and I have personally benefited from the protection afforded by the Affordable Care Act.

Because of the ACA, and the work of the congressional Democrats, folks with pre-existing conditions like me will not be denied coverage simply because we are more likely to have to use that coverage for our healthcare needs.

When going through physically draining treatments like surgeries, radiation, and chemotherapy, and they are very, very draining, Americans and their families should be able to focus on getting better, and rebuilding their lives, not on trying to avoid having to declare bankruptcy because of an unpaid medical bill, which is the No. 1 cause of personal bankruptcies that have been filed in this country.

I often hear my Republican colleagues discussing the high cost of healthcare after the passage of the ACA, but they consistently fail to recognize how much higher the financial and health related costs would be for working families without these critical protections and programs.

Sadly, the proposals that have been put forth by my Republican colleagues, will do nothing to lower the prices, or increase access to this care. The percentage of Americans without health insurance is down to the lowest level in our Nation's history.

Medicare can finally negotiate directly with drug companies to ensure that American seniors are not paying more than they need to pay for their prescriptions. The fact of the matter is that the price of insulin would already be limited to $35.00 a month for working families on private insurance, as well as Medicare, if my Republican colleagues had not intentionally gone out of the way to block this from being signed into law.

Because of President Biden, congressional Democrats, and your really important work at HHS, out of pocket insulin costs for people on Medicare are now capped at $35.00 per month, and many private drug companies are following suit, and taking action to lower their costs of insulin, of the drugs that they sell.

We know Congress definitely has to do more. That is not enough. I am very proud to be a co-lead of the Affordable Insulin Now Act, which ensures that no American ever pays more than $35.00 out of their pocket per month for their life-saving insulin drug, and lowering the cost of insulin for Medicare beneficiaries is phenomenal.

It is a phenomenal victory in the fight to make healthcare and prescription drugs far more affordable for working families. As Americans with diabetes below the age of 65 know full well, this simply is not enough. It does not go far enough. The budget put forward by you and the President would ensure that Americans in group, and also individual market plans also have access to these lifesaving drugs at prices that they can afford, and that their families can afford.

Secretary Becerra, can you talk about who the additional folks are that would be helped by this expansion, and why it is so vitally important that we get this done for the American people?

Secretary BECERRA. Congresswoman, everything you said I agree with, and I applaud you for your courage in fighting past the cancer that you have had. We should give everyone that opportunity, the way you have just marshalled through that. And if we were to expand care, we would find that more Americans would stay healthier longer, live better lives, and be able to rest, have peace of mind.

The expansion of healthcare gives everyone the chance to really pursue what they are best at, but if you have to worry whether or not you will have insurance if you try to change jobs, or if you worry if you will be able to get the care you need for cancer, if you change jobs, those are the kinds of things that really panic Americans.

Expanding healthcare so that not just those on Medicare for example, get $35.00 a month insulin, but every American gets that, is crucial because you want to know that you are saving some money. You can do other things, even if it is something as basic as giving your grandchild a birthday gift now that you can afford it.

Mrs. MCBATH. Well, thank you so very much. We really appreciate all the work that you have done and keep up the good work.

Secretary BECERRA. Thank you.

Chairwoman FOXX. Thank you, Ms. McBath. Ms. McClain, you are recognized for 5 minutes.

Mrs. MCCLAIN. Thank you, Madam Chair, and thank you for being here. I know there has been a lot of talk today about the unaccompanied minors and the children and whatnot, so I want to try and clarify it, and just get some simple answers.

You vet the sponsors who you place the unaccompanied minors with, right?

Secretary BECERRA. That is correct.

Mrs. MCCLAIN. Okay. How many total unaccompanied minor children do you think you deal with every year?

Secretary BECERRA. Every year? I believe, and I could try to get you the accurate numbers, but I believe in 2021 it was something over 120,000 children. Yes.

Mrs. MCCLAIN. Okay. Roughly 120 give or take.

Secretary BECERRA. Yes. In 2022, close to that as well.

Mrs. MCCLAIN. I have heard, you know, I know the New York Times obtained data from your office, and your department saying that your agency had failed to reach more than 85,000 unaccompanied minors. Is that inaccurate?

Secretary BECERRA. Completely inaccurate.

Mrs. MCCLAIN. Okay. Do you know who they contacted from your office? This is just a bogus story that the Times put out?

Secretary BECERRA. It is that they use statistics in the wrong way.

Mrs. MCCLAIN. Okay.

Secretary BECERRA. We try to track children, and as I mentioned in a previous exchange, we reach out to these children, to the children, and to the sponsors.

Mrs. MCCLAIN. If they do not respond, they get checked as they have not responded. Okay.

Secretary BECERRA. We make note all the time.

Mrs. MCCLAIN. How many unaccompanied minor children are actually unaccounted for?

Secretary BECERRA. Are what?

Mrs. MCCLAIN. Are unaccounted for?

Secretary BECERRA. We——

Mrs. MCCLAIN. Let me give you an answer, example. We vet and place 120,000.

Secretary BECERRA. Yes, correct.

Mrs. MCCLAIN. Give or take, right? Of those, how many are not accounted for? How many of those people do not respond?

Secretary BECERRA. When you say accounted for, are you saying how many do we try to check on their status?

Mrs. MCCLAIN. I am going to say you try and check all of them.

Secretary BECERRA. Correct.

Mrs. MCCLAIN. Right? Okay.

Secretary BECERRA. Correct.

Mrs. MCCLAIN. Okay. How many of those people do not respond, and we are not able to track?

Secretary BECERRA. The vast majority, I think it is over 80 percent we have been able to reach either the child, or the sponsor, and we make an effort three times for each child.

Mrs. MCCLAIN. Okay. So roughly 20 percent.
Secretary BECERRA. Did not respond.
Mrs. MCCLAIN. We are unaccounted for?
Secretary BECERRA. Not unaccounted for, because they are with their sponsor likely.
Mrs. MCCLAIN. Well how do you know they are with their sponsor if you have not been able to contact the child, or you have not been able to contact the sponsor?
Secretary BECERRA. When we placed them there with the sponsor.
Mrs. MCCLAIN. Okay. I place you today, but if you do not respond right, the sponsor does not respond, or the child does not respond, how do you still know they are with the sponsor?
Secretary BECERRA. Well HHS does not have the jurisdiction to try to follow those children, and so when you say they are unaccounted for, you are implying that we should be able to account for them. Once they are placed——
Mrs. MCCLAIN. You are.
Secretary BECERRA. I am sorry?
Mrs. MCCLAIN. You are. My point is let us just say you placed 120, right?
Secretary BECERRA. Correct.
Mrs. MCCLAIN. There is a whole batch of unaccounted children that we do not know. We do not know if they are being trafficked, right, because we know human trafficking is a problem. We do not know if they are in child labor, right? In my State of Michigan, we had this issue with child labor. We do not know what is happening to these children.
We are making some pretty broad assumptions, that is all I am saying. Are you disputing that fact?
Secretary BECERRA. No. I am not. Can I clarify?
Mrs. MCCLAIN. Sure.
Secretary BECERRA. This is not like a foster care program where the agency——
Mrs. MCCLAIN. No. It is worse.
Secretary BECERRA. In many respects you are right because there is no connection.
Mrs. MCCLAIN. Right.
Secretary BECERRA. Saying their unaccounted implies that there is a way to account for them, and Congress never gave us the——
Mrs. MCCLAIN. Well there is a way.
Secretary BECERRA. How?
Mrs. MCCLAIN. There is a way. You just told me that you are accountable for——
Secretary BECERRA. No. I cannot account for them because I do not have jurisdiction. I do not have jurisdiction.
Mrs. MCCLAIN. Let me just go back then. Then why are you tracking them anyway if you don't have any jurisdiction, you should not be following them anyway, is that what you're telling me?
Secretary BECERRA. Congresswoman, because we——
Mrs. MCCLAIN. Is that what you are telling me?
Secretary BECERRA. We believe it is important.
Mrs. MCCLAIN. You do have jurisdiction?

Secretary BECERRA. No.

Mrs. MCCLAIN. Then why are you doing it?

Secretary BECERRA. We believe it is in the best interests of the child.

Mrs. MCCLAIN. I believe it is in the best interest of the child, so would you agree with me that there is 20 percent of the people, children that are just twisting in the wind that we are making a bunch of assumptions on?

Secretary BECERRA. Absolutely not.

Mrs. MCCLAIN. I think it is very convenient that you say oh, we care so much about the kids, the ones we account for, the ones that we cannot account for, eh that is really not my, you know, that is not my jurisdiction.

Secretary BECERRA. No. Congresswoman, remember we try to reach every child.

Mrs. MCCLAIN. Let us just use the same context and go. Are you accountable or not accountable?

Secretary BECERRA. Do you—if you give us the authority.

Mrs. MCCLAIN. I am asking you the questions. Are you accountable or not accountable, yes or no?

Secretary BECERRA. We do not have the authority from Congress to try to keep account of these children once they are placed.

Mrs. MCCLAIN. That is not your job is to——

Secretary BECERRA. That is not what we are saying.

Mrs. MCCLAIN. Your job is to vet them?

Secretary BECERRA. That is not what we are saying.

Mrs. MCCLAIN. Then let them go.

Secretary BECERRA. That is why we try to reach out to these kids.

Mrs. MCCLAIN. I do not think you know what you are saying because you use the laws that are convenient for you, when if we really truly care about the children, we would care about it when it is convenient, and when it is not convenient, and we would begin to fix a problem that we know we have as opposed to try and cover our butts. I yield back, thank you.

Secretary BECERRA. If Congress gives us the jurisdiction to try to account for these kids.

Chairwoman FOXX. Thank you, Mr. Secretary, thank you, Ms. McClain. Mr. DeSaulnier, you are recognized for 5 minutes.

Mr. DESAULNIER. Thank you, Madam Chair. Mr. Secretary, nice to see you. The pride of McClatchy High School. I want to talk to you about kids' mental health. What the Surgeon General has said, what the American Psychology and Psychiatric Association has said. The urgency, and as fellow Californians are well aware of the benefits of social media, and technology, but also the challenges, particularly around young people.

Surgeon General said that a third of young girls in this country, American girls, have contemplated suicide. 10 percent of young people in the United States have attempted suicide. We know this connection now. The amazing investments we have made in behavioral health, and when we look at Johns Hopkins, UCSF, Stanford, you are alma mater. I was just there 2 weeks ago to visit their center for youth mental health and social media.

These connections, my own view is the private sector is using what we have learned from neuroscience, particularly in cognitive development, to addict young people, and it goes right to some of the more unpleasant parts of human nature. So can you talk a little bit about what we can do to get on top of this?

We are losing a generation according to the Surgeon General, and the professionals, about how young people are spending three and half hours a day on social media and media. We know what they are doing. We know with these amazing investments.

We have probably learned more than in the last 50 years on cognitive development because of imaging, and the investments at NIH and on behavioral health, on how this is affecting people. It is frustrating to see what is happening literally every day in this country. What can we do to partner with you, and it should in my view, and Madam Chair, we have had these discussions.

This should be a nonpartisan issue of great urgency, is to putting some guardrails on "innovation" to make sure that we are doing no harm to future generations of Americans.

Secretary BECERRA. Congressman, as you know, technology is outpacing our ability to keep up with it, and so once we come up with a way to try to help these children survive, and improve their mental health status, something else comes up that is new in social media and so forth. It becomes very difficult.

We are trying to partner with many of the institutions and agencies that are trying to help kids, to try to improve opportunities to get to them before social media takes them down the wrong path. We are for example, trying to do far more mental health in our schools, and we are encouraging school districts to work with us to see if they could qualify to get Medicaid dollars directly, so they can provide behavioral health services at their school sites for kids.

We will try to do what we can to expand access to healthcare. I will tell you one of the most important things we can do is finally treat mental health on parity with physical health because we still have insurers who are not reimbursing for mental health services, when they would reimburse for other physical health services, so we have to do more to really put mental health on par with physical health.

Mr. DESAULNIER. I appreciate that. A sense of urgency, that word I think is imperative. I look forward to working with you. On a different subject, as a survivor of cancer with a form of Leukemia that is chronic, I was just told again at your alma mater, I do not spend a lot of time on the peninsula, but I did. Some of the work they are doing they now think again, because of public investment, that you can cure what historically my form of Leukemia is chronic.

I was asked to go speak to the head of UCSF's cancer program, who spent years running London's cancer programs. He talked about the difference in the cultures. He wanted to talk to me in frustration about all the amazing diagnoses and treatments they have, but the disparity that they cannot get. He told me with quite a lot of passion, there are people within an hour of this institution that I can save their lives, but they cannot access that treatment.

What can we do about disparity specifically in cancer? Then secondarily, I just want to mention the drug that keeps me alive in

my pocket, when I started taking it was $500.00 a day. It is now less than $100.00, but it is still in Australia, it is a little over $25.00 a day.

Executives, when I ask them, they say that is part of our business model. Americans pay to subsidize lower care. In the 30 seconds that we have left could you talk a little bit about the disparities.

Secretary BECERRA. Just generally. This is what happens when you treat healthcare as a commodity, that you game the price. It is a matter of whether you can afford the price, not whether you can get the healthcare you need. That has got to change. We have to do more to make sure that we are reaching people at the beginning.

Health—cancer screenings went down some 9 million Americans missed their health screening during COVID. We need to get back to doing the basics of prevention, so we can try to keep people from ever catching cancer.

Chairwoman FOXX. Thank you, Mr. DeSaulnier. Ms. Miller, you are recognized for 5 minutes.

Mrs. MILLER. Thank you. Mr. Secretary, do puberty blockers pose a health risk to children and teenagers?

Secretary BECERRA. Congresswoman, if a medical professional has been recommending healthcare for an individual, then I would believe that that healthcare professional had the best interests of that individual in mind in prescribing or recommending certain treatment or medicines.

Mrs. MILLER. What does your own FDA say are the risks of these chemical castration drugs and puberty blockers to young people?

Secretary BECERRA. Well, no drug would be on the market if it were not considered safe and effective by the FDA. Therefore those drugs——

Mrs. MILLER. Right. What does the FDA—what is your own FDA saying the risks are?

Secretary BECERRA. Well, with any drug there will be some level of risk.

Mrs. MILLER. Yes. You are not answering my question. What does your FDA say the risks are because people want to know the risks?

Secretary BECERRA. I am—Congresswoman, I am trying to answer you the question. If the Food and Drug Administration has put a drug out for the market, for consumers to use, it is because they have found that drug, after doing research and looking at the evidence, they have found that drug to be safe and effective for its use.

Mrs. MILLER. Okay. Well, I will answer the question. Your own FDA has admitted these puberty blockers cause brain swelling, brain tumors, vision loss, even blindness. Why is the Biden administration and your agency continuing to promote these blockers when you know that they are harmful to children and young adults?

Secretary BECERRA. Congresswoman, as I said, you have proven me—shown me nothing that says that the FDA did not go through a process to ensure that a particular drug was safe and effective.

It would not be on the market if it were not. We would find FDA in court for having put a drug out there into the market.

Mrs. MILLER. I would like to enter into the record the FDA's warnings, which I have up here also.

Chairwoman FOXX. Without objection.

[The information of Mrs. Miller follows:]

AAP News™

Risk of pseudotumor cerebri added to labeling for gonadotropin-releasing hormone agonists

July 1, 2022
from the Food and Drug Administration
Article type: FDA Update
Topics: Endocrinology, Hematology/Oncology, Nephrology, Therapeutics, Urology

The Food and Drug Administration (FDA) has added a warning about the risk of pseudotumor cerebri (idiopathic intracranial hypertension) to the labeling for gonadotropin-releasing hormone (GnRH) agonists that are approved for the treatment of central precocious puberty in pediatric patients. These products include Lupron Depot-Ped (leuprolide acetate), Fensolvi (leuprolide acetate), Synarel (nafarelin), Supprelin LA (histrelin) and Triptodur (triptorelin).

The new warning includes recommendations to monitor patients taking GnRH agonists for signs and symptoms of pseudotumor cerebri, including headache, papilledema, blurred or loss of vision, diplopia, pain behind the eye or pain with eye movement, tinnitus, dizziness and nausea.

The FDA assessed the potential risk of pseudotumor cerebri with use of GnRH agonists in pediatric patients by reviewing post-marketing safety data submitted by the GnRH agonist manufacturers, searching the FDA Adverse Event Reporting System and conducting a literature search.

Six cases were identified that supported a plausible association between GnRH agonist use and pseudotumor cerebri. All six cases were reported in birth-assigned females ages 5 to 12 years. Five were undergoing treatment for central precocious puberty and one for transgender care. The onset of pseudotumor cerebri symptoms ranged from three to 240 days after GnRH agonist initiation.

Symptoms included visual disturbances (n=5), headache or vomiting (n=5), papilledema (n=3), blood pressure increase (n=1) and abducens neuropathy (n=1). Treatments included lumbar puncture (n=3), acetazolamide therapy (n=5) and ventricular peritoneal shunting (n=1).

At the time of the FDA's review, symptoms had resolved in three patients, were resolving in one patient, had not resolved in one patient, and one patient's status was unknown. GnRH agonist therapy was discontinued in three patients; the status of continued therapy was unknown for the remaining three patients.

The incidence rate of pseudotumor cerebri associated with GnRH agonist use in pediatric patients could not be reliably established due to the small number of cases and data limitations.

The FDA's Office of Pediatric Therapeutics (OPT), Division of Pediatrics and Maternal Health (DPMH) and Division of General Endocrinology (DGE) contributed to this article. OPT resides in the Office of Clinical Policy and Programs in the Office of the Commissioner. DPMH resides in the Office of Rare Diseases, Pediatrics, Urologic and Reproductive Medicine. DGE resides within the Office of Cardiology, Hematology,

Endocrinology and Nephrology. Both DPMH and DGE reside within the Office of New Drugs in the Center for Drug Evaluation and Research.

Resource

Information for health care professionals on reporting adverse events to the FDA

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Mrs. MILLER. In a written answer to me after the last hearing you wrote that taxpayer dollars should be used to pay for sex reassignment surgeries and chemical castration. Drugs for children. Do you still hold that taxpayers should be paying for this?

Secretary BECERRA. Congresswoman, maybe you should read what I actually said.

Mrs. MILLER. I did.

Secretary BECERRA. That is not what I said.

Mrs. MILLER. Yes. You believe that taxpayers should pay for this, and why are you going around parents and medical professionals and putting out guidance directed toward children and young adults, promoting the use of chemical castration drugs and puberty blockers that cause significant health risks?

Secretary BECERRA. Congresswoman, I assure you I did not say what you just said.

Mrs. MILLER. Your own agency, the CDC, has directed toward young people guidance using these dangerous drugs with the potential serious, life altering side effects. I would like to know did the second dose of the COVID mRNA vaccine cause increased—caused myocarditis in young people and teenage boys? Young adult men, and teenage boys?

Secretary BECERRA. Congresswoman, again those drugs that the FDA found safe and effective have helped save millions of lives, and today we are able to go about our business in a far safer way, even though COVID is still with us.

Mrs. MILLER. Well, how did the risk of myocarditis and health complications from the second dose of the mRNA vaccine compares to the risk of serious complications from COVID in young men and teenage boys? How did that compare?

Secretary BECERRA. The fact that the FDA and the CDC have recommended the vaccine shows that the evidence is there to make it clear to Americans that it is safer to use the vaccine and protect yourself against COVID than the risks of other type of health effects.

Mrs. MILLER. Your agency, the CDC, has put this out. I would like everybody to notice the alarming red line. That is the increase in myocarditis among young men and teenage boys after they received the COVID vaccine. I would like to know why the Biden administration continues to push this on our young men and teenage boys?

Even pregnant women and babies to receive this vaccine, but especially our young men and teenage boys who, we can see, are at increased risks for myocarditis. I would just like to say that you do not follow the science, you ignore medical evidence, and you are pushing a political narrative and agenda, by pushing puberty

blockers and chemical castration on children, and pushing a second dose of the COVID mRNA vaccine on young boys, when you knew it was causing myocarditis. Thank you, and I yield back.

Chairwoman FOXX. Thank you. Ms. Hayes, you are recognized for 5 minutes.

Mrs. HAYES. Thank you. Wow. We are hitting all the points this morning. I guess I have got to tighten up my chart game. I will also just say what I am hearing, just completely separate from the questions I am going to ask, is some opportunities for bipartisan support.

When it comes to unaccompanied migrant children. Congress is actually the body that makes the laws and has the ability to give HHS the jurisdiction and the funding and resources to do exactly what I am hearing so many of my colleagues say is critically important to them.

I welcome a partnership with anyone on the other side to do just that, to make sure that these kids are safe, and not twisting in the wind, as we have heard this morning, so I am here. 2458 Rayburn.

Moving on to my questions, which seem even more relevant today. I want to talk to you a little bit about black maternal mortality. We just heard this week that Olympic track and field champion Tori Bowie died from childbirth complications in this country. I was never more aware of the risk to black women and their maternal health as I am now that I am in Congress.

American moms are dying at the highest rate in the developed world with black moms experiencing pregnancy related deaths three times higher than white women. Long-standing variations in access to quality healthcare, underlying chronic conditions, structural racism, and implicit bias contribute to these extreme disparities.

According to the CDC, social determinants of health prevent many minority groups from having fair economic, physical, and emotional health opportunities. To close these long-standing disparities, I recently led the Social Determinants for Moms Act, included in the Black Maternal Health Momnibus Act, which was introduced by Representatives Underwood and Adams.

The Social Determinants for Moms Act establishes a whole of government task force to develop comprehensive strategies to eliminate preventable maternal morbidity, and maternal health disparities. President Biden's budget includes 937 million for the maternal and child health block grants, an increase of 122 million from Fiscal Year 2023 enacted rates.

Approximately—I am sorry, approximately 145 million will support investments to address disparities in maternal mortality and morbidity, including proposals to address social determinants of maternal health.

Secretary Becerra, how does the Department of Health and Human Services plan to invest the 145 million dollars to ensure the most underserved communities are reached, and additionally, would a task force dedicated to eliminating preventable maternal mortality and maternal health disparities be a resource to HHS?

Secretary BECERRA. Congresswoman, thank you very much for the question, and all the work that you have done on this. We hope that the president's budget can be fulfilled, because that would let

us reach many communities. We would use some of that money to not wait for folks to come to us, but to go to them where they live.

For example, we are planning to continue to expand our access to women who are planning pregnancy, through the doula program, so we can make sure that women are receiving care. Not just at the point of delivery, but before that so they are preparing for that delivery, and having good health outcomes.

We are going to continue to work with community health centers, with those programs to reach out to do community health service work, to try to make sure we are getting to people early because someone who is an athlete at a young age, of I think 32, should not be dying in her home alone because she is pregnant.

Mrs. HAYES. Yes.

Secretary BECERRA. That is where we are. People are not being reached. We intend to use the resources to reach them.

Mrs. HAYES. Thank you. Rightfully, that should not be happening in the United States of America. My next question, 12.5 million children currently are potentially eligible for childcare subsidies under Federal rules, but only 16 percent receive subsidies in Fiscal Year 2019.

Last Congress, Democrats in the House passed the Build Back Better Act, which included programs for the expansion of high-quality childcare. Unfortunately, this failed in the Senate, but we know that we definitely need to update our childcare system. What would it mean to expand childcare, not only access, but accessibility to American families, so that they are able to afford care?

Secretary BECERRA. Well, as you just said, we would be able to get to more than one in seven children who need that childcare. We would be able to expand that dramatically. We also would be able to increase the wages of those workers that we depend on to care for those kids because right now I believe the average wage of a childcare worker is a little over $13.00 an hour.

You can flip burgers and make more money. We hope that you are able to secure some of the funding. I believe we are calling for some 400 billion dollars in new investments, and childcare services and Head Start, in the President's budget. We hope you can get us there as far as you can.

Mrs. HAYES. Thank you. I yield back.

Chairwoman FOXX. Thank you, Ms. Hayes. Mr. Kiley, you are recognized for 5 minutes.

Mr. KILEY. Good morning, Mr. Secretary. You have been asked about the huge increase in illegal child labor by migrant children. Here is the New York Times story headline, as migrant children were put to work, U.S. ignored warnings. Sub-headline, the White House and Federal agencies were repeatedly alerted to signs of children at risk. The warnings were ignored, or missed.

Now you have testified that these children are being exploited by unscrupulous employers, is the term that you have used. You also mentioned that some of this is outside your jurisdiction, which is fair enough. Maybe as a point of common ground could we agree that we have not done enough, or specifically, the Department of Labor needs to do more to crack down on these unscrupulous employers? Do you agree with that?

Secretary BECERRA. I am certain the Department of Labor would tell you that they would love more resources to go out and do the oversight, and enforcement work to make sure kids are not being abused.

Mr. KILEY. As it is they have not done enough. You would agree with that?

Secretary BECERRA. I am sorry?

Mr. KILEY. You would agree they have not done enough as it is?

Secretary BECERRA. They have done a great deal with the resources they have.

Mr. KILEY. I see. There has been a 70 percent increase in illegal child labor. Does that mean there has been—is there 70 percent less staff right now at the Department of Labor? I am trying to understand why this is a resource question?

Secretary BECERRA. My suspicion is if you look at their budget to do the oversight and enforcement, it has not grown to meet the needs.

Mr. KILEY. I see. Thank you. Mr. Secretary, did forcing 2-year-olds to wear masks save lives?

Secretary BECERRA. Do what now?

Mr. KILEY. Did forcing 2-year-olds to wear masks save lives?

Secretary BECERRA. Making sure people wore masks when it was appropriate was essential to make sure that we would be able to get out of this pandemic.

Mr. KILEY. Sure. That was not my question. Could you answer the question that I asked?

Secretary BECERRA. Which is?

Mr. KILEY. Did forcing 2-year-olds to wear masks save lives?

Secretary BECERRA. Who did the forcing?

Mr. KILEY. Well, your department, or the Head Start which is under your department, had a mask mandate until late last year for 2-year-olds and above, even outdoors. Can you point to any public health benefit of that policy?

Secretary BECERRA. We never forced anyone to do anything because we do not have the jurisdiction or authority to do that. What we did was provide guidance on what would be the policy.

Mr. KILEY. Mr. Secretary, did Head Start have a mask mandate?

Secretary BECERRA. We provide a mask mandate, a requirement for jurisdictions that wish to receive money to provide particular services.

Mr. KILEY. Head Start did have a mask mandate for kids. Yes?

Secretary BECERRA. We had a mask mandate for jurisdiction, excuse me, for agencies that wish to get Federal dollars to provide services.

Mr. KILEY. That is a yes. Can you point to any benefit.

Secretary BECERRA. It is not a yes, to your question.

Mr. KILEY. Any public health benefit from that policy, whether it was recommended, or enforced, or forced, of requiring young children to wear masks?

Secretary BECERRA. Did families benefit from the policy of using all protection, all precautions to avoid contracting COVID? Yes.

Mr. KILEY. I am not asking you to rephrase my question to some abstract question that you would rather answer. I am asking that you, as the person who is the Secretary of Health and Human

Services, right now can you point to any evidence that there was a public health benefit to forcing young children to wear masks?

Secretary BECERRA. Well, the fact that today we are not losing lives the way we lost them when we first got into this pandemic is a clear sign.

Mr. KILEY. You think that was because you forced 2-year-olds to wear masks?

Secretary BECERRA. That is your interpretation. What I am saying to you is that using good policies that give us the precautions to keep our families from contracting COVID are helping save lives.

Mr. KILEY. I want to quote you from an article from NPR on January 2022. It says the United States is an outlier and recommending masks from the age of 2 years old. The World Health Organization does not recommend masks for children under age five, while the European equivalent of the CDC doesn't recommend them for children under age 12.

In retrospect, was it a mistake for the United States to defy the international norm on child masking?

Secretary BECERRA. The U.S. had been working closely with our international partners, and we have done more than any other country to try to help our country, our partner countries.

Mr. KILEY. That is not what I asked you. I asked you, was it a mistake to defy the international norm on the issue of child masking?

Secretary BECERRA. We continued to use all the best practices when it comes to making sure people take the precautions.

Mr. KILEY. Is there a reason you are not answering my question, Mr. Secretary?

Secretary BECERRA. I am answering the question the best I can because you keep phrasing questions that are already geared to get a particular answer.

Mr. KILEY. Mr. Secretary, a few weeks ago we had the testimony from your counterpart, the Secretary of Education, who gave false testimony to this Committee. He claimed that he did not encourage states to adopt student vaccine mandates. I wanted to ask your own recollection of your own advocacy. Did you encourage or support the adoption of student vaccine mandates by states, or school districts?

Secretary BECERRA. We have encouraged states to use all the precautions necessary to protect their populations, including students.

Mr. KILEY. Did you—including student vaccine mandates?

Secretary BECERRA. All the precautions to help states protect their populations.

Mr. KILEY. Right, but specifically did you support student vaccine mandates?

Secretary BECERRA. We have supported all the policies that showed that they help save lives.

Mr. KILEY. Did you support student vaccine mandates? Yes, or no?

Secretary BECERRA. We have supported all policies that helped states make sure people's lives are saved.

Mr. KILEY. Mr. Secretary, Madam Chair, I think we had an opening from you asking for the witness to give frank and honest answers, and we are just not getting that today I am afraid, and that is very unfortunate. I yield back.

Secretary BECERRA. Congressman, if pose questions in a way that I could respond to them I would.

Chairwoman FOXX. Thank you, Mr. Kiley. Ms. Stevens, you are recognized for 5 minutes.

Ms. STEVENS. Thank you, Madam Chair, and just as a point of record and reference, COVID killed a million people in this country and some of us were in Congress. Some of us were taking the calls, like I did, on behalf of Michigan, when we did not have the ventilators, and we had a twice impeached president who was laughing at supply chain disruptions.

Some of us were here on January 6th, when a president twice impeached now was eating popcorn as the Capitol was being attacked. We are here with the Secretary of Health and Human Services, a member, a former member of this body, someone who is dedicated to the health outcomes of this Nation.

Now, I only wish that the other side of the aisle could care just as much about the things that they are making up as they do about the real problems impacting Americans. My colleague from Connecticut spoke about a maternal mortality crisis in this Nation, the highest in the industrial world.

Mr. Secretary, we salute the Biden administration for your commitment to expanding access to quality, affordable health care, a very basic thing. You were here when we passed the Affordable Care Act and we have been expanding on that and trying to improve outcomes for people, in the middle of a health crisis, a Supreme Court overturned Roe v. Wade, adding and doubling to the challenge of women.

Some of us have the physical reality of what it is like to get pregnant and to be fighting for the access to care, not cheering when Roe v. Wade is overturned and now 14 states passing extreme abortion bans with no exceptions for rape, incest, or the life of the mother. Say that again, for the life of the mother, a human being.

Secretary Becerra, what steps has HHS taken to ensure that women continue to have access to comprehensive reproductive health care in the wake of this almost 1 year later horrible ruling from the Supreme Court to overturn Roe v. Wade?

Secretary BECERRA. Congresswoman, we are engaged in a number of activities. We have taken actions against health care providers that have deprived women of the health care they need at the time during their pregnancy. We are making sure we defend women's access to Mifepristone, a medication abortion medication, an abortion medication that has been in use for more than 20 years.

We are continuing to work with family planning programs to make sure women get the right information about the care that they are entitled to. We have taken actions to defend any individual whose rights to health care have been discriminated against and violated, and we continue to make every effort to work with our State and local partners, to make sure a woman has access to the care she needs wherever she may have to go to get it.

Ms. STEVENS. Well, thank you so much for that response, and I know my good colleague, Ms. Manning from the great State of North Carolina, has played a leading role in making sure that women have continued access to Mifepristone. Women bear a disproportionate burden of autoimmune disease, thyroid disease and other gynecological diseases like endometriosis, certainly compared to male counterparts.

I just want to take this moment to continue to implore your office, with the great role that you play at HHS, to continue prioritizing research to improve understanding of the mechanisms, diagnoses, and treatment of diseases that disproportionately impact women.

You can go on the NIH site and this condition, that condition, is not researched enough because it is only impacting 50 percent of the population, except for of course for our colleagues on the other side of the aisle, who are possessed about reproductive care and stripping it away from women. Thank you for utilizing your role in that regard.

Along the theme of equal access to health care for all people, I would just like to inquire about continued support for disabled Americans, a group of workers whose rights and opportunities are so often stifled in the workplace. Essential laws like Section 504 of the IDEA work together to protect children and adults with disabilities from exclusion and unequal treatment in schools, jobs, and the community.

Secretary Becerra, what can HHS do to strengthen enforcement of civil rights mandates, including Section 504 of the Rehabilitation Act, to ensure that the 64 million people with disabilities in this country have adequate and equal access to health care?

Secretary BECERRA. Congresswoman, thank you for the question. We are continuing to try to reform and improve the regulations that we have that let us enforce Section 504 or Section 1557 of the Affordable Care Act when it comes to anti-discrimination provisions.

We hope that Congress will provide us with the resources our Office for Civil Rights requires in order to be able to do the work to enforce the law when we get reports of violations.

Ms. STEVENS. Thank you. I yield back, thanks.

Chairwoman FOXX. Mr. Bean, you are recognized for 5 minutes.

Mr. BEAN. Thank you very much, Madam Chair. Good afternoon to you, good afternoon, Mr. Secretary. Welcome. We are glad to have you here. You say the 85,000 number of child—of children that you have lost is incorrect. You say that it is more like 20 percent of the 120,000 that we—that are unreachable. Is that a better number to use, the 20 percent of 120,000 that we cannot find?

Secretary BECERRA. Let me correct you. We have not lost any children. All the children that are within our care stay in-house. When we assign them, after vetting a custodian that placement, then we relinquish, or we lose the jurisdiction to do more with that child.

We cannot lose someone we do not have—we do not keep track of or have the jurisdiction to keep track of.

Mr. BEAN. You said that your agency tries to contact them afterwards just to check in, but you do not have contact with them. You call them unreachable. Is that——

Secretary BECERRA. Those efforts that we make are beyond the statutory requirements that Congress has imposed on us. We do that because we think it is good practice to try to reach those children after we place them. They are not obligated to respond back to us.

Mr. BEAN. Losing 20 percent is not that—that is a horrible record, but you are not excited about that record.

Secretary BECERRA. It is not that we have lost them.

Mr. BEAN. You do not know where they are? I mean they are unreachable if you do not know where they are.

Secretary BECERRA. We do not have jurisdiction to keep tabs on them. As I said, this is not like a foster care program——

Mr. BEAN. You are working with—but you are the one, you are the one that placed them there.

Secretary BECERRA. That is right. We are the parent; we are the parent——

Mr. BEAN. Are you concerned? I mean, if I lost a kid, I would be really worried about it, and now that reports that these kids are coming up, they are working in slaughterhouses, and we do not know where the others are. They could be doing far worse things. I mean, you do not seem too concerned. I want your concern about it.

Secretary BECERRA. Oh, we are very concerned, and I hope you find that compelling enough that you will act to change the law to give the Federal Government jurisdiction, more jurisdiction to keep account of these kids.

Mr. BEAN. What are you doing differently? Your track record is losing 20 percent of them. What are you doing differently going forward to say that you could have 100 percent? Is there anything less than 100 percent that you would be happy with?

Secretary BECERRA. If you would require that the child or the sponsor to stay in touch with us, that would help us. We do not have the authority to require that. We cannot lose kids that we do not have jurisdiction to keep tabs of.

Mr. BEAN. What are you doing differently, now that you are only having 80 percent? What are you changing? What are we doing differently?

Secretary BECERRA. That is a great question. We are trying to work closer with the Department of Labor, because they may spot some trends, and they could say to us, by the way, it looks like in this part of the country——

Mr. BEAN. Are you doubling down? Do you give a sponsor more than one kid if they cannot—are we doing more than one kid to a sponsor who does not check in and let us know that the child is okay?

Secretary BECERRA. We vet every potential sponsor, have them go through all the background checks, make sure they understand their responsibilities before they place that child——

Mr. BEAN. I would check that out, because evidently, it is not working if you are only doing 80 percent that are checking back in with you.

Secretary BECERRA. You are conflating two different things. You are conflating different things. The vetting process has nothing to do with our post-release checks. Those post-release checks are things that we do because we think it is a good thing to do.

Mr. BEAN. What number are you going to say that when you lose kids, how many is too many and say you know, we cannot take any more? We have just got too many. We have got so many things going on at HHS that we just cannot keep track anymore. Let us let somebody do this or let us just—let us say that we just cannot take any more kids? Is there a number that you would say we cannot do anymore?

Secretary BECERRA. Well first, we do not have the privilege to say we cannot take any more kids. We have to take a child that has been——

Mr. BEAN. Not batting 80 percent and losing 20 percent.

Secretary BECERRA. We do not—we have assigned those kids and once they are assigned, they are the responsibility of those sponsors.

Mr. BEAN. Do COVID vaccines prevent—do COVID vaccines prevent COVID? Does that prevent COVID?

Secretary BECERRA. Does COVID—do COVID vaccines help keep people out of the hospital. They help prevent severe COVID.

Mr. BEAN. Okay, but they do not prevent COVID? They do not prevent COVID.

Secretary BECERRA. They help prevent——

Mr. BEAN. Penn State University says you are seven times more likely to get myocarditis after taking the vaccine than not taking the vaccine, seven times, especially if you are a young man.

That does not seem to bother HHS. We are still full throttle on telling everybody to get the—get these vaccines. What number or what multiplier will you say enough is enough, and we need to give warnings to young men who are being still urged to take these vaccines? What number will you say enough is enough?

Secretary BECERRA. More than a million Americans have died, many of those young men who have died. How many men have died from myocarditis? Is there a number.

Mr. BEAN. It is a big number. If you got—I know them. They call my office.

Secretary BECERRA. Is it a million?

Mr. BEAN. There is a number that you would say enough is enough, I want to follow the science. You have seen the dramatic rise, the surge, the skyrocketing myocarditis, but you are okay with that.

Secretary BECERRA. Young men are dying from COVID in numbers that are far greater than anything that could happen with any of the side effects——

Mr. BEAN. I wish you could talk to some of these families that have myocarditis and deal with that. With that, I yield back, Madam Chair.

Chairwoman FOXX. Thank you very much. Ms. Wild, you are recognized for 5 minutes.

Ms. WILD. Thank you, Madam Chairman, Chairwoman. Secretary, thank you so much for being here. I want to shift gears entirely, to a subject that I find of great interest, mostly because it

is something that has been highlighted to me for—by my constituents on so many occasions, and that is the issue of postpartum mental health.

I know that the National Maternal Mental Health hotline recently updated its number to 1–833-TLC-MAMA, which is great, and as I said, I have heard from so many women about postpartum experiences that have been very, very difficult. I am happy that there is now a 24/7 free telephone line that connects these mothers with professional counselors who can provide emotional support and so forth.

For any mother who might be listening in today or might see this hearing in the future, is there anything that they should know about this important resource that your department has provided?

Secretary BECERRA. Congresswoman, thank you for the question. Absolutely, that they should know that if they reach out and call that number, there is a good chance that we will be able to direct them to services that they can utilize, to make sure that they are taking not just good care of themselves, but of any family member as well. We encourage them to use the hotline to find out what services are available to them.

Ms. WILD. Well, I promise you my office will make sure that we are pushing the availability of that number out. It is something that I was not very aware of prior to this.

I also—and then I just want to switch gears to the Low Income Home Energy Assistance Program, otherwise known as LIHEAP, which for those who are watching provides federally funded assistance in managing costs associated with home energy bills and weatherization and that kind of thing.

It is something that in Pennsylvania, many families are relying on these investments to lower the cost of staying warm or in fact to receive heat at all in the winter or staying cool in the summer. The president's proposed budget would allow LIHEAP grantees, those funds to assist low-income households with their water and wastewater utility bills, which would be something new.

Can you talk about why that would be important and about LIHEAP generally and its successes?

Secretary BECERRA. Congresswoman, first I have to thank you and many of your colleagues for giving us the additional resources in LIHEAP to actually reach out and now expand the scope of services. What we are finding is that many Americans are suffering, in some cases dying, because of heat or in some cases because of cold.

What we want to do is make sure that the LIHEAP program is there to help them as best possible in the way they need it. For some, it will be the issue of heat, some it will be an issue of air conditioning during the summer. Some will be making sure they can stay warm and get the type of heating that they need.

For other folks, it may be something different, as you mentioned, now water. We are trying to make sure that we do not forget that people have to have access to potable water that is safe to drink, and if you cannot drink safe, potable water, you are in really big trouble.

We want LIHEAP to work for families where they are, and we will let those on the ground that actually administer the programs determine how best to utilize those LIHEAP resources.

Ms. WILD. Well, it would seem to make a lot of sense. Most people are aware that the energy cost, whether it is gas or electric to help with air conditioning and particularly heating in the winter, is incredibly important. A lot of people do not think about the necessity of water to every single human being, and how expensive it can be.

Can you talk, again getting back to my interest in maternal health and postpartum health, we know that maternal exposure to heat is associated with an increased risk of preterm and early term birth, low and decreased birth weight, stillbirth and other—and harmful newborn stress. Can you talk about the importance of continuing and expanding the LIHEAP programs generally, especially as it relates to vulnerable populations, and if you could focus particularly on expectant mothers and children?

Secretary BECERRA. I know you know this. My wife, who is an OB/GYN, can tell you this as well, that a woman goes through significant stress during pregnancy, and the last thing you need is to have that stress compounded by a lack of heating or a lack of air conditioning and hot temperatures, or lack of access to potable water.

LIHEAP should be there to help, and again let those on the ground who know how best to use the resources with families in their jurisdiction determine how best to use those LIHEAP dollars, and certainly when it comes to maternal health, the last thing you would want is to have a woman who is stressed because she is already pregnant, now have to stress more because she does not know how she is going to——

Ms. WILD. It is not just emotional stress. We are also talking about physical health during pregnancy, right?

Secretary BECERRA. Absolutely, both, both.

Ms. WILD. Okay. Thank you very much, Mr. Secretary. I yield back.

Chairwoman FOXX. Thank you, Ms. Wild. Mr. Burlison, you are recognized for 5 minutes.

Mr. BURLISON. Thank you, Madam Chair. In 2018, you were the California Attorney General, correct?

Secretary BECERRA. Yes sir, yes sir.

Mr. BURLISON. At that time, you investigated, I believe it is called Humboldt County? I am not from California so—the Department of Health?

Secretary BECERRA. I believe so. You would have to—you are making me go back a bit in history, but I believe you are right.

Mr. BURLISON. You investigated them because of systematic issues related to the care of children, correct?

Secretary BECERRA. Yes.

Mr. BURLISON. Okay. You obtained in a stipulated judgment against that agency; correct?

Secretary BECERRA. Okay. My recollection is yes. Sorry.

Mr. BURLISON. Okay. In your press release, when you announced the judgment, you stated, and I am going to quote "The institutions of Humboldt County entrusted to protect children failed them. What can be more important than public agencies performing their duties to safeguard the security and welfare of our kids?" Do you still agree with that statement?

Secretary BECERRA. It sounds like you were reading verbatim, so I would say yes, if it is a quote.

Mr. BURLISON. I think anybody should agree with this statement. This is where it comes to the crux of this hearing, which is why so many of my colleagues are asking this question. We have a whistleblower that appeared before the Judiciary, who stated that 85,000 minors are missing from your agency. Now you say it is not 85; you say that it is somewhere around 25.

Secretary BECERRA. Well, that is completely inaccurate. They are not missing from our agency. We no longer have jurisdiction over those children.

Mr. BURLISON. You cannot get ahold of these children.

Secretary BECERRA. We do not have jurisdiction to get ahold of the children.

Mr. BURLISON. Okay. Let me—let me ask you this question. You say you do not have jurisdiction, but you have bent the law to get jurisdiction to call these families. You are willing to go beyond what your authority is in order to make phone calls. You just stated that in testimony.

Secretary BECERRA. Yes. We did not bend the law; we went beyond the law to try to see if we could reach these kids.

Mr. BURLISON. What you are saying is that it is not important enough to go beyond the law to find out what happened to these children?

Secretary BECERRA. No, because we do go beyond the law.

Mr. BURLISON. Okay. Let me ask this. Within the law, what your authority is, what authority do you have to place the children with a sponsor?

Secretary BECERRA. We do have authority to place the child.

Mr. BURLISON. You place the children with the sponsor?

Secretary BECERRA. Correct.

Mr. BURLISON. What do you do—how do you decide who they can be placed with?

Secretary BECERRA. We usually work with the parents if they are in the home country. We work with the child, especially if they are older, and we try to work to find out who they know or who they consider to be a close and could be protective of the child. Many, about one in three of our placements are with the actual parent of the child.

Mr. BURLISON. Do you not think that there could be something that you could do in the perimeter of the law that you have purview over, to reduce the number of children that you lose track of?

Secretary BECERRA. Okay, Congressman, let me—we go beyond the law to try to reach out to them. We do not lose any child because we no longer have jurisdiction over them.

Mr. BURLISON. You do not know where they are.

Secretary BECERRA. The problem is, you have not given us jurisdiction for us or any other agency to find out where they are.

Mr. BURLISON. What I am saying is on the front end, why can you not come up with a solution on the front end to keep track of the children that you placed?

Secretary BECERRA. Well, we—we have tried to do what we can through the post-release service calls, to try to see if we can find out if they are doing okay, to check in with them. As I said, they

have no obligation to answer the phone or speak to us once they are placed with their sponsor.

Congressman, if you wish to change the authorities and give us more jurisdiction or give more jurisdiction to the Department of Labor, I think we would be more than willing to talk to you about that.

Mr. BURLISON. Let me ask you this.

Secretary BECERRA. You cannot keep saying we lose kids when we do not have jurisdiction over them.

Mr. BURLISON. Okay, take my time back. Let me ask you this. I am going to move on, because this is—this is disturbing to me. In 2022 last year, you issued new guidance direction to the Office of Refugee Resettlement, to make "all reasonable efforts to facilitate access to abortion services if requested by the unaccompanied child"; correct?

Secretary BECERRA. Yes, correct.

Mr. BURLISON. Okay. My question is, when you are handling these unaccompanied children, what efforts are you taking to ensure that they are separated from the individual that, you know, if they were involved in an assault of any kind or they are being used for sex trafficking, do you not see that the impacts that you are having, that you could have to a child who is basically captive in sex trafficking, and you are enabling their captors to be able to get—to help them get an abortion so they can get back to work?

Secretary BECERRA. Again Congressman, you are conflating two different things and coming up with a question that——

Mr. BURLISON. My question is if you are keeping track of these children, you would know.

Secretary BECERRA. We are not. If they are in our care, we do keep track of them because they are in our custody. Once they are placed with a vetted sponsor, we no longer have custody. We cannot keep track of them, because they have no obligation to stay in touch with us.

Mr. BURLISON. Turn a blind eye?

Secretary BECERRA. No.

Mr. BURLISON. You do not know. You do not have the authority. You do not——

Secretary BECERRA. We do not have the authority.

Mr. BURLISON. You are going to make sure that they have access to abortion services.

Secretary BECERRA. We do not turn a blind eye, but we do not have the authority.

Mr. BURLISON. Okay, thank you. I yield back.

Secretary BECERRA. Appreciate that.

Chairwoman FOXX. Thank you. Ms. Leger Fernandez, you are recognized for 5 minutes.

Ms. Leger Fernandez. Thank you, Madam Chair. Thank you so much, Secretary Becerra, for joining us here today. I truly appreciated, as we opened our hearing today, your summary of how both congressional Democrats and President Biden's administration have worked to actually bring down the cost of prescription drugs, have worked to make sure that more people have access to health care.

While we have been doing that and so much more for American families, American families, rural communities, and just this country in general, we have done so much. We have also been doing it at the same time that we have been reducing the Federal deficit, by $1.7 trillion in 2 years.

The Biden administration, Democrats in the Senate and House, leads to both fiscal responsibility and paying attention to what our families need. I represent rural communities, you have been out to my district, and there is a huge need for better health care and better access to resources.

I want to talk about one of the little problems, and that is that it is often very difficult for these smaller communities, these smaller organizations, to actually apply for competitive grants for alcoholism, substance use disorder and treatment, and those kinds of things. We have people, we have organizations that say I have to pass up this, because I do not have the capacity.

I am constantly asking what can the administration, what can HHS do to provide the assistance so we get those kinds of projects and programs actually operating in our smaller, rural, and frontier communities?

Secretary BECERRA. Congresswoman, thank you for the question because you are right. It is difficult to compete against the big guys, especially when you are in a distant location. We are trying to work closer with rural America to try to make some of these resources available. Some grants are designated to go into rural America.

We are working very hard to try to keep some of the authorities and services that have really helped rural America. For example, telehealth, which was one of the greatest godsends for men and women, families in America, rural America who during COVID could not really go visit, physically, their health care provider.

Telehealth has been instrumental in helping a lot of these families stay in better health. We are going to do everything we can to try to help and in that regard. You are right, when it is a competitive grant, Congress, you all determine how that grant is administered. We try to make sure everyone can be competitive.

We do, for example, offer training and assistance for those who wish to compete for some of those grants, so they can try to compete against the big guys.

Ms. Leger Fernandez. Right, and the more assistance you can provide, sort of from the executive on, that would really be helpful, so that we can have more of the rural areas. I mean this administration and Congress last cycle did so much for rural America.

I put together pamphlets so that I could go out into my district and say look at everything we have done in rural America. Part of the problem that we still need to look at is rural hospitals. Like too many hospitals in rural America are closing their OB/GYN or cutting their hours. I know we have the new rural emergency hospital designation, which is going to be very helpful, as it increases Medicare reimbursement.

I would love to brainstorm with you a bit about what else can we do, because hospitals that provide inpatient care are ineligible for 340(b), which is a major source of funding. Do you have some ideas on how we could increase the success of our rural hospitals?

Secretary BECERRA. We have already had plenty of discussion about 340(b) and how we have to try to preserve it but take away the elements that keep prices from coming down and being utilized by more providers.

What I would say to you is one thing. I would love any Member who would take me up on this offer, and that is to try to make sure that our graduate medical education slots, the residency slots that are used to train upcoming physicians, that we are able to place more of these in places like rural America, inner city America.

What we are finding is that if a budding doctor goes through his or her training in a particular location, after two or 3 years of that residency, there is a good chance that they like where they have been working, and they will stay. You have created a new resource for those communities in rural America, for example.

We are trying to direct where we can a focus on under-served areas, to place some of these graduate medical education slots. We are also, for example, trying to beef up the number of slots we have in our Public Health Service Corps, where if you commit to provide 5 years of service as a doctor after you graduate from medical school and residency, we will pay for your medical education.

My son-in-law is right now practicing in Salinas, California as a pediatrician. He got 4 years of medical school paid for by the Federal Government, but now he is committed to serve in that underserved area of Salinas, California for 5 years.

Ms. Leger Fernandez. Thank you very much, Mr. Secretary, and I really do appreciate how we are having a rural focus with this administration. Thank you.

Chairwoman FOXX. Mr. Williams, you are recognized for 5 minutes.

Mr. WILLIAMS. Thank you, Madam Chairman. Mr. Secretary, I am very disappointed in the evasive nature of your answers here today, particularly on our side of the aisle. In reviewing your background, I see that you spent 24 years in this chamber and serving in the House, and also that you are a lawyer.

The fact that you bring politics and law into this conversation instead of medical background and medical expertise, I think, explains very much the nature and lack of answers in your questions. I am an engineer. I come from a very different sort of background, very new to this whole environment of politics.

I find it astounding that this charade of answers and—is allowed to continue. I will just give you a few examples from your testimony today, and again this could only be crafted by the expertise of someone with your background, where quite often you talk about that your Department goes beyond the law to provide these heroic services, and in the same breath you will say you do not have jurisdiction.

Which is it? What I have noticed when I go back home and talk to ordinary Americans, that they are incredibly frustrated with people that do not answer directly. There are real issues that the American people want to know.

For example, the learning loss and emotional harm done to children as young as two forced to wear a mask by your department, under your leadership, and yet you will not provide an answer. These are parents of small children that are dealing with the fall-

out, and yet you choose to play games and you choose to evade direct questions.

This is what frustrates America about this town, and about an administration that puts politicians and lawyers in charge of health care. That is not the kind of leadership that the American people expect, and I find it shameful, and frankly I find it shameful because I come from a different discipline.

On a nuclear submarine, you do not have that option. There are no sea lawyers on submarines. They do not send us out. I understand that the Soviet Union did, that they sent political officers out with their submarines, not necessary on Americans—on American ships because we are always interested in getting the job done.

That is exactly what the American people expect, and that is nothing similar to the nature of your answers sir, or your disregard for this body, where you served for 24 years. I do want to point out that the American people are watching, and they expect answers. Why did you continue a policy of requiring 2-year-olds to wear masks in the classroom and out on the playground, and what medical benefit did that provide?

Secretary BECERRA. I hear a question, so you want me to answer the question about——

Mr. WILLIAMS. That is a question.

Secretary BECERRA. As I have said before Congressman, what we try to do at the Department of Health and Human Services, because we don not operate childcare programs, we don not operate school classrooms, we try to——

Mr. WILLIAMS. This evasiveness of Head Start funding, that if you do not require children to wear these masks and comply with our principles, you will cutoff funding, you are saying that is not coercive? You are saying that you, on the one hand, do not have jurisdiction? This is exactly what I am talking about.

Then on the other hand, that you have this stick that you use with funding? That is so disingenuous sir, and I will tell you sir the American people see through it and they are sick of it. Do you care to answer the question? What medical benefit was there to masking children, 2 years old, in the classroom and on the playground? A medical answer, not a legal answer.

Secretary BECERRA. I will give you, Congressman, the answer that we got from the medical experts that guided the policies that HHS put forward, and that is that the best precautions that we can take to prevent COVID infection are things like masking, distancing, making sure you are washing your hands, getting vaccinated.

Mr. WILLIAMS. Two-year-olds? Two-year-olds.

Secretary BECERRA. Every American can benefit——

Mr. WILLIAMS. Everyone equally.

Secretary BECERRA. Every American can benefit from these precautions.

Mr. WILLIAMS. That is scientific, sir?

Secretary BECERRA. There I would agree with you. There are studies that show that some benefit more than others. Obviously, if you are in the——

Mr. WILLIAMS. Are you paid, sir, to have the judgment in your area of leadership, to provide that kind of counsel, that hey, maybe

the children under five, that is not necessary? Is that your purview, or is that maybe, what did you say, not in your jurisdiction? My time has expired, sir. I hope you will be more forthright in the future, thank you.

Chairwoman FOXX. Ms. Manning, you are recognized for 5 minutes.

Ms. MANNING. Secretary Becerra, I want to thank you for your service to our country. I want to thank you for your valiant attempt to answer actual questions in the hearing today, and I also want to thank you for trying your best to save lives during the global pandemic, with all the information and you and all medical professionals had at the time, for your attempt to save young lives and old lives and everybody in between.

I also want to thank you for visiting my district, where you attended a roundtable with my constituents to talk about—to listen to them talk about the importance of Federal funding for federally qualified health centers, which provide critical health care to the most vulnerable among us.

I want to thank you for attending a roundtable on the devastating impact of the Dobbs decision on reproductive health care for women. Not only on the freedom of women to decide whether, when, and with whom to have children, but also the negative effect on women seeking care for miscarriages, and hearing from physicians in my district about how they are handicapped in their ability to provide the best care to their patients, because of confusing and restrictive legislation passed by extreme State legislators in the absence of Federal legislation that is so dearly needed to protect women's health care.

As you stated to my colleague, Ms. Bonamici, pregnant women are more than three times more likely to die during pregnancy in states that enact abortion restrictions. This is an appalling outcome, and this Congress should be taking action to protect the health of women and girls in this country, not standing by while women and girls' lives are being put at risk by extreme politicians.

Secretary Becerra, even before the Dobbs decision, the Trump administration took many harmful steps to undermine access to reproductive care, by allowing employers to evade the Affordable Care Act's requirement to cover contraception without imposing cost sharing on individuals.

Earlier this year, HHS, DOL and the Treasury proposed rules to roll back these harmful actions, while creating a new pathway for women to receive contraception when their employers seek religious exemptions. Can you talk about how the proposed rules will expand access to contraception, and also tell us what HHS can do to ensure that insurers comply with Federal law and cover contraceptives?

Secretary BECERRA. Congresswoman, there is no doubt that without contraception services, we would have far more difficult pregnancies, we would have many more cases of families that are in dire need, and what we find is that contraceptive services, which are usually undertaken by a woman after consultation with her medical provider, an expert, and in consultation with those who are trusted advisors help us make sure that when we see a family ready to grow, it is because they have really been working to plan

that. We are going to do everything we can to make sure that contraceptive services are available, that the information and counseling that a woman should have so she can make the right decision is provided to her, and certainly we will do everything we can to protect the rights of that woman to receive those services.

If anyone attempts to prevent that and discriminates against that woman, we will take whatever action we can to enforce her rights to be protected against discrimination.

Ms. MANNING. Thank you. I am going to change topics here. You said earlier to Mr. DeSaulnier that mental health should be put on par with physical health.

You were talking about the mental health crisis in our schools, and I just want to mention that I am trying to do that with my Mental Health Wellness in Schools bill, which would put mental health services information on par with physical health and health care and services.

The most recent CDC report did outline a severe decline in students' mental health after the pandemic, and particularly mental health issues faced by teenaged girls. In the president's budget, HHS requested $90 million for school behavioral health program, what works in schools.

Can you walk us through this program and talk about how it will help combat youth mental health problems?

Secretary BECERRA. Congresswoman, as you are aware, the mental health challenges facing our young people are growing dramatically. The closer we can get to providing that care where they are on a daily basis would help them. We are going to try to work with schools as much as we can, to make those mental health services available to all those young people.

Ms. MANNING. Thank you. My time is about to expire, so I will yield back. Thank you so much for your service.

Secretary BECERRA. Thank you.

Chairwoman FOXX. Thank you, Ms. Manning. Ms. Houchin, you are recognized for 5 minutes.

Ms. HOUCHIN. Thank you, Madam Chair. Thank you, Mr. Secretary, for coming to testify before us today. Nearly 3 months ago, I sent a letter to the Center for Medicare and Medicaid Services concerning your department's intent to impose a minimum staffing ratio on nursing homes in the coming months.

This administration chooses not to cooperate with congressional communication. I would like to take the opportunity to discuss that issue with you today. As you know, long-term care facilities are still recovering from the COVID–19 pandemic as they try to backfill open practitioner positions during the national workforce shortage.

According to the Bureau of Labor Statistics, Indiana's long-term care facilities had over 46,000 practitioners in February 2020. As of 2022, that number fell below 40,000. Now just last week, I had constituents in my office explaining to me their concern on how this rule will hinder their ability to care for patients.

Mr. Secretary, why I am still hearing from providers that HHS and CMS are unwilling to consider and discuss their concerns?

Secretary BECERRA. Congresswoman, please if there are particular providers, I believe that we, HHS and CMS have not been

willing to speak to them, please let me know who they are because we have reached out to providers throughout the country to talk about the staffing levels of nursing homes.

Ms. HOUCHIN. Okay, we will do that.

Secretary BECERRA. Great.

Ms. HOUCHIN. If this rule is to be introduced, the providers in my district have made it clear that long-term and post-acute nursing care facilities will be unable to provide continued care in rural areas such as the district that I serve, and that is quite frankly unacceptable.

It will push patients to unnecessarily higher levels of care, costing already high-cost programs, driving those costs even higher, not to mention the fact that the higher levels of care are not always optimal for these patients.

Instead of implementing a top-down rule that will force providers to increase their staffing minimums, I encourage your department to take time to meet with these providers and consider how we can best support their success, particularly as they are still recovering from the pandemic.

I would like to discuss another example, moving on, where your department is, in my view, just not listening to the providers. Of more than 6.7 million patients with Alzheimer's across the country, more than 110,000 of them are Hoosiers.

As you know, the FDA has approved monoclonal antibody treatment created in Indiana that has demonstrated it can slow down Alzheimer's for individuals with mild cognitive impairment. Medicare has traditionally covered all FDA approved drugs, yet it has continuously chosen to not allow for unencumbered access to Alzheimer's treatment. Why is this, Mr. Secretary?

Secretary BECERRA. Congresswoman, I have tried many times to explain this, because I myself, my wife, we have all gone through this, I suspect maybe you have as well, where someone in your family may have been afflicted by Alzheimer's or some other form of dementia.

It is very difficult, and I appreciate and applaud all those people who are trying to push this through aggressively as possible to get the kind of care that would help their family members get better. Where I think I have to try to explain this constantly is that once the Federal Food and Drug Administration takes action and says a particular medicine can be put out for consumption because it will be safe and effective, the decision then becomes on the Medicare side whether or not that drug will be listed as——

Ms. HOUCHIN. What is the answer? Why is that not available to those patients?

Secretary BECERRA. The standards are different between what the Food and Drug Administration uses to put out a drug, and what CMS determines whether or not to include it within Medicare.

Ms. HOUCHIN. Why is that?

Secretary BECERRA. By law, Congress passed a statute that says FDA treats its work, with a different standard than CMS. FDA has done its work does not mean that CMS automatically then takes what FDA did and uses it for Medicare.

Ms. HOUCHIN. Those living in rural districts such as mine are more likely to be affected by this if the CMS policy for coverage with evidence development moves forward. The logistical challenges for patients and caregivers alike, as well as health care providers in these rural areas, will make it increasingly challenging to meet the needs of those patients.

Are you willing to consider that CMS could reevaluate the current policy of requiring coverage with evidence development for this class of therapeutics?

Secretary BECERRA. CMS, as we are speaking, is doing an ongoing reevaluation because once the information that they get is sufficient for them to say, "we now have passed the bar to include that drug within coverage within Medicare," they will announce it. It is an ongoing process within CMS.

Ms. HOUCHIN. I urge you to allow for immediate access to FDA-approved treatments for patients that would benefit from these important therapeutics, just as it does for all other classes of FDA-approved medicines. I will not stop advocating for improved health care in rural areas.

I worry that continued suboptimal performance will continue if HHS leadership does not make meaningful to those affected in rural districts. Madam Chairman, I yield back.

Chairwoman FOXX. Thank you. Ms. Omar, you are recognized for 5 minutes.

Ms. OMAR. Thank you. Secretary Becerra, it is really good to see you. My daughter, who welcomed you to her school the other day, sent her greetings when I told her that you will be coming to testify.

I wanted to talk to you about drug pricing. I know that we did an incredible job with the Inflation Reduction Act. It was a historic effort to reform and improve the affordability of health care, and many of my constituents and seniors are particularly excited about the fact that there are—there is a law that would also place an out-of-pocket limit on senior drug pricing, and require drug companies to provide rebate when they raise their list prices faster than the rate of inflation.

Many of them are also excited that you now have the ability to negotiate prescription drug prices. I wanted to ask you how are these tools, these new tools that we provided, going to help you do just that, lower the cost for people on Medicaid?

Secretary BECERRA. Within the Medicare program, it is working tremendously well. It is going to help us if we can get people to understand what benefits they now have. Some people still do not recognize that they are not obligated to pay more than $35 for their month's supply of insulin. Many people are not aware that they will not pay a penny anymore for a vaccine for say shingles, which could cost between two and three hundred dollars.

One of the things we are really working on is communicating more, reaching people, going to districts of Members of Congress so we can work with you to make sure people understand what these new benefits are in the president's new prescription drug law.

Ms. OMAR. As you know, the Administration for Child and Families hosted its annual tribal consultation, and they were able to

look at policies and priorities in June. Can you talk to us a little bit about this important gathering?

Secretary BECERRA. At the Department of Health and Human Services, we do consultation with our tribal partners. We believe that sovereignty is an important pillar of tribal governance, and we work closely with our tribal governments to make sure that we know where they would like to see HHS go, our Indian Health services.

We engage in very robust consultation with tribal leadership, to make sure that when we are putting out policy, it is with the understanding that Indian country is supportive and on board.

Ms. OMAR. As you know, approximately 7 percent of all American Indians and Alaska Natives live in urban and suburban areas. Can you also speak to the importance for the Department as they do this consultation, and what are they willing to do in order to communicate with urban Indian communities and organizations?

Secretary BECERRA. We consider very important the voice of tribal members who live in urban communities, and may not live on tribal land, and we have mechanisms to make sure that their voice is included in all of these consultations, because we want to make sure that when we say "Indian country," we include every member of a tribal community, whether or not they live on tribal territory.

Ms. OMAR. As someone who represents the largest Native urban communities, I really do appreciate that. That is important. I wanted to switch gears and talk to you about this report that came out from HHS Inspector General's Office about the failures of the State child welfare agencies to properly report missing children to the National Center for Missing and Exploited Children.

It was shockingly 69 percent of the missing children were not being reported in accordance with Federal requirements. Of the 69 percent, 47 percent of the missing children during the audit period were never reported to NCMEC at all.

The IG recommended the Administration for Children and Families work with the State agencies to ensure proper compliance. It looks like ACF agreed. Can you give us an update on the agencies and how they are dealing to address this issue?

Secretary BECERRA. Thank you for the question, Congresswoman. We are trying to move forward by adopting many of the recommendations by the Inspector General. We would like to be able to work as closely as possible with the local agencies that are the enforcers of child welfare laws. We want to make sure that every tool that we have, that we can put at their disposal, resources as well, we advise them of.

I suspect you will find that many of these local agencies are very stressed, understaffed. We will do everything we can and with your support, we might be able to get the resources and authorities to work closer with these agencies, to make sure all children are protected.

Ms. OMAR. I will be following up with you on that. Thank you, and I yield back.

Chairwoman FOXX. Thank you. Ms. Chavez-Deremer, you are recognized for 5 minutes.

Ms. CHAVEZ-DEREMER. Thank you, Madam Chairwoman. Secretary Becerra, thank you for coming today. As some of my col-

leagues have mentioned, your impatience to place undocumented children with sponsors at a faster rate than your caseworkers could handle placed thousands of kids in dangerous conditions, where they were exploited for labor, kids as young as 12, some even died.

These are chilling—this is a chilling failure of leadership. President Biden has decided to keep you on board, as we have an obligation to the American people to work together. Let us make sure this never happens again. Yes or no, do you commit yourself and your staff to working with me and the Committee staff on this issue, that includes providing us materials which can educate us as to how the sponsorship process has been abused?

Secretary BECERRA. Congresswoman, thank you for the question, and we have been working directly with the Committee and members on this committee in the past. We look forward to working with you to make sure that we are doing everything possible to protect the children who are in our care.

Ms. CHAVEZ-DEREMER. Have you reviewed how to improve the vetting process for sponsors since the New York Times story, and what improvements have you made to date?

Secretary BECERRA. Congresswoman, we have been reviewing the vetting process since—well since I became Secretary, because it is an ongoing process. The circumstances have changed, as you would know, very dramatically. In 2021, there were large numbers of children in our care. Today, the number is greatly smaller.

What we are trying to do is constantly be on top of what it takes to make sure that we care for the kids who are in our temporary custody well, but we also make the right placements once they are able to go out into the community.

Ms. CHAVEZ-DEREMER. Okay. With that being said, you have concluded—which areas of Congress, which areas do you think Congress needs to address, and aside from comprehensive immigration reform, which we are already doing that with the Dignity Act, tell me, where can Congress help you?

Secretary BECERRA. I appreciate the question, and there is a very simple answer to that, because many of the questions many of your colleagues have asked are why are we not accounting for children? I keep trying to explain that we only have jurisdiction based on what Congress has given us.

Someone has to be able to account for these kids in a better way, these migrant children who are ending up working in these exploitive conditions. We do not have the authority to check up on them, to followup and require them to check in with us a foster care program might have with a U.S. citizen child.

If you want to help us, make sure that someone in the Federal Government, maybe it is not HHS; maybe you decide it is Department of Labor; maybe you decide it is done through the states. There is a gap. When we have the kids in our custody, they are not exploited in the labor workplace.

Once we place them with a parent or a close relative, we do not have jurisdiction. Who will make sure that they are accounted for or taken care of? There is the gap, and I would hope that rather than make accusations, Members would try to work with us to make sure that if they really care about kids, we are making sure that they are accounted for who has jurisdiction.

Ms. CHAVEZ-DEREMER. Let me add onto that. Talk to me a little bit about the child labor space. Within your department's jurisdiction, what areas would you be willing to partner with me and the Committee to strengthen those guardrails needed to protect these kids?

Secretary BECERRA. We can work with you—right now, we are working with the Department of Labor. They are trying to give us any signals.

If there are some signs that a particular person who might want to sponsor a child, or in particular areas of the country we see that type of exploitive behavior, if we get that information early, we can have then the red flag go off if someone is seeking to sponsor a child who fits that profile or lives in that area.

We can work with you if it happens to be your congressional district, or if you are interested in helping us merge and better tie the work that the different agencies can do, and then where you can really help us, get the local agencies, the State and local agencies, the licensing care facilities at a State level, the community organizations that work with families, migrant kids, to work closely with you and with us to make sure that we are all trying to do this seamlessly so there is no gap in who is accounting for these children.

Ms. CHAVEZ-DEREMER. Thank you. I think there is little words that can describe the anger that we all felt when we read the New York Times story and when it broke. We do feel like there was a betrayal of trust for our most vulnerable kids in this country, and you know, they are surrounded by those strange faces, and I just can't imagine that for my own kids or anybody else's kids.

I do expect that I will work with you, but I do expect that you will honor those commitments that you have made to me today and with that, Madam Chair, I yield back.

Secretary BECERRA. I look forward to it.

Chairwoman FOXX. Thank you. Ms. Jayapal, you are recognized for 5 minutes.

Ms. JAYAPAL. Thank you, Madam Chair. Thank you so much, Secretary Becerra, for joining us today. Your work to promote health affordability and health equity from your time here in Congress as a Member of the House, to your tenure as Attorney General of California, to your current work leading the Department of Health and Human Services for the administration has just been vital to our progress, and I am deeply grateful to you.

The contrast between the priorities of my colleagues across the aisle and Democrats could not be clearer. When Democrats controlled the House, we passed bills that gave people the freedom to get the health care they need, by expanding coverage and lowering costs. Now, this Majority is pushing bills that continue to take away the right to health care, including gender-affirming care and abortion, while doing absolutely nothing to lower costs for patients.

Secretary Becerra, my Republican colleagues have proposed Federal bans on gender-affirming care, and more than 19 states have passed bills restricting care. What do medical experts say about the importance of access to gender-affirming care for transgender people?

Secretary BECERRA. Congresswoman, it is long-standing medical practice to offer gender-affirming care. It has been shown to not only provide for the physical health care needs of an individual, but the mental health care needs of individuals.

Whether it is because the science has shown us that it works or whether it is because through practice we have professionals, doctors who can tell you how it is worked, we know that gender-affirming care has helped us bring some level of comfort and a better life for so many Americans, who are in search of gender-affirming care.

Ms. JAYAPAL. In fact, is it true that there is a long list of medical associations that endorse gender-affirming care, and the positive health effects that gender-affirming care has for people with gender dysphoria?

Secretary BECERRA. That is correct.

Ms. JAYAPAL. There has been an increase in violent rhetoric and threats against transgender people and their doctors, including at children's hospitals, that provide gender-affirming care. For example, Boston Children's Hospital received a bomb threat resulting in a lockdown.

Secretary Becerra, how do you predict that this will impact children's mental health and safety?

Secretary BECERRA. Congresswoman, I think it is very obvious. If you see on the news that there are bomb threats, there are attacks, there is violence committed against those who are trying to help an individual who needs gender-affirming care, you take on the burden of saying it is because of me that that person may have been attacked or harmed, and you also recognize that that could be me next, because they are attacking that person because of the care I need.

The kind of stress that imposes on any individual, including a young person, we can only imagine.

Ms. JAYAPAL. I know that HHS has taken action to address and increase critical care for trans youth. I want to thank you for that. Can you tell me a bit about your efforts to improve access to quality mental health care for trans people and trans youth, and why this has better outcomes for trans youth in removing their right to medical care?

Secretary BECERRA. Well first and foremost, every American is entitled to get the health care that they need, and so transgender Americans are no different. We are doing what we are doing because it is their right, and we have an obligation to defend their rights and protect their health care interests.

At the same time, we know that the closer we can get to providing them with that care, for example in a school, the more likely that that child will have good outcomes, not just in terms of health but in school and moving forward in life. We are going to try to put that care as close to that individual as we can.

Ms. JAYAPAL. Well, I really want to thank you, Mr. Secretary. I think you know I am the proud mother of an incredible trans daughter, and I have watched the role that good medicine has played in her life and good care, health care, has played in her life.

My heart breaks for parents that are in states that have banned this evidence-based life-saving medical care that kids need, and for

those who face these coinciding increases in violent rhetoric against trans people. I am deeply concerned that this Republican Majority continues to make this a priority for their time leading the House, restricting the freedom of families to make health care decisions, overtaking real action to tackle our health care crisis.

Seems to me that if we did a poll across the country and asked Americans what they would want us to focus on, it would be on lowering the cost of prescription drugs, on lowering the cost of basic health care, making sure that seniors can get dental, vision and hearing, other things that are critically important, not banning gender-affirming care for so many young people and trans people across this country.

I want to thank you for your leadership. I yield back, Madam Chair.

Chairwoman FOXX. Thank you, Ms. Jayapal. Mr. Scott, you are recognized for 5 minutes.

Mr. SCOTT. Thank you, and thank you Secretary Becerra for being with us today. It is been a long day. First, a quick assurance.

Can we count on you to continue to follow the science and CDC recommendations in response to COVID–19 and any future pandemic, in terms of vaccines, masks and other recommendations, including how they might affect children 2 years old or under and ignore the politics and misinformation?

Secretary BECERRA. We will follow the science and we will try not to let the politics get in the way.

Mr. SCOTT. Thank you. Notwithstanding the court situation, are prevention services still available under the Affordable Care Act?

Secretary BECERRA. Yes, they are.

Mr. SCOTT. We have heard a lot about religious discrimination. Some view the victim of discrimination as I do, if you apply for services that a provider will not provide you services because of your religion, you are the victim of discrimination.

Others have kind of turned it around, that if a provider has to provide you the services if he does not want to because of your religion, the provider becomes the victim of discrimination. Can we count on the patients who are seeking benefits under HHS-funded programs, to the extent possible under the law, to be free from discrimination?

Secretary BECERRA. Absolutely. If you are entitled to receive a health care service, we are going to defend your right to get it. At the same time, whether it is because of your ethnicity, your race, your religion, your religious values that someone is trying to deprive you of your rights, we will try to defend that as well.

Mr. SCOTT. Thank you. We have signed up over 16 million people under the Affordable Care Act. Are there any ongoing barriers to signing up that we need to address?

Secretary BECERRA. Congressman, there is always some impediment. Rural America, tough to get to people everywhere. In urban areas, we still have a lot of disinformation and not enough information about what the benefits are. We are going to continue to go where people are, instead of waiting for folks to come to us. That is how we were able to have such success in getting more than 60 million Americans enrolled in Obamacare.

Mr. SCOTT. Thank you. We have had a lot of discussion about unaccompanied children, excuse me. First, you have identified sponsors. What do the sponsors promise to do?

Secretary BECERRA. In order to sponsor a child, they must commit to protecting the health and welfare of that child. They must provide for the safe housing of that child, and make sure that the interests of the child are promoted. If the child is of school age, the child has an opportunity to go to school.

They are essentially committing to be the guardians, the custodians of that child during this temporary status while they're going through their immigration proceedings.

Mr. SCOTT. That is a temporary placement while they are going through the proceedings?

Secretary BECERRA. That is correct.

Mr. SCOTT. Does the Department provide any services during this time?

Secretary BECERRA. By law and by statute, we lose jurisdiction over these children once they are placed with a vetted sponsor. We do try to followup with phone calls to the child and to the sponsor, and as I have continued to point out, they do not have an obligation to respond to us because we do not have jurisdiction. We try to make an effort to at least followup to see how the placement is going.

Mr. SCOTT. Well, you have described this as a gap. What agency would be the appropriate agency to have continuing jurisdiction?

Secretary BECERRA. Well, that is a great question, because remember, this is not like a foster care program where the State has custody of a child and places that child with a foster parent or home, where the State continues to hold jurisdiction over the child. If things do not go well, the State can take action.

These children are here under a temporary status while they are undergoing their immigration proceedings, and because they have come in without an adult guardian, we are caring for them temporary until we find a sponsor who says we will take over that responsibility.

The gap exists because there is nobody then who oversees that sponsor, and there is where Congress would have given us, us or someone else, authorities.

Mr. SCOTT. If we gave you that responsibility, would we have to provide some funding so that you can actually fulfill your responsibility?

Secretary BECERRA. Without a doubt.

Mr. SCOTT. Thank you. Madam Chair, I ask unanimous consent to submit for the record a letter from the Centers for Medicare and Medicaid Services regarding the waiver it afforded to St. Francis Health System, to maintain its chapel candle, so long as it took reasonable measures to mitigate fire risks. This letter corrects the mischaracterization of my colleagues concerning this issue.

Chairwoman FOXX. Without objection.

[The letter follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500
Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

May 4, 2023

Michael J. Lissau
Senior Vice President and General Counsel
Saint Francis Health System
6161 South Yale Avenue
Tulsa, OK 74136

Dear Mr. Lissau:

Thank you for meeting with us today and for the productive conversations related to a recent finding by The Joint Commission (TJC) during your recent reaccreditation survey. We believe today's discussion and agreed upon solution enables St. Francis South Hospital to maintain a living flame in the hospital chapel while mitigating fire risks.

As we discussed, TJC issued a deficiency citation based on the National Fire Protection Association (NFPA) Health Care Facilities Code (NFPA 99), which contains associated "Elimination of Sources of Ignition" requirements under sections 11.5.1.1.2 & 11.5.1.1.3, and which require no open flame within one foot of a nasal cannula and 15 feet of any other oxygen delivery equipment.

As per our discussion earlier today, and after CMS's further discussion with TJC, CMS is providing St. Francis South Hospital a waiver for the living flame of the sanctuary candle in the chapel of this hospital. This waiver is contingent upon the hospital providing a plan of correction to TJC that includes taking some simple, appropriate steps to mitigate fire risks (e.g., signage posted outside or in the chapel warning patients, visitors, and staff of keeping oxygen equipment and their delivery devices sufficiently far from any flame in the chapel to serve as the primary action by the hospital to mitigate the fire risks, and, if possible, the use of a rope or other barrier to serve as a secondary mitigation measure). We recommend continuing to engage with TJC on implementing these solutions and addressing this deficiency citation in a way that mitigates fire risks while still ensuring you can maintain this feature of your chapel.

Once these agreed upon actions have been implemented, CMS will consider this particular matter closed.

Again, thank you for your continued efforts to provide vital health care services to your patients and your community, while also promoting their safety.

Sincerely,

\s\

Scott J. Cooper, MMSc, PA-C
CAPT, USPHS
Director
Division of Continuing & Acute Care Providers

Chairwoman FOXX. Thank you, Mr. Scott. Mr. Secretary, I wrote to you on December 22, 2022 about our concerns about HHS policies about children who identify as a gender that is not their biological gender. Specifically, I expressed my concerns about parental rights not being respected in basic decisionmaking about life-changing treatments and surgeries.

You failed to respond timely or completely. I again wrote to you on January 12th, 2023, to request you provide timely and complete responses. You responded but Mr. Secretary, you neither fully nor completely responded to my questions, and particularly my document request.

Will you commit to providing timely and complete responses to my questions and documented requests to my letters of December 22, 2022, and January 12, 2023, yes or no?

Secretary BECERRA. Madam Chair, we will work in good faith with you to try to address any requests that you make in your oversight capacity.

Chairwoman FOXX. Will you commit to providing timely and complete responses to all letters I send you henceforth?

Secretary BECERRA. Congresswoman, we will again work with you closely and certainly in good faith to try to address any request. As you know, the long-standing practice in the executive branch is to try to respond to the requests of the Chairs of the Committee, so we can make sure that you have that information.

Chairwoman FOXX. Well, you are going to need to work just a tad harder to comply. Mr. Secretary, in my earlier letters to you, I noted how the family is the most basic unit of society, and parents have the inalienable right and responsibility to educate and rear their children.

There are examples around the country where Child Protective Services has taken children from the homes of loving parents because parents do not support life-altering surgeries or other medical interventions on their children who have been diagnosed with gender dysphoria.

In California, one parent lost custody of her daughter and the court permitted only 1 hour of visitation each week, because the mother did not want her daughter to receive gender interventions. In Ohio, a husband and wife lost custody of their 17 year-old daughter because they would not consent to cross-sex hormones.

Instead of standing up for parents, the Biden administration has pushed to make it easier for children with healthy bodies to access puberty blockers, cross-sex hormones, and life-altering irreversible surgeries. I am saying children.

HHS has even weaponized its Office for Civil Rights to threaten providers and health plans that refuse to assess children diagnosed with gender dysphoria in receiving surgical or hormonal medical interventions.

What planned regulations and guidance documents do you have under consideration for the Child Abuse Prevention and Treatment Act, Family Violence Prevention and Services Act, and childcare programs that will discuss policies related to gender diverse, gender minority, or transgender issues?

Secretary BECERRA. Congresswoman, that was either a very long question or I missed the actual question in the comments.

Chairwoman FOXX. What regulations and guidance do you have planned under the legislation Child Abuse Prevention and Treatment Act, Family Violence Prevention and Services Act, and childcare programs?

Secretary BECERRA. We will do everything through regulation that we can to make sure we can enforce the statutory provisions in those acts, to make sure that we are protecting every individual that is entitled to those protections under those new laws. We will do everything for a transgender child that we would do for any child, because they have the same rights to access care that they need.

Chairwoman FOXX. You mean you are going to protect children who have one biological sex and may think that they have a different biological sex. What is your estimated timing for such regulations and guidance?

Secretary BECERRA. Congresswoman, I can get back to you on that, because I cannot say that there is a particular timeframe. I would say that gender-affirming care is a standard of care that is recognized by every major medical association in this country, and that means that you are talking over a million providers who have been part of that process of affirming that type of care.

What we are going to do is make sure that when it comes to implementing the laws that you and your colleagues have passed, that we do it without discriminating against any group, and we protect every individual.

Chairwoman FOXX. It is unfortunate that you do not have the same feeling about protecting the lives of unborn children, so that they would have the chance to be born and live life. Mr. James, you are recognized for 5 minutes.

Mr. JAMES. Thank you, Madam Chairwoman. Good morning, Mr. Secretary, how are you? Well, I guess it is afternoon now. Good afternoon, Mr. Secretary.

Secretary BECERRA. Good afternoon.

Mr. JAMES. Secretary Becerra, in the State of the Union this year, the President of the United States of America stood on the House floor and lied to the American people. He stood on the floor and said that the Republicans wanted to take away your Social Security and Medicare.

In reaction to these lies, I proposed H.R. 875, divorce the debt negotiation proceedings from health care, so that our seniors were not used as pawns in that negotiation. As a result of these lies, I get comments back from my constituents, one from Rochester Hills who writes "Rep. James, I am concerned about the debt negotiations that were underway in Congress, and they could jeopardize current and future Social Security and Medicare benefits, which I rely on."

Another of my constituents from Sterling Heights wrote in saying "It is outrageous that some are suggesting cutting Social Security and Medicare in the debt debate." I have heard a lot about misinformation in this hearing today, but the greatest purveyor of misinformation in the past few months has been the Biden administration.

There is been a lot of fearmongering, and to establish the trend, the White House also lied about cuts to VA benefits. I am a combat

veteran. I have felt the sting of not only the physical wounds of war but the unseen wounds of war.

The increase above the President's budget of over $18 billion that went to the VA has invalidated that misinformation from this administration. Mr. Secretary, what also concerns me in addition to this misinformation of the Biden administration is that it seems to be more concerned with expanding government run programs when free market options exist to bring down the cost of health care.

Many of my constituents ask me why must the government continue to spend more and more and more to force them, to make them beneficial, rather than supporting free market alternatives that could at least alleviate a little bit of pressure on the taxpayers to foot the bill, while also increasing quality and choice?

Right now, my understanding is Medicare Part A is expected to go insolvent in 2031. Is that also your understanding?

Secretary BECERRA. Medicare Part A will face a challenge unless Congress—you all act to provide it with more resources, yes.

Mr. JAMES. Do you believe that Congress should act to maintain the long-term stability, security, and sustainability of Medicare?

Secretary BECERRA. Yes, of course, and the President provides a proposal to do so.

Mr. JAMES. Would you agree that increasing expenditures has put us in this mess in the first place? I will even credit you, both administrations, Democrat and Republican, spending without controls, without checks, and without commiserate attention to the nutritious and environments that we are putting our people in.

Do you believe that spending, in Democrats and Republicans, have put us in a situation, where Social Security and Medicare could go insolvent within our lifetimes?

Secretary BECERRA. Well Congressman, as you know, Social Security and Medicare do not rely on what the budget that you pass on a yearly basis does, because Social Security and Medicare operate on their own terms.

Mr. JAMES. Okay. Irresponsible fiscal policies. Do you believe that irresponsible fiscal policies have put us in the position where our seniors now and in the future are at risk, and do you believe that Congress and the administration have a responsibility to fix that?

Secretary BECERRA. Fiscal policies must be enacted that keep the interests of our families in mind. Social Security and Medicare operate on their own terms.

Mr. JAMES. Sir, do you believe that Congress and the administration have a short-and long-term responsibility to get Social Security and Medicare back on the right track?

Secretary BECERRA. I would hope that you would act to make sure that we get Social Security and Medicare working——

Mr. JAMES. Okay. I am going to assume that is a no, unless it is a yes. I do not want to put words in your mouth. OK. I am going to assume that is a no. Madam Chair, before I conclude, I do not want seniors to lose their benefits, and I am going to do everything I can to protect seniors' benefits. With that, I yield.

Chairwoman FOXX. Thank you. I would like to thank the Secretary again for taking the time to testify before the Committee

today, and without objection, there being no further business, the Committee stands adjourned.



June 13, 2023

The Honorable Charles Schumer
Senate Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Senate Minority Leader
United States Senate
Washington, D.C. 20510

The Honorable Kevin McCarthy
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, D.C. 20510

Dear Congressional Leaders,

As Governors representing ten states, we urge you to take bipartisan action to protect current levels of funding for and increase recurring federal investment in child care as you develop the budget for Fiscal Year 2024. Of the many funding priorities before you, few are as critical to America's working families as ensuring access to child care. Quality child care makes it possible for parents to work and employers to hire, all while giving young children a strong foundation to learn and thrive.

Across the country, businesses and employers are ringing the alarm that the shortage of available child care options is hurting our economy. The bottom line is that Americans cannot work without safe, reliable, quality child care for their family. Without sustained investment in child care, businesses will continue to struggle to hire the people they need. Almost half of all working parents say the number of hours they can work has been compromised by lack of child care options, and one fifth say they have had to leave the labor market entirely. Child care is truly "the workforce behind the workforce."

While families across the country are struggling to find and pay for child care, many rural families are especially impacted. Sixty percent of rural Americans live in a child care desert, and the average rural family now spends 12 percent of their income on child care.

Long under-resourced, the American child care system is now strained to its breaking point. Many child care centers are struggling to keep their doors open, and many child care teachers have left the field. Nearly 90,000 fewer people are working in the child care industry today than in February 2020, resulting in a 9.7% national decline in the size of the child care workforce.

One of the biggest drivers of this decline is low pay for child care teachers. Child care teachers need to be able to afford to stay in the classroom in jobs they love. Inflation has made that impossible for many, and competition for workers from other industries has driven wages up to levels that child care programs are unable to meet.

We deeply appreciate the critical funding you provided to support child care through the pandemic. As that one-time funding ends, the need for more federal support for quality child care is urgent. We urge bipartisan action to make this essential, recurring investment in our children, our economy, and the future of our country.

Sincerely,

Governor Roy Cooper
State of North Carolina

Governor Jared Polis
State of Colorado

Governor Josh Green, M.D.
State of Hawaii

Governor Tony Evers
State of Wisconsin

Governor Michelle Lujan Grisham
State of New Mexico

Governor Phil Murphy
State of New Jersey

Governor Jay Inslee
State of Washington

Governor Laura Kelly
State of Kansas



Governor Dan McKee
State of Rhode Island



Governor JB Pritzker
State of Illinois

The New York Times https://www.nytimes.com/2023/04/17/us/politics/migrant-child-labor-biden.html

As Migrant Children Were Put to Work, U.S. Ignored Warnings

The White House and federal agencies were repeatedly alerted to signs of children at risk. The warnings were ignored or missed.

By Hannah Dreier
April 17, 2023

In the spring of 2021, Linda Brandmiller was working at an arena in San Antonio that had been converted into an emergency shelter for migrant children. Thousands of boys were sleeping on cots as the Biden administration grappled with a record number of minors crossing into the United States without their parents.

Ms. Brandmiller's job was to help vet sponsors, and she had been trained to look for possible trafficking. In her first week, two cases jumped out: One man told her he was sponsoring three boys to employ them at his construction company. Another, who lived in Florida, was trying to sponsor two children who would have to work off the cost of bringing them north.

She immediately contacted supervisors working with the Department of Health and Human Services, the federal agency responsible for these children. "This is urgent," she wrote in an email reviewed by The New York Times.

But within days, she noticed that one of the children was set to be released to the man in Florida. She wrote another email, this time asking for a supervisor's "immediate attention" and adding that the government had already sent a 14-year-old boy to the same sponsor.

Ms. Brandmiller also emailed the shelter's manager. A few days later, her building access was revoked during her lunch break. She said she was never told why she had been fired.

Over the past two years, more than 250,000 migrant children have come alone to the United States. Thousands of children have ended up in punishing jobs across the country — working overnight in slaughterhouses, replacing roofs, operating machinery in factories — all in violation of child labor laws, a recent Times investigation showed. After the article's publication in February, the White House announced policy changes and a crackdown on companies that hire children.

But all along, there were signs of the explosive growth of this labor force and warnings that the Biden administration ignored or missed, The Times has found.

Again and again, veteran government staffers and outside contractors told the Health and Human Services Department, including in reports that reached Secretary Xavier Becerra, that children appeared to be at risk. The Labor Department put out news releases noting an increase in child labor. Senior White House aides were shown evidence of exploitation, such as clusters of migrant children who had been found working with industrial equipment or caustic chemicals.

As the administration scrambled to clear shelters that were strained beyond capacity, children were released with little support to sponsors who expected them to take on grueling, dangerous jobs.

In interviews with The Times, officials expressed concern for migrant children but shifted blame for failing to protect them.

H.H.S. officials said the department vetted sponsors sufficiently but could not control what happened to children after they were released. Monitoring workplaces, they said, was the job of the Department of Labor.

Officials at the Labor Department said inspectors had increased their focus on child labor and shared details about workers with H.H.S., but said it was not a welfare agency.

And White House officials said that while the two departments had passed along information about migrant child labor, the reports were not flagged as urgent and did not make clear the scope of the problem. Robyn M. Patterson, a White House spokeswoman, said in a statement that the administration was now increasing scrutiny of employers and reviewing its vetting of sponsors.

"It's unacceptable that companies are using child labor, and this administration will continue working to strengthen the system to investigate these violations and hold violators accountable," the statement read.

But the White House declined to comment on why the administration did not previously react to repeated signs that migrant children were being widely exploited.

"If I saw it, they could have put it together," said Ms. Brandmiller, who is also an immigration lawyer. "There were so many opportunities to connect those dots that no one ever did." An H.H.S. spokeswoman said the agency had no record of Ms. Brandmiller's concerns. The company that ran the emergency shelter declined to comment.

Ms. Brandmiller said she still worried about the 14-year-old boy, Antonio Diaz Mendez.

Antonio is living in Florida City, Fla., far from his family in Guatemala. In an interview last summer, he sat on the mildewed porch of a house crowded with other migrant children. He said he was working long shifts in a refrigerated warehouse, packing vegetables for distribution around the country, and had not seen his sponsor in months.

He missed his grandmother and sometimes went days without talking to anyone. He wanted to go to school, but felt trapped because he needed to earn money to repay his debts, support himself and help his siblings.

No one, he said, had ever come to check on him.

'This Is BS'



Over the past two years, more than 250,000 migrant children have come alone to the United States. Kirsten Luce for The New York Times

Soon after President Biden took office, the growing numbers of migrant children touched off tension between the new administration and longtime government staff members.

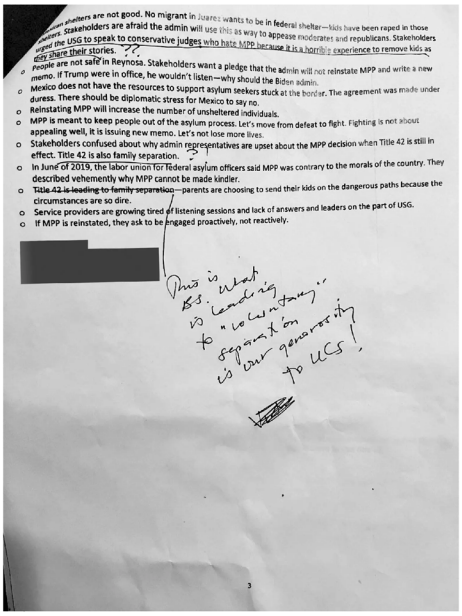
The president had promised to abide by a 2008 anti-trafficking law that requires the federal government to accept children traveling alone from most countries and allows them to stay in the United States during the yearslong process of applying for legal status.

But the law did not anticipate that a pandemic would ravage the economies of Central American countries. Parents in deepening poverty began sending their children to the United States to earn money — part of a phenomenon some immigration advocates call "voluntary family separation."

In 2021, as images of children sleeping under foil blankets in overflow centers dominated the news, Susan E. Rice, the White House's head of domestic policy, told staff members she was frustrated with the situation, according to five people who worked with her. Ms. Rice vented in a note she scribbled on a memo detailing the position of advocates, who believed a pandemic-era border closure was compelling parents to send unaccompanied children, sometimes called U.C.s.

"This is BS," Ms. Rice wrote, according to a copy of the memo reviewed by The Times. "What is leading to 'voluntary' separation is our generosity to UCs!"

In a statement, Ms. Patterson, the White House spokeswoman, said that any suggestion that Ms. Rice felt constrained by the demands of the law was false and that she was "proud to be doing the right thing and treating children with dignity and respect."



- [redacted] shelters are not good. No migrant in Juarez wants to be in federal shelter—kids have been raped in those shelters. Stakeholders are afraid the admin will use DHS as way to appease moderates and republicans. Stakeholders urged the USG to speak to conservative judges who hate MPP because it is a horrible experience to remove kids as they share their stories.
- People are not safe in Reynosa. Stakeholders want a pledge that the admin will not reinstate MPP and write a new memo. If Trump were in office, he wouldn't listen—why should the Biden admin.
- Mexico does not have the resources to support asylum seekers stuck at the border. The agreement was made under duress. There should be diplomatic stress for Mexico to say no.
- Reinstating MPP will increase the number of unsheltered individuals.
- MPP is meant to keep people out of the asylum process. Let's move from defeat to fight. Fighting is not about appealing well, it is issuing new memo. Let's not lose more lives.
- Stakeholders confused about why admin representatives are upset about the MPP decision when Title 42 is still in effect. Title 42 is also family separation.
- In June of 2019, the labor union for federal asylum officers said MPP was contrary to the morals of the country. They described vehemently why MPP cannot be made kindler.
- ~~Title 42 is leading to family separation~~—parents are choosing to send their kids on the dangerous paths because the circumstances are so dire.
- Service providers are growing tired of listening sessions and lack of answers and leaders on the part of USG.
- If MPP is reinstated, they ask to be engaged proactively, not reactively.

[redacted]

This is what U.S. leadership is looking like to the rest of the world

A copy of a 2021 memo with handwritten notes by Susan E. Rice, the White House's domestic policy adviser. Identifying information has been redacted.

Under the law, the Department of Health and Human Services is responsible for vetting sponsors to ensure they will provide for children's well-being and protect them from trafficking or exploitation. But as shelters filled with children, the department began loosening some vetting restrictions and urging case managers to speed the process along.

Longtime H.H.S. staff members complained that the changes endangered children. White House aides and administration officials grew exasperated, believing that these workers were clinging to protocols that kept children in shelters when it was better for them to be in a home with an adult.

"It was maddening," said Vivian Graubard, a White House adviser who worked with Ms. Rice on migrant child issues.

At least five Health and Human Services staff members filed complaints and said they were pushed out after raising concerns about child safety.

Jallyn Sualog was the most senior career member of the H.H.S. division responsible for unaccompanied migrant children when Mr. Biden took office. She had helped build the program after the passage of the 2008 law and, as a lifelong Democrat, had celebrated Mr. Biden's win.

But soon, she said, she began to hear reports that children were being released to adults who had lied about their identities, or who planned to exploit them.

She warned her bosses in a 2021 email, "If nothing continues to be done, there will be a catastrophic event." She continued to email about situations she described as "critical" and "putting children at risk."

Jallyn Sualog was moved out of her position at the Health and Human Services Department after raising concerns about migrant child safety. Lexey Swall for The New York Times

Concerned that no one was listening, Ms. Sualog filed a complaint in the fall of 2021 with the H.H.S. Office of Inspector General, the agency's internal watchdog, and requested whistle-blower protection. She also took the unusual step of speaking with congressional staffers about her worries.

"I feel like short of protesting in the streets, I did everything I could to warn them," Ms. Sualog said of the administration. "They just didn't want to hear it."

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Did you find this information helpful? Yes No

In late 2021, she was moved out of her position. She filed a complaint with the federal office responsible for enforcing whistle-blower protection rules, arguing that she had been illegally retaliated against.

Last fall, the Office of the Inspector General released a report that discussed Ms. Sualog's case and several demotions and dismissals at the agency that "may have risen to the level of whistle-blower chilling."

Ms. Sualog settled with the agency, which agreed to pay her legal fees, and resigned last month.

An H.H.S. spokeswoman declined to comment on Ms. Sualog's complaint but said the agency does not retaliate against whistle-blowers. While some staffers disagreed with the administration's approach, the spokeswoman said, significant changes were needed to address the increase in unaccompanied migrant children.

Even as veteran employees left, others kept sounding alarms. In January, shortly before the Times investigation was published, a group of workers sent another memo to their H.H.S. bosses saying the system had resulted in unsafe discharges. "We are pulling humanity out of 'Health and Human Services,'" they wrote.

Troubling Trends

Social workers noted red flags in the Little Village neighborhood of Chicago, where hundreds of migrant children have been sent. Jamie Kelter Davis for The New York Times

Some of the most persistent warnings that children were being funneled into dangerous jobs came from outside the government. H.H.S. releases most children to sponsors without follow-up care, but it hires organizations to provide thousands of the most high-risk children with several months of support services.

Last spring, Matt Haygood, senior director of children's services at the U.S. Committee for Refugees and Immigrants, one of the largest of these organizations, sent an email with the subject line "Trafficking Concerns" to several H.H.S. officials.

"We have identified some troubling trends in the Chicago metro area," he wrote, including vans picking up children at odd hours, suggesting that they were being driven to factory jobs. Mr. Haygood asked if H.H.S. would consider adding the neighborhood to a watchlist, so that prospective sponsors there would be more closely vetted.

An H.H.S. staff member replied that more than 200 children, most of them Guatemalan, had recently been released to the neighborhood and confirmed that many of those cases had been marked as suspicious: Adults were sponsoring multiple children, and minors were working instead of attending school.

"There are certainly plenty of other concerning trafficking red flags," the staff member wrote. Mr. Haygood expected the agency to add more safeguards for children released to the area, Little Village. Instead, H.H.S. decided they were not needed.

In response to The Times, an H.H.S. spokeswoman said the department had already put protections in place for children being released to a few streets in the city and at the time saw expanding those measures as overreach.

At a small fast-food restaurant in Little Village one recent afternoon, Guatemalan teenagers played video games on their phones and flirted in Indigenous languages. Several said they worked full time overnight in factories, in violation of child labor laws. Few had enrolled in school.

A teenager looking at her phone at Dennis B&K, a small fast-food restaurant in Little Village. Some migrant children in the neighborhood said they worked overnight shifts at factories. Jamie Kelter Davis for The New York Times

One, Marvin Che, said he came to the United States last year, when he was 16, and had been working 12-hour overnight shifts alongside other migrant children packing products at the manufacturer Pactiv Evergreen, including Hefty plastic party cups. “We came alone, so we have to work hard,” Marvin said.

A spokeswoman for Pactiv Evergreen said that its company policy prohibited minors from working at manufacturing sites, and that it would make sure its staffing agencies were complying. A representative for Reynolds Consumer Products, which owns the Hefty brand, said Pactiv Evergreen no longer made its party cups.

Other social service organizations said they, too, had flagged clusters of suspicious cases, including in Nashville and Dallas.

“We’re waiting for the congressional hearing that’s like, ‘How did this happen to all these kids?’” Mr. Haygood said.

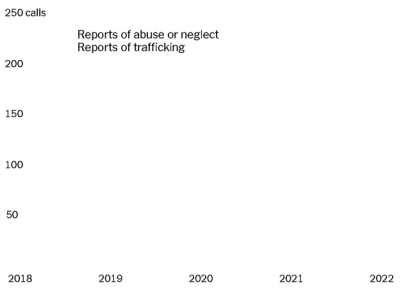
In the last two months, congressional leaders from both parties have questioned why so many migrant children ended up in exploitative jobs, and two oversight hearings are planned in the House on Tuesday.

An H.H.S. spokeswoman said the department was aware that some migrant children worked long hours because they are under intense pressure to earn money, but the agency’s legal responsibility for children ends once they are released. Still, the department is working to provide a few months of case management to all unaccompanied migrant children, she said.

For now, most children released to sponsors have little support aside from an H.H.S. hotline. According to internal documents obtained by The Times, reports of trafficking to that hotline increased by about 1,300 percent over the past five years.

Reports of Trafficking and Abuse of Migrant Children

Monthly calls to H.H.S. reporting trafficking, neglect or abuse of minors placed with sponsors.



Source: A New York Times analysis of data from the Department of Health and Human Services • By Eli Murray

In one call last year, a child living in Charlotte, N.C., said his sponsor had found him a job in a restaurant and told him "he needs to work to eat." In another, a child said his sponsor had never enrolled him in school after he was released from an El Paso shelter, and was forcing him to pay for rent and food.

The H.H.S. spokeswoman said the agency asks local law enforcement to check on children who might be in danger.

A Hard Life in Florida

Three boys from Guatemala who were released to the same sponsor in Florida and work full time in construction. "There are a lot of kids here living the same life," Antonio said. Kirsten Luce for The New York Times

Antonio arrived at the border shortly after turning 14, and spent several weeks at a shelter before moving to Florida. A former neighbor had agreed to be his sponsor, but Antonio, who had never spent a night away from his town, had not understood how isolated he would be in the United States.

He took jobs with employers willing to hire a child without a work permit — sometimes in landscaping and sometimes in housecleaning. He also enrolled in eighth grade and discovered that he loved biology.

He scraped by until the end of the school year, but he needed to earn more money. Instead of continuing to ninth grade, he found the job packing vegetables. He worked numbing shifts that left him chilled each night even though he worked in the heaviest jacket he could afford. A spokeswoman for the company, Jalaram Produce, said it does not hire minors.

Antonio had not told anyone back home how much he was struggling. "I don't want them to worry about me," he said. His father became more absent during the pandemic, and he knew his grandmother had no other way to feed his young sisters. He said he might feel less lonely after he turned 16 and qualified to enroll in night school.

Antonio called his middle school graduation the proudest day of his life. He bought a frame for his certificate and sent a photo to his siblings back home. Kirsten Luce for The New York Times

This was a common hope among migrant children in his neighborhood. A few blocks away, a boy working construction said he felt ashamed about not knowing how to read. He, too, was released in 2021 — at age 12 — and was immediately put to work by a man who had sponsored at least five children. At a day-labor pickup site, a 13-year-old released last year to a man he had never met said he wished he could enroll in middle school and start learning English.

“People don’t know,” Antonio said, “but there are a lot of kids here living the same life.”

Warning Signs

Inside the White House, Ms. Rice was at the center of the migrant children crisis. As she pressed to move children out of shelters more quickly, clues began to emerge about what was happening to them once they left.

In the summer of 2021, near the height of the crush at the border, H.H.S. managers wrote a memo detailing their worry about increasing reports that children were working alongside their sponsors, a sign of possible labor trafficking. Ms. Rice’s team received the memo, and Ms. Rice was also told what it said, according to two people familiar with the conversations.

Andrew J. Bates, White House deputy press secretary, disputed that, saying Ms. Rice “did not see the memo and was not made aware of its contents.”

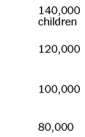
Around the same time, Ms. Rice’s team was told about concerns over a large group of children who had been released to one city in Alabama, according to six current and former staff members. The situation was the subject of frequent updates as H.H.S. sent case managers to the city to check on children, and coordinated with the Labor Department and Homeland Security Investigations to look into whether they were working in poultry plants.

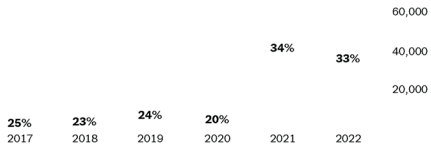
One former top White House adviser remembered thinking at the time that the development was worrisome and that it suggested other cases could be going overlooked.

A White House spokeswoman denied that senior officials were told about the situation.

A few months later, Ms. Rice’s staff learned that H.H.S. could not reach a growing number of migrant children just a month after their release, according to a former senior White House official.

Losing Track of Sponsored Children
An increasing share of migrant children **could not be reached** by H.H.S. after a month.





Source: A New York Times analysis of data from the Department of Health and Human Services • Note: Cases where children were marked "not applicable" as participants in a followup contact by H.H.S. were excluded. • By Eli Murray and Michael H. Keller

But the White House largely treated these as discrete events, not as signs of a mounting problem.

Tyler Moran, Mr. Biden's senior adviser for migration at the time, said she relied on H.H.S. to tell her how to weigh information, such as the memo from the department's worried managers and the calls to children that were going unanswered. Staff members, she said, had not pointed to a broader child labor crisis. "The White House deferred to the agencies to let us know when things were really a problem," Ms. Moran said.

The Department of Labor was sending up signals of its own. In 2022, investigators began uncovering signs of migrant child labor inside industrial workplaces, including several auto part factories in the South. The department put out news releases warning of a rise in child labor violations.

Last summer, labor investigators began a major operation at a sanitation company that eventually found that more than 100 mostly Spanish-speaking children were working the overnight shift scouring meatpacking plants around the country. Many of the children had come through the migrant shelter system and been released to sponsors.

As investigators found more and more migrant children working for the cleaning company around the country, H.H.S. briefed Ms. Rice's team about the situation regularly over a period of months, according to two people familiar with the conversations.

The Labor Department also included details about the sanitation company and auto parts operations in weekly cabinet-level reports. "It was like, 'We have problems here,'" said Martin J. Walsh, the secretary of labor until last month. "We sent reports to the White House, so they knew we were working on this stuff."

When the Labor Department updated its public dashboard in December, it showed a 69 percent increase in child labor violations since 2018.

A spokeswoman for the Labor Department said that the White House had been aware of the rise in child labor because it was widely public. But Mr. Bates, the White House deputy press secretary, said officials there had not known of the increase in child labor until The Times's February report.

'At Least I'm Helping'

"What I want most for Antonio is for him to be able to go back to school," said Pastor Abel Gomez, left, who leads the Spanish-language church that Antonio attends. Kirsten Luce for The New York Times

Even after Ms. Brandmiller's warnings, the man who had sponsored Antonio, Juan Rivera, was allowed to receive another boy: He said he sponsored a 15-year-old and set him up with a job on a palm tree plantation.

Mr. Rivera said in an interview that he had done Antonio a favor by helping him come to the United States. He kept records of his expenses, including the cost of picking up Antonio after he left the shelter, food and clothes when he first arrived, and a twin-size mattress for his shared room. The debt had taken Antonio about a year to pay off.

He said he occasionally saw Antonio in the area and assumed that he was working hard and sending money home. "American kids just study, but our kids are poor and have to work," he said. "One has to suffer to earn a little money here."

This spring, Antonio's landlord decided the house had become overcrowded. Antonio found a new home, but the rent was twice as high. He changed jobs again, picking up better-paying day labor shifts, and said he no longer hoped to attend night school. Instead, he is trying to save several thousand dollars to hire a lawyer who might help him secure a permit to work legally, in a less grueling job.

"I need to earn lot of money now," Antonio said. "It's gotten hard, but at least I'm helping."

On Sundays, he attends a Spanish-language church with a vibrant youth group. The pastor, Abel Gomez, said Antonio sometimes sits with him after the service and cries about the pressure he feels.

"What I want most for Antonio is for him to be able to go back to school," Mr. Gomez said. "But I know it's complicated for him because there's no one to support him."

Mr. Gomez said he would like to help young congregants like Antonio more — even take them in. But it would be impossible. There are too many in the same situation, and more seem to arrive each week.

Ana Ley contributed reporting. Kitty Bennett contributed research.

Hannah Dreier is a Pulitzer Prize-winning reporter on the investigations team. Email her at hannah.dreier@nytimes.com. More about Hannah Dreier

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Migrant Children Worked As U.S. Ignored Warnings

The New York Times https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html

Alone and Exploited, Migrant Children Work Brutal Jobs Across the U.S.

Arriving in record numbers, they're ending up in dangerous jobs that violate child labor laws — including in factories that make products for well-known brands like Cheetos and Fruit of the Loom.

By Hannah Dreier Photographs by Kirsten Luce

Hannah Dreier traveled to Alabama, Florida, Georgia, Michigan, Minnesota, South Dakota and Virginia for this story and spoke to more than 100 migrant child workers in 20 states.
hannah.dreier@nytimes @hannahdreier

Published Feb. 25, 2023 Updated Feb. 28, 2023

Cristian works a construction job instead of going to school. He is 14.

Carolina packages Cheerios at night in a factory. She is 15.

Wander starts looking for day-labor jobs before sunrise. He is



13.



It was almost midnight in Grand Rapids, Mich., but inside the factory everything was bright. A conveyor belt carried bags of Cheerios past a cluster of young workers. One was 15-year-old Carolina Yoc, who came to the United States on her own last year to live with a relative she had never met.

About every 10 seconds, she stuffed a sealed plastic bag of cereal into a passing yellow carton. It could be dangerous work, with fast-moving pulleys and gears that had torn off fingers and ripped open a woman's scalp.

The factory was full of underage workers like Carolina, who had crossed the Southern border by themselves and were now spending late hours bent over hazardous machinery, in violation of child labor laws. At nearby plants, other children were tending giant ovens to make Chewy and Nature Valley granola bars and packing bags of Lucky Charms and Cheetos — all of them working for the processing giant Hearthside Food Solutions, which would ship these products around the country.

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"Sometimes I get tired and feel sick," Carolina said after a shift in November. Her stomach often hurt, and she was unsure if that was because of the lack of sleep, the stress from the incessant roar of the machines, or the worries she had for herself and her family in Guatemala. "But I'm getting used to it."



Hearthside Food Solutions, one of the United States' largest food contractors, makes and packages products for well-known snack and cereal brands. Kirsten Luce for The New York Times

These workers are part of a new economy of exploitation: Migrant children, who have been coming into the United States without their parents in record numbers, are ending up in some of the most punishing jobs in the country, a New York Times investigation found. This shadow work force extends across industries in every state, flouting child labor laws that have been in place for nearly a century. Twelve-year-old roofers in Florida and Tennessee. Underage slaughterhouse workers in Delaware, Mississippi and North Carolina. Children sawing planks of wood on overnight shifts in South Dakota.

Largely from Central America, the children are driven by economic desperation that was worsened by the pandemic. This labor force has been slowly growing for almost a decade, but it has exploded since 2021, while the systems meant to protect children have broken down.

The Times spoke with more than 100 migrant child workers in 20 states who described jobs that were grinding them into exhaustion, and fears that they had become trapped in circumstances they never could have imagined. The Times examination also drew on court and inspection records and interviews with hundreds of lawyers, social workers, educators and law enforcement officials.

In town after town, children scrub dishes late at night. They run milking machines in Vermont and deliver meals in New York City. They harvest coffee and build lava rock walls around vacation homes in Hawaii. Girls as young as 13 wash hotel sheets in Virginia.



Oscar Lopez, a ninth grader, works overnight at a sawmill in South Dakota. On this day, he skipped school to sleep after a 14-hour shift. Kirsten Luce for The New York Times

In many parts of the country, middle and high school teachers in English-language learner programs say it is now common for nearly all their students to rush off to long shifts after their classes end.

"They should not be working 12-hour days, but it's happening here," said Valeria Lindsay, a language arts teacher at Homestead Middle School near Miami. For the past three years, she said, almost every eighth grader in her English learner program of about 100 students was also carrying an adult workload.

Migrant child labor benefits both under-the-table operations and global corporations, The Times found. In Los Angeles, children stitch "Made in America" tags into J. Crew shirts. They bake dinner rolls sold at Walmart and Target, process milk used in Ben & Jerry's ice cream and help debone chicken sold at Whole Foods. As recently as the fall, middle-schoolers made Fruit of the Loom socks in Alabama. In Michigan, children make auto parts used by Ford and General Motors.

The number of unaccompanied minors entering the United States climbed to a high of 130,000 last year — three times what it was five years earlier — and this summer is expected to bring another wave.

These are not children who have stolen into the country undetected. The federal government knows they are in the United States, and the Department of Health and Human Services is responsible for ensuring sponsors will support them and protect them from trafficking or exploitation.

But as more and more children have arrived, the Biden White House has ramped up demands on staffers to move the children quickly out of shelters and release them to adults. Caseworkers say they rush through vetting sponsors.

While H.H.S. checks on all minors by calling them a month after they begin living with their sponsors, data obtained by The Times showed that over the last two years, the agency could not reach more than 85,000 children. Overall, the agency lost immediate contact with a third of migrant children.

An H.H.S. spokeswoman said the agency wanted to release children swiftly, for the sake of their well-being, but had not compromised safety. "There are numerous places along the process to continually ensure that a placement is in the best interest of the child," said the spokeswoman, Kamara Jones.

Far from home, many of these children are under intense pressure to earn money. They send cash back to their families while often being in debt to their sponsors for smuggling fees, rent and living expenses.

"It's getting to be a business for some of these sponsors," said Annette Passalacqua, who left her job as a caseworker in Central Florida last year. Ms. Passalacqua said she saw so many children put to work, and found law enforcement officials so unwilling to investigate these cases, that she largely stopped reporting them. Instead, she settled for explaining to the children that they were entitled to lunch breaks and overtime.

Sponsors are required to send migrant children to school, and some students juggle classes and heavy workloads. Other children arrive to find that they have been misled by their sponsors and will not be enrolled in school.

The federal government hires child welfare agencies to track some minors who are deemed to be at high risk. But caseworkers at those agencies said that H.H.S. regularly ignored obvious signs of labor exploitation, a characterization the agency disputed.

In interviews with more than 60 caseworkers, most independently estimated that about two-thirds of all unaccompanied migrant children ended up working full time.

A representative for Hearthside said the company relied on a staffing agency to supply some workers for its plants in Grand Rapids, but conceded that it had not required the agency to verify ages through a national system that checks Social Security numbers. Unaccompanied migrant children often obtain false identification to secure work.

"We are immediately implementing additional controls to reinforce all agencies' strict compliance with our longstanding requirement that all workers must be 18 or over," the company said in a statement.

At Union High School in Grand Rapids, Carolina's ninth-grade social studies teacher, Rick Angstman, has seen the toll that long shifts take on his students. One, who was working nights at a commercial laundry, began passing out in class from fatigue and was hospitalized twice, he said. Unable to stop working, she dropped out of school.

"She disappeared into oblivion," Mr. Angstman said. "It's the new child labor. You're taking children from another country and putting them in almost indentured servitude."

On the Night Shift



Children being processed by the U.S. Border Patrol in Roma, Texas. In the past two years alone, 250,000 unaccompanied minors have come into the country. Kirsten Luce for The New York Times

When Carolina left Guatemala, she had no real understanding of what she was heading toward, just a sense that she could not stay in her village any longer. There was not much electricity or water, and after the pandemic began, not much food.

The only people who seemed to be getting by were the families living off remittances from relatives in the United States. Carolina lived alone with her grandmother, whose health began failing. When neighbors started talking about heading north, she decided to join. She was 14.

"I just kept walking," she said.

Carolina reached the U.S. border exhausted, weighing 84 pounds. Agents sent her to an H.H.S. shelter in Arizona, where a caseworker contacted her aunt, Marcelina Ramirez. Ms. Ramirez was at first reluctant: She had already sponsored two other relatives and had three children of her own. They were living on $600 a week, and she didn't know Carolina.

When Carolina arrived in Grand Rapids last year, Ms. Ramirez told her she would go to school every morning and suggested that she pick up evening shifts at Hearthside. She knew Carolina needed to send money back to her grandmother. She also believed it was good for young people to work. Child labor is the norm in rural Guatemala, and she herself had started working around the second grade.

One of the nation's largest contract manufacturers, Hearthside makes and packages food for companies like Frito-Lay, General Mills and Quaker Oats. "It would be hard to find a cookie or cracker aisle in any leading grocer that does not contain multiple products from Hearthside production facilities," a Grand Rapids-area plant manager told a trade magazine in 2019.

General Mills, whose brands include Cheerios, Lucky Charms and Nature Valley, said it recognized "the seriousness of this situation" and was reviewing The Times's findings. PepsiCo, which owns Frito-Lay and Quaker Oats, declined to comment.

Three people who until last year worked at one of the biggest employment agencies in Grand Rapids, Forge Industrial Staffing, said Hearthside supervisors were sometimes made aware that they were getting young-looking workers whose identities had been flagged as false.

"Hearthside didn't care," said Nubia Malacara, a former Forge employee who said she had also worked at Hearthside as a minor.

In a statement, Hearthside said, "We do care deeply about this issue and are concerned about the mischaracterization of Hearthside." A spokesman for Forge said it complied with state and federal laws and "would never knowingly employ individuals under 18."

Kevin Tomas said he sought work through Forge after he arrived in Grand Rapids at age 13 with his 7-year-old brother. At first, he was sent to a local manufacturer that made auto parts for Ford and General Motors. But his shift ended at 6:30 in the morning, so he could not stay awake in school, and he struggled to lift the heavy boxes.

"It's not that we want to be working these jobs. It's that we have to help our families," Kevin said.

By the time he was 15, Kevin had found a job at Hearthside, stacking 50-pound cases of cereal on the same shift as Carolina.

'So Many Red Flags'



Cristian, 14, has been working in construction in North Miami for two years instead of going to school. Federal law bars minors from a long list of such jobs. Kirsten Luce for The New York Times

The growth of migrant child labor in the United States over the past several years is a result of a chain of willful ignorance. Companies ignore the young faces in their back rooms and on their factory floors. Schools often decline to report apparent labor violations, believing it will hurt children more than help. And H.H.S. behaves as if the migrant children who melt unseen into the country are doing just fine.

"As the government, we've turned a blind eye to their trafficking," said Doug Gilmer, the head of the Birmingham, Ala., office of Homeland Security Investigations, a federal agency that often becomes involved with immigration cases.

Mr. Gilmer teared up as he recalled finding 13-year-olds working in meat plants; 12-year-olds working at suppliers for Hyundai and Kia, as documented last year by a Reuters investigation; and children who should have been in middle school working at commercial bakeries.

"We're encountering it here because we're looking for it here," Mr. Gilmer said. "It's happening everywhere."

Children have crossed the Southern border on their own for decades, and since 2008, the United States has allowed non-Mexican minors to live with sponsors while they go through immigration proceedings, which can take several years. The policy, codified in anti-trafficking legislation, is intended to prevent harm to children who would otherwise be turned away and left alone in a Mexican border town.

When Kelsey Keswani first worked as an H.H.S. contractor in Arizona to connect unaccompanied migrant children with sponsors in 2010, the adults were almost always the children's parents, who had paid smugglers to bring them up from Central America, she said.

But around 2014, the number of arriving children began to climb, and their circumstances were different. In recent years, "the kids almost all have a debt to pay off, and they're super stressed about it," Ms. Keswani said.

She began to see more failures in the vetting process. "There were so many cases where sponsors had sponsored multiple kids, and it wasn't getting caught. So many red flags with debt. So many reports of trafficking."

Now, just a third of migrant children are going to their parents. A majority are sent to other relatives, acquaintances or even strangers, a Times analysis of federal data showed. Nearly half are coming from Guatemala, where poverty is fueling a wave of migration. Parents know that they would be turned away at the border or quickly deported, so they send their children in hopes that remittances will come back.

In the last two years alone, more than 250,000 children have entered the United States by themselves.

The shifting dynamics in Central America helped create a political crisis early in Mr. Biden's presidency, when children started crossing the border faster than H.H.S. could process them. With no room left in shelters, the children stayed in jail-like facilities run by Customs and Border Protection and, later, in tent cities. The images of children sleeping on gym mats under foil blankets attracted intense media attention.

The Biden administration pledged to move children through the shelter system more quickly. "We don't want to continue to see a child languish in our care if there is a responsible sponsor," Xavier Becerra, secretary of health and human services, told Congress in 2021.



A detention site in the Rio Grande Valley in March 2021. The Biden administration has faced pressure to move unaccompanied children through the system quickly. Pool photo by Dario Lopez-Mills

His agency began paring back protections that had been in place for years, including some background checks and reviews of children's files, according to memos reviewed by The Times and interviews with more than a dozen current and former employees.

"Twenty percent of kids have to be released every week or you get dinged," said Ms. Keswani, who stopped working with H.H.S. last month.

Concerns piled up in summer 2021 at the Office of Refugee Resettlement, the H.H.S. division responsible for unaccompanied migrant children. In a memo that July, 11 managers said they were worried that labor trafficking was increasing and complained to their bosses that the office had become "one that rewards individuals for making quick releases, and not one that rewards individuals for preventing unsafe releases."

Staff members said in interviews that Mr. Becerra continued to push for faster results, often asking why they could not discharge children with machine-like efficiency.

"If Henry Ford had seen this in his plants, he would have never become famous and rich. This is not the way you do an assembly line," Mr. Becerra said at a staff meeting last summer, according to a recording obtained by The Times.

The H.H.S. spokeswoman, Ms. Jones, said that Mr. Becerra had urged his staff to "step it up." "Like any good leader, he wouldn't hesitate to do it again — especially when it comes to the well-being and safety of children," she said.

During a call last March, Mr. Becerra told Cindy Huang, the O.R.R. director, that if she could not increase the number of discharges, he would find someone who could, according to five people familiar with the call. She resigned a month later.

He recently made a similar threat to her successor during a meeting with senior leadership, according to several people who were present.

'It Was All Lies'



Migrant children were among the day laborers who gathered on a school day in Homestead, Fla., to find roofing, landscaping or other work. Kirsten Luce for The New York Times

While many migrant children are sent to the United States by their parents, others are persuaded to come by adults who plan to profit from their labor.

Nery Cutzal was 13 when he met his sponsor over Facebook Messenger. Once Nery arrived in Florida, he discovered that he owed more than $4,000 and had to find his own place to live. His sponsor sent him threatening text messages and kept a running list of new debts: $140 for filling out H.H.S. paperwork; $240 for clothes from Walmart; $45 for a taco dinner.

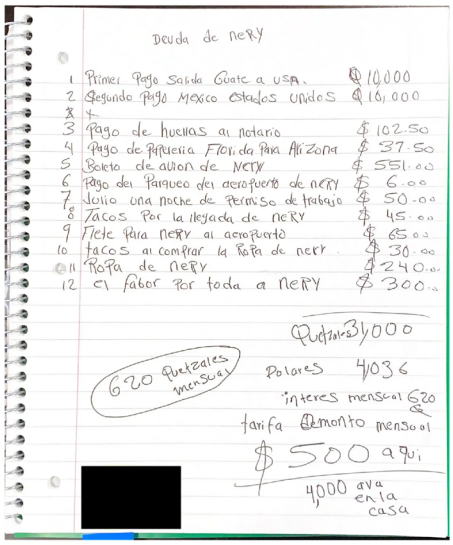
“Don’t mess with me,” the sponsor wrote. “You don’t mean anything to me.”

Nery began working until 3 a.m. most nights at a trendy Mexican restaurant near Palm Beach to make the payments. “He said I would be able to go to school and he would take care of me, but it was all lies,” Nery said.

His father, Leonel Cutzal, said the family had become destitute after a series of bad harvests and had no choice but to send their oldest son north from Guatemala.

“Even when he shares $50, it’s a huge help,” Mr. Cutzal said. “Otherwise, there are times we don’t eat.” Mr. Cutzal had not understood how much Nery would be made to work, he said. “I think he passed through some hard moments being up there so young.”

Nery eventually contacted law enforcement, and his sponsor was found guilty last year of smuggling a child into the United States for financial gain. That outcome is rare: In the past decade, federal prosecutors have brought only about 30 cases involving forced labor of unaccompanied minors, according to a Times review of court databases.



A handwritten ledger, in Spanish, of Nery Cutzal’s debts to his sponsor, including money for tacos and clothes. The child owed more than $4,000, plus interest. Court information has been redacted for privacy.

Unlike the foster care system, in which all children get case management, H.H.S. provides this service to about a third of children who pass through its care, and usually for just four months. Tens of thousands of other children are sent to their sponsors with little but the phone number for a national hotline. From there, they are often on their own: There is no formal follow-up from any federal or local agencies to ensure that sponsors are not putting children to work illegally.

In Pennsylvania, one case worker told The Times he went to check on a child released to a man who had applied to sponsor 20 other minors. The boy had vanished. In Texas, another case worker said she had encountered a man who had been targeting poor families in Guatemala, promising to help them get rich if they sent their children across the border. He had sponsored 13 children.

“If you’ve been in this field for any amount of time, you know that there’s what the sponsors agree to, and what they’re actually doing,” said Bernal Cruz Munoz, a caseworker supervisor in Oregon.

Calling the hotline is not a sure way to get support, either. Juanito Ferrer called for help after he was brought to Manassas, Va., at age 15 by an acquaintance who forced him to paint houses during the day and guard an apartment complex at night. His sponsor took his paychecks and watched him on security cameras as he slept on the basement floor.

Juanito said that when he called the hotline in 2019, the person on the other end just took a report. “I thought they’d send the police or someone to check, but they never did that,” he said. “I thought they would come and inspect the house, at least.” He eventually escaped.

Asked about the hotline, H.H.S. said operators passed reports onto law enforcement and other local agencies because the agency did not have the authority to remove children from homes.

The Times analyzed government data to identify places with high concentrations of children who had been released to people outside their immediate families — a sign that they might have been expected to work. In northwest Grand Rapids, for instance, 93 percent of children have been released to adults who are not their parents.

H.H.S. does not track these clusters, but the trends are so pronounced that officials sometimes notice hot spots anyway.

Scott Lloyd, who led the resettlement office in the Trump administration, said he realized in 2018 that the number of unaccompanied Guatemalan boys being released to sponsors in South Florida seemed to be growing.



Jose Vasquez, 13, photographed at the church he attends in Grand Rapids, Mich. He works 12-hour shifts, six days a week, at an egg farm outside the city. Kirsten Luce for The New York Times

“I always wondered what was happening there,” he said.

But his attention was diverted by the chaos around the Trump administration’s child separation policy, and he never looked into it. The trend he saw has only accelerated: For example, in the past three years, more than 200 children have been released to distant relatives or unrelated adults around Immokalee, Fla., an agricultural hub with a long history of labor exploitation.

In a statement, H.H.S. said it had updated its case management system to better flag instances when multiple children were being released to the same person or address.

Many sponsors see themselves as benevolent, doing a friend or neighbor a favor by agreeing to help a child get out of a government shelter, even if they do not intend to offer any support. Children often understand that they will have to work, but do not grasp the unrelenting grind that awaits them.

“I didn’t get how expensive everything was,” said 13-year-old Jose Vasquez, who works 12-hour shifts, six days a week, at a commercial egg farm in Michigan and lives with his teenage sister. “I’d like to go to school, but then how would I pay rent?”

Occupational Hazards



Carolina Yoc, back right, worked on math problems after a night shift at a Grand Rapids food plant. The 13-year-old girl sitting next to her said she also worked nights at a factory. Kirsten Luce for The New York Times

One fall morning at Union High School in Grand Rapids, Carolina listened to Mr. Angstman lecture on the journalist Jacob Riis and the Progressive Era movement that helped create federal child labor laws. He explained that the changes were meant to keep young people out of jobs that could harm their health or safety, and showed the class a photo of a small boy making cigars.

"Riis reported that members of this family worked 17 hours a day, seven days a week," he told the students. "The cramped space reeked of toxic fumes." Students seemed unmoved. Some struggled to stay awake.

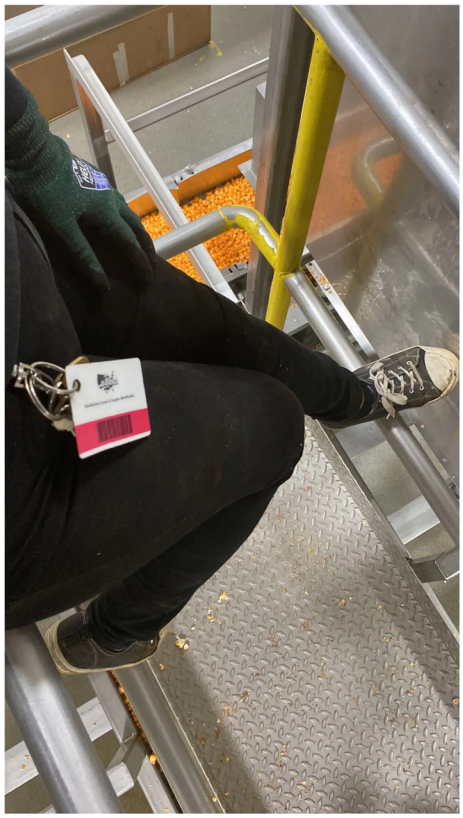
Teachers at the school estimated that 200 of their immigrant students were working full time while trying to keep up with their classes. The greatest share of Mr. Angstman's students worked at one of the four Hearthside plants in the city.

The company, which has 39 factories in the United States, has been cited by the Occupational Safety and Health Administration for 34 violations since 2019, including for unsafe conveyor belts at the plant where Carolina found her job. At least 11 workers suffered amputations in that time. In 2015, a machine caught the hairnet of an Ohio worker and ripped off part of her scalp.

The history of accidents "shows a corporate culture that lacks urgency to keep workers safe," an OSHA official wrote after the most recent violation for an amputation.

Underage workers in Grand Rapids said that spicy dust from immense batches of Flamin' Hot Cheetos made their lungs sting, and that moving heavy pallets of cereal all night made their backs ache. They worried about their hands getting caught in conveyor belts, which federal law classifies as so hazardous that no child Carolina's age is permitted to work with them.

Hearthside said in a statement that it was committed to complying with laws governing worker protections. "We strongly dispute the safety allegations made and are proud of our safety-first culture," the statement read.



A selfie taken by a 17-year-old at a Hearthside facility in Grand Rapids. She said older men at the factory sometimes harassed her.

Federal law bars minors from a long list of dangerous jobs, including roofing, meat processing and commercial baking. Except on farms, children younger than 16 are not supposed to work for more than three hours or after 7 p.m. on school days.

But these jobs — which are grueling and poorly paid, and thus chronically short-staffed — are exactly where many migrant children are ending up. Adolescents are twice as likely as adults to be seriously injured at work, yet recently arrived preteens and teenagers are running industrial dough mixers, driving massive earthmovers and burning their hands on hot tar as they lay down roofing shingles, The Times found.

Unaccompanied minors have had their legs torn off in factories and their spines shattered on construction sites, but most of these injuries go uncounted. The Labor Department tracks the deaths of foreign-born child workers but no longer makes them public. Reviewing state and federal safety records and public reports, The Times found a dozen cases of young migrant workers killed since 2017, the last year the Labor Department reported any.

The deaths include a 14-year-old food delivery worker who was hit by a car while on his bike at a Brooklyn intersection; a 16-year-old who was crushed under a 35-ton tractor-scraper outside Atlanta; and a 15-year-old who fell 50 feet from a roof in Alabama where he was laying down shingles.



From left: Oscar Nambo Dominguez, 16, was crushed last year under an earthmover near Atlanta. Edwin Ajacalon, 14, was hit by a car while delivering food on a bike in Brooklyn. Juan Mauricio Ortiz, 15, died on his first day of work for an Alabama roofing company when he fell about 50 feet.

In 2021, Karla Campbell, a Nashville labor lawyer, helped a woman figure out how to transport the body of her 14-year-old grandson, who had been killed on a landscaping job, back to his village in Guatemala. It was the second child labor death she had handled that year.

“I’ve been working on these cases for 15 years, and the addition of children is new,” Ms. Campbell said.

In dairy production, the injury rate is twice the national average across all industries. Paco Calvo arrived in Middlebury, Vt., when he was 14 and has been working 12-hour days on dairy farms in the four years since. He said he crushed his hand in an industrial milking machine in the first months of doing this work.

“Pretty much everyone gets hurt when they first start,” he said.

Targeting the Middlemen



Young workers exited an overnight cleaning shift last October at a JBS pork plant in Worthington, Minn. Their employer, a sanitation company, was later fined for violating child labor laws. Kirsten Luce for The New York Times

Charlene Irizarry, the human resources manager at Farm Fresh Foods, an Alabama meat plant that struggles to retain staff, recently realized she was interviewing a 12-year-old for a job slicing chicken breasts into nuggets in a section of the factory kept at 40 degrees.

Ms. Irizarry regularly sees job applicants who use heavy makeup or medical masks to try to hide their youth, she said. “Sometimes their legs don’t touch the floor.”

Other times, an adult will apply for a job in the morning, and then a child using the same name will show up for orientation that afternoon. She and her staff have begun separating other young applicants from the adults who bring them in, so they will admit their real ages.

Ms. Irizarry said the plant had already been fined for one child labor violation, and she was trying to avoid another. But she wondered what the children might face if she turned them away.

“I worry about why they’re so desperate for these jobs,” she said.

In interviews with underage migrant workers, The Times found child labor in the American supply chains of many major brands and retailers. Several, including Ford, General Motors, J. Crew and Walmart, as well as their suppliers, said they took the allegations seriously and would investigate. Target and Whole Foods did not respond to requests for comment. Fruit of the Loom said it had ended its contract with the supplier.

One company, Ben & Jerry’s, said it worked with labor groups to ensure a minimum set of working conditions at its dairy suppliers. Cheryl Pinto, the company’s head of values-led sourcing, said that if migrant children needed to work full time, it was preferable for them to have jobs at a well-monitored workplace.

The Labor Department is supposed to find and punish child labor violations, but inspectors in a dozen states said their understaffed offices could barely respond to complaints, much less open original investigations. When the department has responded to tips on migrant children, it has focused on the outside contractors and staffing agencies that usually employ them, not the corporations where they

perform the work.

In Worthington, Minn., it had long been an open secret that migrant children released by H.H.S. were cleaning a slaughterhouse run by JBS, the world's largest meat processor. The town has received more unaccompanied migrant children per capita than almost anywhere in the country.

Outside the JBS pork plant last fall, The Times spoke with baby-faced workers who chased and teased one another as they came off their shifts in the morning. Many had scratched their assumed names off company badges to hide evidence that they were working under false identities. Some said they had suffered chemical burns from the corrosive cleaners they used.

Not long afterward, labor inspectors responding to a tip found 22 Spanish-speaking children working for the company hired to clean the JBS plant in Worthington, and dozens more in the same job at meat-processing plants around the United States.

But the Labor Department can generally only issue fines. The cleaning company paid a $1.5 million penalty, while JBS said it had been unaware that children were scouring the Worthington factory each night. JBS fired the cleaning contractor.

Many of the children who were working there have found new jobs at other plants, The Times found.

"I still have to pay back my debt, so I still have to work," said Mauricio Ramirez, 17, who has found a meat processing job in the next town over.

'Not What I Imagined'



Cristian Lopez, 16, pictured with his 12-year-old sister, Jennifer, works at a Hearthside facility in Grand Rapids. Kirsten Luce for The New York Times

It has been a little more than a year since Carolina left Guatemala, and she has started to make some friends. She and another girl who works at Hearthside have necklaces that fit together, each strung with half a heart. When she has time, she posts selfies online decorated with smiley faces and flowers.

Mostly, though, she keeps to herself. Her teachers do not know many details about her journey to the border. When the topic came up at school recently, Carolina began sobbing and would not say why.

After a week of 17-hour days, she sat at home one night with her aunt and considered her life in the United States. The long nights. The stress about money. "I didn't have expectations about what life would be like here," she said, "but it's not what I imagined."

She was holding a debit card given to her by a staffing agency, which paid her Hearthside salary this way so she did not have to cash checks. Carolina turned it over and over in her palm as her aunt looked on.

"I know you get sad," Ms. Ramirez said.

Carolina looked down. She wanted to continue going to school to learn English, but she woke up most mornings with a clenched stomach and kept staying home sick. Some of her ninth grade classmates had already dropped out. The 16-year-old boy she sat next to in math class, Cristian Lopez, had left school to work overtime at Hearthside.

Cristian lived a few minutes away, in a bare two-room apartment he shared with his uncle and 12-year-old sister, Jennifer.

His sister did not go to school either, and they had spent the day bickering in their room. Now night had fallen and they were eating Froot Loops for dinner. The heat was off, so they wore winter jackets. In an interview from Guatemala, their mother, Isabel Lopez, cried as she explained that she had tried to join her children in the United States last year but was turned back at the border.

Cristian had given his uncle some of the money he earned making Chewy bars, but his uncle believed it was not enough. He had said he would like Jennifer to start working at the factory as well, and offered to take her to apply himself.

Cristian said he had recently called the H.H.S. hotline. He hoped the government would send someone to check on him and his sister, but he had not heard back. He did not think he would call again.

Research was contributed by Andrew Fischer, Seamus Hughes, Michael H. Keller and Julie Tate.

Hannah Dreier is a Pulitzer Prize-winning reporter on the investigations team. hannah.dreier@nytimes
More about Hannah Dreier

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Alone, Underage and Exploited for Labor

THE TENNESSEAN

CONTRIBUTORS | Opinion *This piece expresses the views of its author(s), separate from those of this publication.*

Hospitals for teens with gender dysphoria shouldn't be political battlegrounds | Opinion

I have questions about what age appropriate healthcare looks like for young people with gender dysphoria, but politicians should not be the ones making these decisions for teens and their parents.

Anna Caudill Guest Columnist

Published 2:12 p.m. CT Oct. 31, 2022 | Updated 2:13 p.m. CT Oct. 31, 2022

Key Points

Anna Caudill is executive director of Post Adoption Learning Services, a member of the Council of Parent Attorneys and Advocates, and mother to two children with disabilities.

When our church community helped us adopt two disabled young boys, I had no idea how hard parenting would be.

I was unprepared for the crushing helpless feeling every time a doctor said one of them needed surgery. I told adoption advocate Mary Beth Chapman more than once that if we could see around the bend in the road, we'd be afraid to go on.

More than once, our Sunday School class prayed us through, reminding me that we were never alone but seen and loved. The rare vacation was always within a half hour of a strong children's hospital, just in case. We joked that the Ronald McDonald House was our summer home.

We persevered, in no small part thanks to the dedicated child life specialists, pediatric nurses, and physicians of children's hospitals. Because of them, my children are not afraid when they head into a hospital for annual ultrasounds or lab work. My sons trust that when they enter a children's hospital, they are safe.

That's why I cannot understand why any elected official would ever try to put Vanderbilt University Medical Center patients or physicians in danger.

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'Intentional campaign of disinformation' harms children

Several Tennessee officials recently joined forces regarding claims that VUMC's does genital reassignment surgeries on young children without parental consent, a claim the hospital says is untrue. Before Vanderbilt confirmed to legislators that they have treated an average of five patients a year since 2018, none younger than 16 and none involving genital alteration, U.S. Sen. Marsha Blackburn joined Tennessee's GOP leadership to echo these claims.

Setting aside how many patients that is, their ages, or how Vanderbilt could guarantee payment for surgeries performed on minors without parental consent — there is the very real issue of the danger these lies can cause.

A similar campaign was focused against Boston Children's Hospital recently. After weeks of the same kind of lies as the ones that have been brought against Vanderbilt, a Massachusetts woman called in a bomb threat, resulting in a lockdown of that clinic along with the entire Children's Hospital campus.

Within days, the American Academy of Pediatrics, American Medical Association, and Children's Hospital Association—Vanderbilt Children's is a member — sent a joint statement begging the Department of Justice for protection from "coordinated attacks...rooted in an intentional campaign of disinformation...resulting in a rapid escalation of threats, harassment, and disruption of care."

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A hospital lockdown is terrifying

The helpless feeling of watching my child in pain is nothing compared to a hospital lockdown. In 2012, the summer my then 7-year-old lay in traction for 46 days following a grueling pelvic reconstruction, a woman became violent in the dead of night. At 2 in the morning I was jolted awake by the lockdown announcement, and police rushed past our room.

I drew the shades. My son slept on, his legs held straight by weights hanging from the bed's edge. I'd topped each of the pins holding his pelvis together with a tiny eraser in the shape of a Disney character so they wouldn't seem so scary to him. More police filed past. I wedged a

chair against the door and tried to gauge whether I could disconnect the hospital bed and squeeze it into the patient bathroom. Would it buy a few more minutes of life? Would it matter? Had we gone through six weeks of hell, with a daily care regimen that sent my baby screaming, to die like this?

Gov. Bill Lee, Senator Blackburn and state Sen. Jack Johnson, and Rep. William Lamberth know what happened to Boston Children's Hospital. They're experienced enough to know there were children terrified in their hospital rooms that day, chemo that was postponed and ambulances that were diverted elsewhere. They know this is no responsible way to represent Tennesseans or the children who come from all over the world for care at one of America's top ten pediatric hospitals.

Sign up for Black Tennessee Voices newsletter:*Read compelling columns by Black writers from across Tennessee.*

Politicians shouldn't make health care decisions for parents

There is nothing helpful, moral, or remotely Christian about knowingly endangering over 100,000 children's lives this year to debate the healthcare choices of five patients. What is the end goal of disrupting the relationship between disabled and sick children and healthcare providers?

Children's hospitals are not a political battleground.

Even though I have questions about what age appropriate healthcare looks like for young people with gender dysphoria, I know without a doubt that politicians should not be the ones making these life altering decisions for teens and their parents.

I also know children who don't have gender dysphoria but do have other conditions requiring gender-affirming treatment.

And as a Christian and a mother to two boys whose lives depend on safe hospitals, I know we can and should have these conversations without resorting to lies and terrorizing children and doctors.

I expect my elected officials to keep children safe from domestic terror threats, not to provoke them for the sake of winning a midterm election.

Anna Caudill is executive director of Post Adoption Learning Services, a member of the Council of Parent Attorneys and Advocates, and mother to two children with disabilities. She

was named a 2013 Angel in Adoption by the Congressional Coalition on Adoption.

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June 6, 2023

The Honorable Virginia Foxx
Chair
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

Dear Chair Foxx:

We write to request that you schedule a hearing to examine the illegal employment of children in unsafe conditions, in violation of both the *Fair Labor Standards Act* (FLSA) and the *Occupational Safety and Health Act* (OSH Act). Proper oversight requires that Committee members have the opportunity to explore the scope of the problem and proposed legislation that has been referred to our Committee that would help address it.

"A self-supporting and self-respecting democracy can plead no justification for the existence of child labor," President Franklin Delano Roosevelt proclaimed in a 1937 message to Congress to support passage of FLSA.[1] Nevertheless, as we near the 85th anniversary of that landmark law later this month, the "existence of child labor" still looms large. High-profile exposés of companies illegally employing and overworking children in dangerous jobs[2] put a face on the

[1] *Message to Congress on Establishing Minimum Wages and Maximum Hours*, THE AMER. PRES. PROJ., https://www.presidency.ucsb.edu/documents/message-congress-establishing-minimum-wages-and-maximum-hours (last visited May 8, 2023).

[2] *A New Child Labor Crisis in America*, N.Y. TIMES (Mar. 9, 2023), https://www.nytimes.com/2023/03/09/podcasts/the-daily/migrant-child-labor-america.html; David J. Neal, *A Restaurant's Florida Franchisees Illegally Used Child Labor and Owed Workers $24,000*, MIAMI HERALD (Mar. 8, 2023), https://www.miamiherald.com/news/business/article272835475.html; *How Child Labor Violations Have Quadrupled Since 2015*, 1A: NPR (Mar. 6, 2023), https://www.npr.org/2023/03/06/1161486299/how-child-labor-violations-have-quadrupled-since-2015; Nandita Bose & Mica Rosenberg, *U.S. to Crack Down on Child Labor Amid Massive Uptick*, REUTERS (Feb. 27, 2023), https://www.reuters.com/business/us-crack-down-child-labor-amid-massive-uptick-2023-02-27/; Hannah Dreier, *Alone and Exploited, Migrant Children Work Brutal Jobs Across the U.S.*, N.Y. TIMES (Feb. 25, 2023), https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-

numbers available in the Wage and Hour Division's (WHD) own data, which show a near quadrupling of the number of children involved in child labor violations since 2015—and these are just the cases that have been detected.[3] This surge in child labor violations is happening while WHD has had steadily decreasing resources to invest in enforcement.[4]

Meanwhile, the National Institute for Occupational Safety and Health (NIOSH)—the agency charged with researching occupational risks to young workers—is likewise constrained by years of flat or diminished funding. In inflation-adjusted dollars, NIOSH has seen its budget cut every year since 2016.[5] With decreased funding, NIOSH has decreased capacity to monitor and report on the hazards children face at work. For example, NIOSH discontinued the Child Agriculture Injury Surveillance program, leaving policymakers with an "absence of timely, valid, and reliable injury data."[6]

Meaningful solutions are on the table. Reps. Hillary Scholten (D-MI) and Nancy Mace (R-SC) have introduced a bipartisan bill (H.R. 2388, *Justice for Exploited Children Act of 2023*) to increase civil monetary penalties for child labor violations. Rep. Dan Kildee (D-MI) has introduced a bill (H.R. 2956, *Combatting Child Labor Act*) to increase both civil monetary penalties and criminal sanctions. Additionally, we plan to introduce soon a comprehensive bill to toughen penalties for child labor violations and unsafe workplaces that harm children, expand research and expertise on these issues, update standards about occupations too hazardous for the employment of children, and track the statistics on the scope of child labor violations. Other legislative solutions may yet surface, especially if we have a proper hearing to discuss the problem.

In short, the scourge of child labor that Congress sought to eliminate 85 years ago with the passage of FLSA is back, and it has returned at time when the agencies we expect to provide timely data and aggressive enforcement lack the resources they need. We ask that you schedule a hearing this month so that Committee members have the opportunity to hear about the nature

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workers-exploitation.html; Terri Gerstein, *Child Labor Has Made a Comeback*, SLATE (Nov. 16, 2022), https://slate.com/business/2022/11/packers-sanitation-child-labor-department-hyundai-chipotle.html; *Child Labor Allegations at Alabama Hyundai Factory Lead to Class Action Lawsuit*, FOX 23 NEWS (Aug. 2, 2022), https://www.fox23.com/news/trending/child-labor-allegations-at-alabama-hyundai-factory-lead-to-class-action-lawsuit/article_96833571-664a-57ce-9413-f32a7018ec0b.html.

[3] *See* Wage & Hr. Div., *Child Labor*, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/whd/data/charts/child-labor (last visited Mar. 13, 2023) (showing 1,012 children in child labor violations in FY15 compared to 3,876 in FY22).

[4] According to WHD data, the number of personnel hours spent on enforcement has decreased *every year since FY17*. *See* Wage & Hr. Div., *WHD: All Acts*, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/whd/data/charts/all-acts (last visited Mar. 13, 2023).

[5] Adjusted to FY24 dollars, the most recent budget peak for NIOSH was FY16 ($446.1 million), and funding has steadily fallen through FY23 ($375.1 million).

[6] Barbara C. Lee & Marsha A. Salzwedel, *Safeguarding Youth from Agricultural Injury and Illness: The United States' Experience*, FRONTIERS PUB. HEALTH (Jan. 30, 2023), https://fjfsdata01prod.blob.core.windows.net/articles/files/1048576/pubmed-zip/.versions/1/.package-entries/fpubh-11-1048576/fpubh-11-1048576.pdf?sv=2018-03-28&sr=b&sig=cNjNVr1%2BGFqKPeOItn4O1wIB39G0gqRUb9yH%2BRj3QP4%3D&se=2023-05-19T16%3A06%3A02Z&sp=r&rscd=attachment%3B%20filename%2A%3DUTF-8%27%27fpubh-11-1048576.pdf.

and scope of the child labor problem confronting the country and the legislative solutions to address it.

Thank you for your prompt attention to this matter.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Ranking Member

ALMA S. ADAMS, Ph.D.
Ranking Member
Subcommittee on Workforce Protections

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SEX & GENDER

What the Science on Gender-Affirming Care for Transgender Kids Really Shows

Laws that ban gender-affirming treatment ignore the wealth of research demonstrating its benefits for trans people's health

By Heather Boerner on May 12, 2022



As attacks against transgender kids increase in the U.S., Minnesotans hold a rally at the state's capitol in Saint Paul in March 2022 to support trans kids in Minnesota and Texas and around the country. Credit: Michael Siluk/UCG/Universal Images Group via Getty Images

Editor's Note (3/30/23): This article from May 2022 is being republished to highlight the ways that ongoing anti-trans legislation is harmful and unscientific.

For the first 40 years of their life, Texas resident Kelly Fleming spent a portion of most years in a deep depression. As an adult, Fleming—who uses they/them pronouns and who asked to use a pseudonym to protect their safety—would shave their face in the shower with the lights off so neither they nor their wife would have to confront the reality of their body.

What Fleming was experiencing, although they did not know it at the time, was gender dysphoria: the acute and chronic distress of living in a body that does not reflect one's gender and the desire to have bodily characteristics of that gender. While in therapy, Fleming discovered research linking access to gender-affirming hormone therapy with reduced depression in transgender people. They started a very low dose of estradiol, and the depression episodes became shorter, less frequent and less intense. Now they look at their body with joy.

So when Fleming sees what authorities in Texas, Alabama, Florida and other states are doing to bar transgender teens and children from receiving gender-affirming medical care, it infuriates them. And they are worried for their children, ages 12 and 14, both of whom are agender—a identity on the transgender spectrum that is neither masculine nor feminine.

"I'm just so excited to see them being able to present themselves in a way that makes them happy," Fleming says. "They are living their best life regardless of what others think, and that's a privilege that I did not get to have as a younger person."

LAWS BASED ON "COMPLETELY WRONG" INFORMATION

Currently more than a dozen state legislatures or administrations are considering—or have already passed—laws banning health care for transgender young people. On April 20 the Florida Department of Health issued guidance to withhold such gender-affirming care. This includes social gender transitioning—acknowledging that a young person is trans, using their correct pronouns and name, and supporting their desire to live publicly as the gender of their experience rather than their sex assigned at birth. This comes nearly two months after Texas Governor Greg Abbott issued an order for the Texas Department of Family and Protective Services to investigate for child abuse parents who allow their transgender preteens and teenagers to receive medical care. Alabama recently passed SB 184, which would make it a felony to provide gender-affirming medical care to transgender minors. In Alabama, a "minor" is defined as anyone 19 or younger.

If such laws go ahead, 58,200 teens in the U.S. could lose access to or never receive gender-affirming care, according to the Williams Institute at the University of California, Los Angeles. A decade of research shows such treatment reduces depression, suicidality and other

devastating consequences of trans preteens and teens being forced to undergo puberty in the sex they were assigned at birth).

The bills are based on "information that's completely wrong," says Michelle Forcier, a pediatrician and professor of pediatrics at Brown University. Forcier literally helped write the book on how to provide evidence-based gender care to young people. She is also an assistant dean of admissions at the Warren Alpert Medical School of Brown University. Those laws "are absolutely, absolutely incorrect" about the science of gender-affirming care for young people, she says. "[Inaccurate information] is there to create drama. It's there to make people take a side."



The truth is that data from more than a dozen studies of more than 30,000 transgender and gender-diverse young people consistently show that access to gender-affirming care is associated with better mental health outcomes—and that lack of access to such care is associated with higher rates of suicidality, depression and self-harming behavior. (Gender diversity refers to the extent to which a person's gendered behaviors, appearance and identities are culturally incongruent with the sex they were assigned at birth. Gender-diverse people can identify along the transgender spectrum, but not all do.) Major medical organizations, including the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry, the Endocrine Society, the American Medical Association, the American Psychological Association and the American Psychiatric Association, have published policy statements and guidelines on how to provide age-appropriate gender-affirming care. All of those medical societies find such care to be evidence-based and medically necessary.

AAP and Endocrine Society guidelines call for developmentally appropriate care, and that means no puberty blockers or hormones until young people are already undergoing puberty for their sex assigned at birth. For one thing, "there are no hormonal differences among prepubertal children," says Joshua Safer, executive director of the Mount Sinai Center for Transgender Medicine and Surgery in New York City and co-author of the Endocrine Society's guidelines. Those guidelines provide the option of gonadotropin-releasing hormone analogues (GnRHas), which block the release of sex hormones, once young people are already into the second of five puberty stages—marked by breast budding and pubic hair. These are offered only if a teen is not ready to make decisions about puberty. Access to gender-affirming hormones and potential access to gender-affirming surgery is available at age 16—and then, in the case of transmasculine youth, only mastectomy, also known as top surgery. The Endocrine Society does not recommend genital surgery for minors.

Before puberty, gender-affirming care is about supporting the *process* of gender development rather than directing children through a specific course of gender transition or maintenance of cisgender presentation, says Jason Rafferty, co-author of AAP's policy statement on gender-affirming care and a pediatrician and psychiatrist at Hasbro Children's Hospital in Rhode Island. "The current research suggests that, rather than predicting or preventing who a child might become, it's better to value them for who they are now—even at a young age," Rafferty says.

A SAFE ENVIRONMENT TO EXPLORE GENDER

A 2021 systematic review of 44 peer-reviewed studies found that parent connectedness, measured by a six-question scale asking about such things as how safe young people feel confiding in their guardians or how cared for they feel in the family, is associated with greater resilience among teens and young adults who are transgender or gender-diverse. Rafferty says he sees his role with regard to prepubertal children as offering a safe environment for the child to explore their gender and for parents to ask questions. "The gender-affirming approach is not some railroad of people to hormones and surgery," Safer says. "It is talking and watching and being conservative."

Only once children are older, and if the incongruence between the sex assigned to them at birth and their experienced gender has persisted, does discussion of medical transition occur. First a gender therapist has to diagnose the young person with gender dysphoria.

After a gender dysphoria diagnosis—and only if earlier conversations suggest that hormones are indicated—guidelines call for discussion of fertility, puberty suppression and hormones. Puberty-suppressing medications have been used for decades for cisgender children who start puberty early, but they are not meant to be used indefinitely. The Endocrine Society

guidelines recommend a maximum of two years on GnRHa therapy to allow more time for children to form their gender identity before undergoing puberty for their sex assigned at birth, the effects of which are irreversible.

"[Puberty blockers] are part of the process of 'do no harm,'" Forcier says, referencing a popular phrase that describes the Hippocratic Oath, which many physicians recite a version of before they begin to practice.

Hormone blocker treatment may have side effects. A 2015 longitudinal observational cohort study of 34 transgender young people found that, by the time the participants were 22 years old, trans women experienced a decrease in bone mineral density. A 2020 study of puberty suppression in gender-diverse and transgender young people found that those who started puberty blockers in early puberty had lower bone mineral density *before* the start of treatment than the public at large. This suggests, the authors wrote, that GnRHa use may not be the cause of low bone mineral density for these young people. Instead they found that lack of exercise was a primary factor in low bone-mineral density, especially among transgender girls.

Other side effects of GnRHa therapy include weight gain, hot flashes and mood swings. But studies have found that these side effects—and puberty delay itself—are reversible, Safer says.

Gender-affirming hormone therapy often involves taking an androgen blocker (a chemical that blocks the release of testosterone and other androgenic hormones) and estrogen in transfeminine teens, and testosterone supplementation in transmasculine teens. Such hormones may be associated with some physiological changes for adult transgender people. For instance, transfeminine people taking estrogen see their so-called "good" cholesterol increase. By contrast, transmasculine people taking testosterone see their good cholesterol decrease. Some studies have hinted at effects on bone mineral density, but these are complicated and also depend on personal, family history, exercise, and many other factors in addition to hormones."

And while some critics point to decade-old study and older studies suggesting very few young people persist in transgender identity into late adolescence and adulthood, Forcier says the data are "misleading and not accurate." A recent review detailed methodological problems with some of these studies. New research in 17,151 people who had ever socially transitioned found that 86.9 percent persisted in their gender identity. Of the 2,242 people who reported that they reverted to living as the gender associated with the sex they were assigned at birth, just 15.9 percent said they did so because of internal factors such as questioning their experienced gender but also because of fear, mental health issues and suicide attempts. The rest reported the cause was social, economic and familial stigma and discrimination. A third

reported that they ceased living openly as a trans person because doing so was "just too hard for me."

THE HARMS OF DENYING CARE

Data suggest the effects of denying that care are worse than whatever side effects result from delaying sex-assigned-at-birth puberty. And medical society guidelines conclude that the benefits of gender-affirming care outweigh the risks. Without gender-affirming hormone therapy, cisgender hormones take over, forcing body changes that can be permanent and distressing.

A 2020 study of 300 gender-incongruent young people found that mental distress—including self-harm, suicidal thoughts and depression—increased as the children were made to proceed with puberty according to their assigned sex. By the time 184 older teens (with a median age of 16) reached the stage in which transgender boys began their periods and grew breasts and transgender girls' voice dropped and facial hair began to appear, 46 percent had been diagnosed with depression, 40 percent had self-harmed, 52 percent had considered suicide, and 17 percent had attempted it—rates significantly higher than those of gender-incongruent children who were a median of 13.9 years old or of cisgender kids their own age.

Conversely, access to gender-affirming hormones in adolescence appears to have a protective effect. In one study, researchers followed 104 teens and young adults for a year and asked them about their depression, anxiety and suicidality at the time they started receiving hormones or puberty blockers and again at the three-month, six-month and one-year mark. At the beginning of the study, which was published in *JAMA Network Open* in February 2022, more than half of the respondents reported moderate to severe depression, half reported moderate to severe anxiety, and 43.3 percent reported thoughts of self-harm or suicide in the past two weeks.

But when the researchers analyzed the results based on the kind of gender-affirming care the teens had received, they found that those who had access to puberty blockers or gender-affirming hormones were 60 percent less likely to experience moderate to severe depression. And those with access to the medical treatments were 73 percent less likely to contemplate self-harm or suicide.

"Delays in prescribing puberty blockers and hormones may in fact worsen mental health symptoms for trans youth," says Diana Tordoff, an epidemiology graduate student at the University of Washington and co-author of the study.

That effect may be lifelong. A 2022 study of more than 21,000 transgender adults showed that just 41 percent of adults who wanted hormone therapy received it, and just 2.3 percent had access to it in adolescence. When researchers looked at rates of suicidal thinking over the past year in these same adults, they found that access to hormone therapy in early adolescence was associated with a 60 percent reduction in suicidality in the past year and that access in late adolescence was associated with a 50 percent reduction.

For Fleming's kids in Texas, gender-affirming hormones are not currently part of the discussion; not all trans people desire hormones or surgery to feel affirmed in their gender. But Fleming is already looking at jobs in other states to protect their children's access to such care, should they change their mind. "Getting your body closer to the gender [you] identify with—that is what helps the dysphoria," Fleming says. "And not giving people the opportunity to do that, making it harder for them to do that, is what has made the suicide rate among transgender people so high. We just—trans people are just trying to survive."

IF YOU NEED HELP If you or someone you know is struggling or having thoughts of suicide, help is available. Call the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK), use the online Lifeline Chat or contact the Crisis Text Line by texting TALK to 741741.

ABOUT THE AUTHOR(S)

Heather Boerner is a health care and science journalist based in Pittsburgh. Her work has appeared in the *Daily Beast*, the *Washington Post*, the *Atlantic*, and NPR. Follow her on Twitter @HeatherBoerner

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September 2022
COMMITTEE ON EDUCATION & LABOR
NO RIGHT TO
DENY CARE:
THE IMPORTANCE OF PRESERVING PREVENTIVE CARE IN THE AFFORDABLE CARE ACT

TABLE OF CONTENTS

Introduction	1
Losing Access to Comprehensive Preventive Care Could Harm Millions of People and Increase Health Care Costs	2
The Affordable Care Act Ensures that Workers Have Access to Preventive Care	2
Recommendations for Which Preventive Services Must be Covered are Developed by Independent Experts — Not Insurance Companies or Politicians	4
Coverage for Preventive Services has Improved the Health of Millions of Americans	5

NO RIGHT TO DENY CARE

INTRODUCTION

The *Affordable Care Act* (ACA) expanded Medicaid for low-income Americans, protected access to coverage for people with preexisting conditions, and created Healthcare.gov and state-based exchanges where individuals can purchase quality, affordable coverage. Additionally, the ACA included another major reform that affected nearly everyone with private health insurance – the requirement for coverage of preventive care without any cost-sharing, such as deductibles or copays.[1] This requirement has not only helped the more than 14 million enrollees in coverage through the ACA exchanges,[2] but also the vast majority of the approximately 155 million Americans who have coverage through their job.[3]

A recent decision by a very conservative court, issued by a very conservative judge, jeopardizes the future of these critical reforms for millions of individual consumers, small business owners, workers, and their families. In the case *Braidwood v. Becerra*, the judge ruled that the Constitution does not allow a requirement for plans to cover certain preventive services.[4] The decision also found that the mandate to cover certain preventive service items, such as medication that can prevent HIV transmission, substantially burdens the religious exercise of one of the plaintiffs.[5] The ruling did not address every issue in the case, but the court indicated that it may also allow certain employers to limit coverage for other vital preventive services.[6]

This case is ongoing, and the decision will hopefully be overturned on appeal, but the stakes for American workers and families are high. Preventive service coverage has been enormously consequential in improving access to care for millions of Americans and it is critical that this protection be preserved.

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[1] Public Health Service Act § 2713 (grandfathered health plans and those offering limited scope benefits such as stand-alone dental and vision plans are exempt from this requirement, however).
[2] Press Release, Biden-Harris Administration Announces 14.5 Million Americans Signed Up for Affordable Health Care During Historic Open Enrollment Period (Jan. 27, 2022), https://www.hhs.gov/about/news/2022/01/27/biden-harris-administration-announces-14-5-million-americans-signed-affordable-health-care-during-historic-open-enrollment-period.html.
[3] Employer Health Benefits: 2021 Annual Survey, Kaiser Family Foundation, available at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.
[4] This case was formerly known as Kelley v. Becerra, but was later changed at the request of the plaintiffs. See Unopposed Motion to Amend Caption at 1, John Kelley, et al, v. Xavier Becerra, et al., No. 4:20-cv-00283-O (N.D. Texas, Aug. 10, 2022) ("The plaintiffs respectfully move to amend the caption so that Braidwood Management Incorporated is the first-listed plaintiff, and that the case be referred to as 'Braidwood Management Inc., et al. v. Xavier Becerra, et al.' going forward").
[5] Braidwood Management Inc., et al, v. Xavier Becerra, et al., No. 4:20-cv-00283-O (N.D. Texas, Sept. 7, 2022), available at https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.92.0.pdf.
[6] In February 2021, the court dismissed plaintiffs' religious claims regarding the contraceptive mandate because the court had previously dealt with those claims by the same plaintiffs in a separate case, DeOtte v Azar. DeOtte v. Azar, 393 F. Supp. 3d. 490 (N.D. Tex. 2019). However, the court's decision in DeOtte was recently reversed by the Fifth Circuit. The plaintiffs now contend that their religious claims regarding the contraceptive mandate are no longer precluded by the DeOtte case and as a result, have asked the court to reconsider those claims. The court signaled that it will further deliberate on the plaintiffs' claims regarding the contraceptive mandate issue. With regards to plaintiffs' objections to other preventive services, the plaintiffs' amended complaint dropped religious objections to providing several other required preventive services, including the human papillomavirus (HPV) vaccine, screenings, and behavioral counseling for sexually transmitted diseases (STDs), and substance use.

NO RIGHT TO DENY CARE

LOSING ACCESS TO COMPREHENSIVE PREVENTIVE CARE COULD HARM MILLIONS OF PEOPLE AND INCREASE HEALTH CARE COSTS

Before the ACA was enacted in 2010, there was no federal requirement for private health plans to cover preventive services. Further, there were no limits on how much Americans might be forced to pay out-of-pocket to get preventive care. As a result, coverage for preventive services varied considerably across the country.[7] Some states required certain types of plans to cover certain preventive services, but the requirements were generally narrow and often did not cap out-of-pocket expenses.

Access to preventive care is essential to long-term health. Through preventive care, doctors and other health care providers can detect problems early when they are more treatable. Preventive services provide tremendous value by reducing the risk for developing a long-term, chronic disease. For example, preventive measures have led to a more than 75 percent reduction in new HIV infections each year since they peaked in 1984.[8] Research has shown that access to preventive care also reduces overall health care spending, as fewer people develop chronic conditions that require expensive treatment.[9]

THE AFFORDABLE CARE ACT ENSURES THAT WORKERS HAVE ACCESS TO PREVENTIVE CARE

The ACA included several reforms that improved the quality and affordability of health care coverage for millions of workers and their families. One of these reforms is a requirement for nearly all private health plans to cover a robust set of preventive services without patients having to pay anything out-of-pocket.[10] This requirement generally applies to all people, regardless of whether an individual gets their coverage through their employer or in the individual market – a combined total of about 170 million people.[11] Studies show that the requirement is one of the most popular parts of the ACA and the majority of Americans say that it is "very important" that it be preserved.[12]

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[7] The Departments of Health and Human Services, Labor, and the Treasury issued interim final regulations in 2010 to implement the Affordable Care Act's preventive service coverage requirement. The preamble to the regulations includes an impact analysis that summarizes preventive service coverage available prior to the enactment of the Affordable Care Act. See, Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41732 (July 19, 2010), available at https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of.

[8] Smith, Dawn K., Kirk, Henry D., Weidle, Paul, J., The Evidence for Initial Intervention Strategies for Ending the HIV Epidemic in the U.S., American Journal of Preventive Medicine, 2021 S1-S5, available at https://www.ajpmonline.org/article/S0749-3797(21)00390-1/fulltext.

[9] Maciosek, Michael V., Coffield, Ashley B., Flottemesch, et al., Use of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost. Health Affairs 2010, 29(9) 1656-1660, available at https://pubmed.ncbi.nlm.nih.gov/20820022/.

[10] Public Health Service Act section 2713 (grandfathered health plans and those offering limited scope benefits such as stand-alone dental and vision plans are exempt from this requirement, however).

[11] See Data Note: Changes in Enrollment in the Individual Health Insurance Market through Early 2019, Kaiser Family Foundation, available at https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/; see also Employer Health Benefits, supra note 3.

[12] Ashley Kirzinger, 5 Charts About Public Opinion on The Affordable Care Act, Kaiser Family Foundation (April 14, 2022), available at https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court/.

NO RIGHT TO DENY CARE

Specifically, under the ACA, health plans and insurance companies must cover – without any cost-sharing – the following four categories of items and services:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;[13]

- Immunizations for routine clinical use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

The range of items and services that that must be covered under these four categories is broad and includes, for example, cancer screenings, contraception, well-woman visits, pre-exposure prophylaxis (PrEP) for HIV prevention, routine vaccinations, screening for sexually transmitted diseases, breastfeeding services and supplies, tobacco cessation interventions, and many others. In just the first category of services that must be covered – those recommended by the USPSTF – there are 45 different types of preventive services.[14] Office visits to receive preventive care as well as services that are integral to receiving certain preventive services, such as specimen collection for recommended screenings, are generally also required to be covered.[15]

[13] The USPSTF published updated breast cancer screening recommendations in January 2016. However, section 223 of Division H of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) requires that for purposes of PHS Act section 2713, USPSTF recommendations relating to breast cancer screening, mammography, and prevention issued before 2009 remain in effect until January 1, 2023. In July 2021, the Departments of Health and Human Services, Labor, and the Treasury issued new guidance clarifying that most health plans must include PrEP coverage without cost-sharing based on the U.S Preventive Services Task Force's "Grade A" recommendation of June 2019. See, The Departments of Health and Human Services, Labor, and the Treasury, FAQs about Affordable Care Act Implementation Part 47 (July 19, 2021), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-47.pdf.

[14] U.S. Preventive Service Task Force Published Recommendations, available at https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&grades%5B%5D=A&grades%5B%5D=B&searchterm=.

[15] See 29 CFR 2590.715-2713; see also FAQs About Affordable Care Act Implementation, Part 54, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-54.pdf.

NO RIGHT TO DENY CARE

RECOMMENDATIONS FOR WHICH PREVENTIVE SERVICES MUST BE COVERED ARE DEVELOPED BY INDEPENDENT EXPERTS – NOT INSURANCE COMPANIES OR POLITICIANS

Although the preventive service coverage requirement is grounded in federal law and enforced by federal and state insurance regulators, the specific items and services that must be covered are recommended by experts in preventive medicine from several entities: the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), and Health Resources and Services Administration (HRSA).

The USPSTF is an organization comprised of experts in disease prevention. Members are independent volunteers who seek to improve the health of people nationwide through evidence-based recommendations about preventive health services. The USPSTF has a rigorous process for the development of their recommendations that ensures they are not influenced by conflicts of interest. Additionally, stakeholders have an opportunity to submit comments on proposed recommendations before they are finalized.

ACIP is a Federal Advisory Committee established by law to offer advice to the Director of the CDC about disease prevention through the use of vaccines.[16] ACIP's members are experts in the fields of immunization practices and public health. Similar to the USPSTF, ACIP adheres to strict procedures to ensure transparency in the development of their recommendations. They hold meetings that are open to the public and they publish their framework for evaluating evidence before voting on each recommendation.

HRSA is one of nine Public Health Service agencies under the Department of Health and Human Services. Since 2016, HRSA has awarded contracts to the American College of Obstetricians and Gynecologists (ACOG) to convene a panel of medical professionals and other health experts to develop and update its preventive service recommendations.[17]

[16] ACIP Charter, Centers for Disease Control and Prevention, available at https://www.cdc.gov/vaccines/acip/committee/charter.html.
[17] Women's Preventive Service Guidelines, Health Resources and Services Administration, available at https://www.hrsa.gov/womens-guidelines.

NO RIGHT TO DENY CARE

COVERAGE FOR PREVENTIVE SERVICES HAS IMPROVED THE HEALTH OF MILLIONS OF AMERICANS

Since the ACA's preventive service coverage requirement took effect, numerous studies have sought to measure its impact on consumer access to preventive care. The studies generally all show that the law has been an enormous success: utilization rates for preventive care are up, racial and ethnic disparities in accessing preventive care are down, people are spending less out-of-pocket, and better health and economic outcomes are being achieved.[18]

Clinical guidelines suggest that a 58-year-old woman who is at risk for heart disease should receive a mammogram, a colon cancer screening, a Pap test, a diabetes test, a cholesterol test, and an annual flu shot. Under a typical insurance plan before the ACA was enacted, these tests could cost more than $300 out of her own pocket.[19] Now, under the ACA, she would not require any out-of-pocket spending. The law has similarly reduced costs for contraception, which used to be a major barrier women faced in accessing contraception. On average, women with private insurance who use oral contraceptives or intrauterine devices have been able to save about $250 a year since the ACA was enacted over ten years ago.[20]

The very coverage that the Braidwood case targeted—Truvada—is the first FDA-approved medication for HIV prevention and the only form of PrEP available for women. Without insurance, Truvada can cost between $1,600 and $2,000 per month, not including the cost of routine HIV testing and ancillary services that are required for continued prescriptions. One in five new HIV cases now affect women[21] and, when taken as recommended, PrEP reduces the risk of getting HIV by 99 percent, according to the CDC.[22] PrEP has also been used in combination with HIV medications to reduce the risk of mother-to-child HIV transmission during pregnancy, treat survivors of intimate partner violence and sexual assault, and protect people living with hemophilia and other immunocompromised people from HIV exposure.

[18] Access to Preventive Services Without Cost-sharing: Evidence from the Affordable Care Act, Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (Jan. 11, 2022), available at https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf
[19] Background; The Affordable Care Act's New Rules on Preventive Care, Centers for Medicare and Medicaid Services (July 14, 2010), available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background#_ftnref6.
[20] Nora Becker, Daniel Polsky, Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing, Health Affairs (July 2015), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0127.
[21] Centers for Disease Control and Prevention, Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, HIV and Women Fact Sheet, (August 8, 2022), https://www.cdc.gov/hiv/pdf/group/gender/women/cdc-hiv-women.pdf.
[22] Centers for Disease Control and Prevention, Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, PrEP Effectiveness, (June 6, 2022), https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html.

NO RIGHT TO DENY CARE

When the ACA preventive services coverage requirements first took effect, it was predicted that there would be both public health and economic benefits; not only would there be reduced transmission and earlier treatment of diseases, but some of the recommended preventive services would also result in savings due to lower health care costs overall and fewer workers and students missing work and school due to illness.[23] Shortly after the coverage requirement took effect, the Department of Health and Human Services estimated that it led to 54 million more Americans receiving preventive care without any out-of-pocket spending.[24] The Department also recently issued a comprehensive review of research examining the impact of the preventive service coverage requirement.[25] This review found that:

- Nearly 150 million people are estimated to have benefited from the law through increased screenings and improved health outcomes.

- Regarding cancer screenings, research suggests that increased access and lower costs have helped cancer survivors obtain the care they need. The greatest improvements have been for colorectal and cervical cancer screenings. Increased screening has resulted in an overall decrease in colorectal cancer incidence, and data show that newly insured immigrants, in particular, are being screened at higher rates than they were before the law took effect.

- The combination of the preventive service coverage requirement and the ACA's requirement that any dependent coverage be available up to age 26 has led to significantly more women receiving vaccinations for human papillomavirus (HPV), which prevents cervical cancer.

- More adults are receiving their annual recommended flu shots.

- The increase in access to contraception has been profound. Cost has historically been a major barrier to accessing contraception and PrEP, and better access is associated with reduced rates of poverty. By one estimate, in the first year after the preventive service coverage requirement took effect, women collectively saved approximately $1.4 billion on out-of-pocket expenses for contraception.

[23] Interim final regulations, supra note 7, at 41733.
[24] Fifty-Four Million Additional Americans Are Receiving Preventive Services Without Cost-Sharing Under The Affordable Care Act, Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (Feb. 14, 2012), available at https://aspe.hhs.gov/reports/fifty-four-million-additional-americans-are-receiving-preventive-services-without-cost-sharing-under-0.
[25] Access to Preventive Services Without Cost-sharing: Evidence from the Affordable Care Act, supra note 19.


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U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
Washington, DC 20530

March 31, 2022

Dear State Attorneys General:

The U.S. Department of Justice (the Department) is committed to ensuring that transgender youth, like all youth, are treated fairly and with dignity in accordance with federal law. This includes ensuring that such youth are not subjected to unlawful discrimination based on their gender identity, including when seeking gender-affirming care. We write to remind you of several important federal constitutional and statutory obligations that flow from these fundamental principles.

People who are transgender are frequently vulnerable to discrimination in many aspects of their lives, and are often victims of targeted threats, legal restrictions, and anti-transgender violence.[1] The Department and the federal government more generally have a strong interest in protecting the constitutional rights of individuals who are lesbian, gay, bisexual, transgender, queer, intersex, nonbinary, or otherwise gender-nonconforming,[2] and in ensuring compliance with federal civil rights statutes. The Department is also charged with the coordination and enforcement of federal laws that protect individuals from discrimination in a wide range of federally-funded programs and activities.[3]

Intentionally erecting discriminatory barriers to prevent individuals from receiving gender-affirming care implicates a number of federal legal guarantees. State laws and policies that prevent parents or guardians from following the advice of a healthcare professional regarding what may be medically necessary or otherwise appropriate care for transgender minors may infringe on rights protected by both the Equal Protection and the Due Process Clauses of the Fourteenth Amendment. The Equal Protection Clause requires heightened scrutiny of laws that discriminate on the basis of sex[4] and prohibits such discrimination absent an "exceedingly

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[1] *See, e.g.*, Michelle M. Johns et al., Ctrs. for Disease Control and Prevention, *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, Morbidity and Mortality Weekly Report 68: 67-71 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6803a3.htm?s_cid=mm6803a3_w (finding that transgender youth reported higher levels of violence victimization compared to their cisgender peers).
[2] *See, e.g.*, Exec. Order No. 13,988, § 1, 86 Fed. Reg. 7023 (Jan. 20, 2021); Pamela S. Karlan, Principal Deputy Assistant Attorney General, Civ. Rts. Div., U.S. Dep't of Justice, Memorandum, *Application of Bostock v. Clayton County to Title IX of the Education Amendments of 1972* (Mar. 26, 2021), https://www.justice.gov/crt/page/file/1383026/download.
[3] Exec. Order No. 12,250, § 1-201, 45 Fed. Reg. 72,995 (Nov. 2, 1980).
[4] *See*, *e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 610-13 (4th Cir. 2020), *as amended* (Aug. 28, 2020), *reh'g en banc denied*, 976 F.3d 399 (4th Cir. 2020), *cert. denied*, 2021 WL 2637992 (June 28, 2021); *Whitaker* v.

persuasive" justification.[5] Because a government cannot discriminate against a person for being transgender "without discriminating against that individual based on sex,"[6] state laws or policies that discriminate against transgender people must be "substantially related to a sufficiently important governmental interest."[7]

A law or policy need not specifically single out persons who are transgender to be subject to heightened scrutiny. When a state or recipient of federal funds criminalizes or even restricts a type of medical care predominantly sought by transgender persons, an intent to disfavor that class can "readily be presumed."[8] For instance, a ban on gender-affirming procedures, therapy, or medication may be a form of discrimination against transgender persons, which is impermissible unless it is "substantially related" to a sufficiently important governmental interest.[9] This burden of justification is "demanding."[10] Such a law or policy will not withstand heightened scrutiny when "the alleged objective" differs from the "actual purpose" underlying the classification.[11] In addition, the Due Process Clause protects the right of parents "to seek and follow medical advice" to safeguard the health of their children.[12] A state or local government must meet the heavy burden of justifying interference with that right since it is well established within the medical community that gender-affirming care for transgender youth is not only appropriate but often necessary for their physical and mental health.[13]

In addition to these constitutional guarantees, many federal statutes require recipients of federal financial assistance to comply with nondiscrimination requirements as a condition of receiving those funds. Relevant statutes include:

- **Section 1557 of the Affordable Care Act**[14] protects the civil rights of people—including transgender youth—seeking nondiscriminatory access to healthcare in a range of health

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Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1051 (7th Cir. 2017), *cert. dismissed*, 138 S. Ct. 1260 (2018); *see also* Brief for the United States as Amicus Curiae Supporting Plaintiffs-Appellees, *Brandt v. Rutledge*, No. 21-2875 (8th Cir. Jan. 21, 2022); En Banc Brief for the United States as Amicus Curiae Supporting Plaintiff-Appellee, *Adams v. School Board of St. John's County*, No. 18-13592 (11th Cir. Nov. 26, 2021); Brief for the United States as Amicus Curiae Supporting Plaintiffs-Appellees, *Corbitt v. Taylor*, No. 21-10486 (11th Cir. Aug. 2, 2021).

[5] *United States v. Virginia*, 518 U.S. 515, 531 (1996) ("Parties who seek to defend gender-based government action must demonstrate an 'exceedingly persuasive justification' for that action.") (quoting *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982)).

[6] *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020).

[7] *Grimm*, 972 F.3d at 608 (quoting *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985) (internal quotations omitted)).

[8] *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("Some activities may be such an irrational object of disfavor that, if they are targeted, and if they also happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed.").

[9] *Virginia*, 518 U.S. at 533.

[10] *Id.*

[11] *Miss. Univ.*, 458 U.S. at 730.

[12] *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

[13] *See, e.g.*, *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891, 893 (E.D. Ark. 2021).

[14] 42 U.S.C. § 18116.

programs and activities.[15] Categorically refusing to provide treatment to a person based on their gender identity, for example, may constitute prohibited discrimination under Section 1557. As the U.S. Department of Health and Human Services has stated, restricting an individual's ability to receive medically necessary care, including gender-affirming care, from their health care providers solely on the basis of their sex assigned at birth or their gender identity may also violate Section 1557.[16]

- **Title IX of the Education Amendments of 1972**[17] prohibits sex discrimination, including sex-based harassment, by recipients of federal financial assistance that operate education programs and activities.[18] Policies and practices that deny, limit, or interfere with access to the recipient's education program or activity because students are transgender minors receiving gender-affirming care may constitute discrimination on the basis of sex in violation of Title IX.

- The **Omnibus Crime Control and Safe Streets Act of 1968**[19] prohibits sex discrimination in certain law enforcement programs and activities receiving federal financial assistance.[20] If a law enforcement agency takes a transgender minor who is receiving gender-affirming care into custody or arrests the child's parents on suspicion of child abuse because the parents permitted such medical care, that agency may be violating the statute's nondiscrimination provision.

- **Section 504 of the Rehabilitation Act of 1973**[21] protects people with disabilities, which can include individuals who experience gender dysphoria.[22] Restrictions that prevent, limit, or interfere with otherwise qualified individuals' access to care due to their gender

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[15] *See, e.g.*, Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972, reprinted at 86 Fed. Reg. 27,984 (May 25, 2021).
[16] U.S. Dep't Health & Hum. Servs., *Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy* (Mar. 2, 2022), https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf.
[17] 20 U.S.C. § 1681, *et seq*.
[18] *See* Karlan, *supra* note 2; *see also Doe v. Snyder*, --- F.4th ---, 2022 WL 711420, at *9 (9th Cir. Mar. 10, 2022); *Grimm*, 972 F.3d at 619.
[19] 34 U.S.C. § 10101, *et seq*.
[20] *See* 34 U.S.C. § 10228(c)(1); *see also* Kristen Clarke, Assistant Attorney General, Civ. Rts. Div., U.S. Dep't of Justice, Memorandum, *Interpretation of Bostock v. Clayton County regarding the nondiscrimination provisions of the Safe Streets Act, the Juvenile Justice and Delinquency Prevention Act, the Victims of Crime Act, and the Violence Against Women Act* (Mar. 10, 2022), https://www.justice.gov/crt/page/file/1481776/download.
[21] 29 U.S.C. § 794. Additionally, Title II of the Americans with Disabilities Act extends disability civil rights protections with respect to all programs, services and activities of state and local governments, regardless of the receipt of federal financial assistance. *See* 42 U.S.C. § 12132.
[22] *See, e.g.*, *Doe v. Penn. Dep't of Corrections*, No. 1:20-cv-00023-SPB-RAL, 2021 WL 1583556, at *12 (W.D. Pa. Feb. 19, 2021), report and recommendation adopted in relevant part, 2021 WL 1115373 (W.D. Pa. March 24, 2021); *Lange v. Houston Cnty.*, 499 F. Supp. 3d 1258, 1270 (M.D. Ga. 2020); *Doe v. Mass. Dep't of Correction*, No. 1:17-cv-12255-RGS, 2018 WL 2994403 at *6 (D. Mass. June 14, 2018); *Blatt v. Cabela's Retail, Inc.*, No. 5:14-CV-04822, 2017 WL 2178123 (E.D. Pa. May 18, 2017).

dysphoria, gender dysphoria diagnosis, or perception of gender dysphoria may violate Section 504.

All persons should be free to access the services, programs, and activities supported by federal financial assistance without fear that they might face unlawful discrimination for doing so. Courts have held that many nondiscrimination statutes contain an implied cause of action for retaliation based on the general prohibition against intentional discrimination, and agencies have made this clear in regulations.[23] Thus, any retaliatory conduct may give rise to an independent legal claim under the protections described above.

* * *

Thank you for your continued commitment to improving the well-being of children and their families. The Department is always available to help ensure that state and local governments, many of which are recipients of federal financial assistance, meet their obligations under federal law. Please feel free to contact the Department's Civil Rights Division for assistance if you have further questions.

Sincerely,



Kristen Clarke
Assistant Attorney General
Civil Rights Division
U.S. Department of Justice

[23] *See, e.g.*, *Jackson v. Birmingham Bd. of Ed.*, 544 U.S. 167, 173 (2005) ("Retaliation against a person because that person has complained of sex discrimination is another form of intentional sex discrimination…"). Examples of agency regulations that prohibit retaliation include 24 C.F.R. § 1.7(e) (Dep't of Housing and Urban Development); 34 C.F.R. § 100.7(e) (Dep't of Education); 38 C.F.R. § 18.7(e) (Dep't of Veterans Affairs); and 45 C.F.R. § 80.7(e) (Dep't of Health and Human Services). Other relevant regulations can be found in the Civil Rights Division's Title VI Legal Manual. Civ. Rts. Div., U.S. Dep't of Justice, *Title VI Legal Manual*, Section VIII, https://www.justice.gov/crt/book/file/1364106/download.

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Children's hospitals are the latest target of anti-LGBTQ harassment

August 26, 2022 · 3:30 PM ET
Heard on All Things Considered



Shannon Bond

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Boston Children's Hospital said it had received "threats of violence toward our clinicians and staff" after false claims were made online that the hospital provides genital surgeries to minors.

Lane Turner/The Boston Globe via Getty Images

Hospitals and doctors around the country are facing harassment and even death threats over the medical care they offer to transgender kids. In many cases, they have been the subject of posts by a Twitter account called Libs of TikTok, as well as stories in conservative media outlets casting gender-affirming care as child abuse and mutilation.

Which raises the question: where should social networks draw the line with accounts promoting narratives that spark harassment campaigns on their platforms and beyond?



NATIONAL

Accusations of 'grooming' are the latest political attack — with homophobic origins

Children's National Hospital in Washington, D.C. became the most recent target this week when Libs of TikTok posted an audio recording in which hospital staff appeared to say that gender-affirming hysterectomies had been performed on minors. The hospital said that claim was incorrect and that none of the people recorded deliver care to patients.

"The information in the recording is not accurate. We do not and have never performed gender-affirming hysterectomies for anyone under the age of 18," Children's National said in a statement to NPR. "The operator speaking provided wrong information."

Sponsor Message

The statement continued: "Since the spreading of misinformation on Twitter, we have been the target of a large volume of hostile and threatening phone calls and emails."

Childrens' hospitals in Boston, Seattle, Chicago, and Portland, Oregon, have also been targeted. Last week, Boston Children's Hospital warned it was receiving "a large volume of hostile internet activity, phone calls, and harassing emails including threats of violence toward our clinicians and staff" after false claims it performs genital surgeries on minors.

The U.S. Justice Department even weighed in, with the U.S. Attorney for Massachusetts calling the attacks "disturbing."

False claims, out-of-context videos

These false narratives about pediatric gender-affirming care are rooted in fundamental "misperceptions," said Dr. Angela Kade Goepferd, a pediatrician and director of the Gender Health Program at Children's Minnesota.

"People have misperceptions that we're doing surgery on young kids. People have misperceptions that we are changing kids from boys into girls at a very young age," they said.

They said care for transgender kids is wide-ranging, from efforts to help children socially transition to puberty-blocking medications, and is undertaken with the input

of pediatric psychologists, clinical social workers, hormone experts and endocrinologists, as well as families. Gender-affirming surgeries are not a routine part of pediatric gender care, they said, and Children's Minnesota does not perform any such surgeries.

Sponsor Message

Some of the claims about Children's National, Boston Children's and other hospitals were pushed by the Libs of TikTok account, which regularly reposts videos and social media posts from LGBTQ people, teachers, schools and other institutions. The clips are sometimes taken out of context and framed to fuel outrage or ridicule of LGBTQ and anti-racist causes, in what the account owner has described as "exposés" of "the crazies."

For example, a short clip about gender-affirming hysterectomies from a video originally posted by Boston Children's that Libs of TikTok reposted makes no mention of patients' ages. But Libs of TikTok tweeted alongside the clip the false claim that the hospital offers the surgery "for young girls."

Libs of TikTok, run by a Brooklyn woman named Chaya Raichik, has 1.3 million followers on its biggest platform, Twitter. It's gained prominence and influence in right-wing circles over the last year as conservatives increasingly try to use anti-LGBTQ sentiment to gain support.

NPR reached out to Raichik for this story. She initially responded and agreed to an interview, but did not respond to a follow-up message. Raichik frequently condemns criticism of her online activities as efforts to "cancel and silence" her. She has said that she has also been targeted with death threats.

Platforms struggle with harassment networks

Twitter and Facebook prohibit bullying and harassment, coordinated mass attacks, and incitement to violence. Both companies ban the use of the word "groomer" as a smear against LGBTQ people under their rules against hate speech.

The platforms have taken down some of the threats against the hospitals. But it's less clear how much accountability the companies can or will put on accounts that draw attention to the targets that end up getting harassed.

Twitter has previously temporarily suspended Libs of TikTok for breaking its rules. The company declined to comment on the account. Following Boston Children's Hospital's reported threats, Libs of TikTok said it had been permanently suspended by Facebook for violating the platform's community standards. But that was quickly reversed, and the account returned to posting on Facebook, saying the social network said that was an error. Facebook declined to comment on the suspension.

Sponsor Message

Libs of TikTok appears to have evaded outright bans by coming right up to the edge of the platforms' rules but not breaking them. The account does not explicitly encourage followers to threaten anyone, and typically uses its target's own words, sometimes stripped of context, to imply wrongdoing.

But while its individual posts may stick to the letter of the platforms' rules, their cumulative effect is what worries researchers like Joan Donovan, who studies online extremism, media manipulation and disinformation at Harvard's Shorenstein Center on Media, Politics and Public Policy.

"We've reached this phase in social media where people know what to do when an account like Libs of TikTok calls out another account or a person or institution," she said. Call-outs can spark harassment campaigns known as "brigading," where commenters pile on a common target.

In the case of the children's hospitals, "the threats have moved from insulting people or targeted accounts online into more direct threats," Donovan said. "The online threat escalates very quickly into offline violence when we start to see these patterns of attack."

For social networks to deal with what Donovan calls "networked incitement," she says effectively tracking those threats means looking beyond single posts on specific platforms.

"The precipitating comments may not be that incendiary, but if that creates a pattern of attack that is recognizable, which it is with an account like Libs of TikTok, then these companies are well within their jurisdiction to warn and then ban the account."

Right-wing groups target LGBTQ events, education and healthcare

Pediatricians and children's hospitals are just the latest targets of right-wing outrage, in a new iteration of decades-old smears of gay, lesbian and transgender people as pedophiles or "groomers."

"The Libs of TikTok account has been a major actor in driving a lot of the harassment campaigns that we've seen over the past year," said Ari Drennen, LGBTQ program director at Media Matters for America, the liberal advocacy group.



NATIONAL

Far right groups shift focus to LBGTQ events. Their hateful aim hasn't changed

In some cases, events and figures publicized by Libs of TikTok have been targeted offline by far-right extremists known for brawling.

On a single day this summer, for example, men with ties to the white nationalist group Patriot Front were arrested outside a Pride event in Coeur D'Alene, Idaho, and alleged members of the far-right Proud Boys crashed a drag queen story hour at a library in San Lorenzo, Calif. Libs of TikTok had tweeted about both events, although there's no conclusive link between the posts and the extremist groups' activities.

As the *Washington Post* reported in April, the account's subjects and posts are regularly featured and promoted by other conservative influencers and media figures, including podcaster Joe Rogan. Raichik has appeared on Tucker Carlson's prime time Fox News show.

The escalating stigmatization of transgender medical care has doctors worried.

"This is a developmentally appropriate, team-based approach that allows kids time to figure out their identities," said Dr. Goepferd of Children's Minnesota.

Threats to hospitals ripple out, affecting not only hospital staff but also patients and families seeking all kinds of care, as well as longer-term research needed in the field. "I worry that this type of false narrative would make research institutions or funders nervous to fund more research into finding out what is the best possible care we could be providing right now," Goepferd said.

"The fact that somewhere the message has gotten through that it's okay to attack physicians, pediatricians, children's hospitals in this way is just a really disturbing

societal trend," they said.

Editor's Note: *Facebook parent Meta pays NPR to license NPR content.*

Editor's Note

Aug. 26, 2022

This story has been updated to clarify that Dr. Angela Kade Goepferd said gender-affirming surgeries are not a routine part of pediatric gender care, and that Children's Minnesota does not perform any gender-affirming surgeries.

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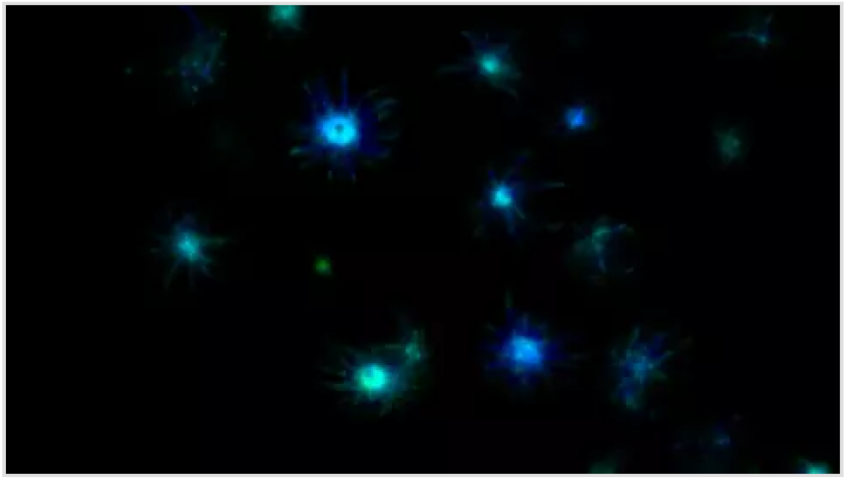
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ACC Underscores Safety of COVID-19 Vaccine

Oct 14, 2022

ACC News Story

With questions again being raised about the safety of COVID-19 vaccines, particularly in adolescent boys and young men receiving mRNA vaccines, the ACC is underscoring the benefits of COVID-19 vaccination, especially for patients with cardiovascular disease and related risk factors who remain among those at greatest risk from the virus.

The ACC has long supported vaccination as a vital protective measure against dangerous illness and for personal and community health. "There is no question that the benefits of COVID-19 vaccination generally outweigh the risks. While we do acknowledge that there is a very small risk of myocarditis after vaccination, particularly in adolescent boys and young men receiving mRNA vaccines, these instances are extremely rare, generally mild and treatable, and in most cases resolve quickly and without intervention," said **Eric Stecker, MD, FACC**, chair of ACC's Science and Quality Committee. "We should be clear that the risk of long COVID, heart damage and death are higher among unvaccinated COVID-19 patients, and we therefore encourage everyone, including young men, to receive a primary (two-shot) vaccination for COVID-19."

Stecker notes that it is reasonable for adolescent and young males to consult with a physician prior to receiving additional mRNA boosters, given the small but elevated risk of myocarditis in this group.

Throughout the pandemic the ACC has developed clinical guidance by critically evaluating the full spectrum of peer-reviewed, scientific evidence to make recommendations on a variety of topics, including vaccination benefits and risks. Most recently, the ***2022 ACC Expert Consensus Decision Pathway on Cardiovascular Sequelae of COVID-19 in Adults*** addressed myocarditis and other myocardial involvement, post-acute sequelae of SARS-CoV-2 Infection, and return to play. New **CardioSmart patient tools** include infographics on long COVID and return to play, as well as a post-COVID health history and symptom checklist and a fact sheet on common heart issues after COVID-19.

"The College welcomes continued scientific study of COVID-19, vaccination and related complications as this is a nuanced topic with continued health ramifications likely to be discovered for years to come," said Stecker. "We encourage people with questions or concerns about COVID-19 vaccination to talk to their clinician to determine the best course of action for their own health needs and concerns."

*For more COVID-19 clinical guidance, published research and expert perspectives, visit ACC's **COVID-19 Hub**.*

Clinical Topics: **COVID-19 Hub, Heart Failure and Cardiomyopathies, Prevention, Sports and Exercise Cardiology**

Keywords: *COVID-19, COVID-19 Vaccines, SARS-CoV-2, Cardiovascular Diseases, Myocarditis, Return to Sport, Vaccination, RNA, Messenger, Heart Injuries, Physicians, Risk Factors*

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Why We Stand Up for Transgender Children and Teens



Moira Szilagyi, MD, PhD, FAAP

August 10, 2022

As I reflect on the recent AAP Leadership Conference, where pediatricians from across the country gathered in person for the first time in three years, I feel a tremendous sense of pride. Pediatricians are guided by our values. We believe in the inherent worth of all children.... that each and every one deserves optimal health and the highest quality care. We stand on science

and keep children front and center. While we know everyone cares about children, especially their own children, the AAP cares about all children, each and every one. This includes children and youth who are transgender.

During the conference, pediatricians spoke up in support of a resolution on the need to expand education and training on gender-affirming care, and I was reminded of a patient encounter from when I was a freshly minted pediatrician.

I was seeing a 16-year-old girl, dressed in black from head to toe, who came in for a well visit. She was in foster care, the landing place for so many LGBTQ+ youth rejected by their biological families, especially when I was first starting my career. She was pretty noncommunicative. At the end of the visit, she said: "If you knew me, you would hate me."

A couple of additional visits followed over the course of several weeks, and she eventually disclosed that she was a lesbian. It was an opportunity for me to reassure her that I admired her, supported her and certainly did not hate her. Her mood changed instantly, and she opened up to me about the struggles she had endured and would face moving forward in a world that would not always be accepting.

The emotional and psychological trauma of rejection, whether by family, friends, society, or lawmakers, can leave scars that never heal. When we fail to accept people for who they are, we pass painful judgements on them and create so much unnecessary emotional and psychological pain.

The emotional and psychological trauma of rejection, whether by family, friends, society, or lawmakers, can leave scars that never heal. When we fail to accept people for who they are, we pass painful judgements on them and create so much unnecessary emotional and psychological pain.

I cannot tell you how many similar conversations I have had over the years with young LGBTQ+ patients. They are all, just like any teen, trying to find their way in life. Our duty to them as doctors is to support them on that journey--to help them become the best person they can be. This is the approach our gender-affirming care policy is grounded in.

There is strong consensus among the most prominent medical organizations worldwide that evidence-based, gender-affirming care for transgender children and adolescents is medically necessary and appropriate. It can even be lifesaving. The decision of whether and when to start gender-affirming treatment, which does not necessarily lead to hormone therapy or surgery, is personal and involves careful consideration by each patient and their family.

At this year's Leadership Conference, there was a second resolution on transgender youth, offered by five pediatricians who disagree with the Academy's approach to gender-affirming care. These pediatricians were unable to recruit a sponsor, which meant no one was willing to support their proposal. During our meeting, this resolution did not advance because it did not receive a second vote on the floor. Much like other formal democratic processes, the AAP Leadership Conference follows a set of standard parliamentary procedures to structure our discussions.

The conference serves to connect AAP state chapters, our national committees, councils and sections and the AAP Board of Directors, which is the policy-making body of the Academy. Part of this meeting involves debate and voting on resolutions, when AAP members have the opportunity to provide input on the Academy's efforts to address important child health issues. Other topics at the Leadership Conference ranged from expanding children's health insurance to reducing child poverty. The resolution process is important, because it keeps AAP leaders apprised of the issues and concerns of our members across the country.

However, we don't need a formal resolution to look at the evidence around the care of transgender young people. Evaluating the evidence behind our recommendations, which the unsponsored resolution called for, is a routine part of the Academy's policy-writing process. Critics of our gender-affirming care policy mischaracterize it as pushing medical or surgical treatments on youth; in fact, the policy calls for the opposite: a holistic, collaborative, compassionate approach to care with no end goal or agenda. The AAP Section on LGBTQ Health and Wellness, as well as other groups within AAP's membership, are engaged in numerous conversations about transgender care and we expect those discussions to continue. It is an important conversation, and one the AAP is eager to lead.

Gender-affirming care is a top issue of concern for pediatricians, and in fact, one of the **top ten resolutions** receiving the most support at the meeting was the one on expanding education and training for pediatricians on gender-affirming care. I was heartened to see this resolution pass with such broad support.

Yet outside of our organization, there is a dangerous movement taking place, led by extremists, targeting youth who are receiving gender-affirming care, and vilifying the

pediatricians providing their care. The result has been rampant disinformation about what this care is and real threats of violence against some of our members.

In some states, efforts are underway to restrict access to gender-affirming care and criminalize the pediatricians who provide it. This has already had a chilling effect on access to care in these communities, and other efforts across the country are focused on doing the same. The people who suffer the most from this discrimination are of course the children and teens just trying to live their lives as their true selves. Pediatricians will not stay silent as these lies are waged against our patients and our peers.

I am proud to lead the American Academy of Pediatrics, proud to stand alongside pediatricians providing gender-affirming care, and proud to support all children.

The views expressed in this article are those of the author, and not necessarily those of the American Academy of Pediatrics.

About the Author

Moira Szilagyi, MD, PhD, FAAP

Moira Szilagyi, MD, PhD, FAAP, is the 2022 president of the American Academy of Pediatrics.

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August 7, 2023

Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Becerra:

Thank you for testifying at the June 13 Committee on Education and the Workforce hearing on "Examining the Policies and Priorities of the U.S. Department of Health and Human Services."

Enclosed are additional questions submitted by Committee members following the hearing. Please provide a written response no later than September 7, 2023, for inclusion in the hearing record. Responses should be sent to Michael Davis of the Committee staff, who can be contacted at (202) 225-7101.

We appreciate your contribution to the work of the Committee.

Sincerely,

Virginia Foxx

Virginia Foxx
Chairwoman

Enclosure

Questions for the Record for
XAVIER BECERRA

Committee on Education and the Workforce
Full Committee Hearing:
"Examining the Policies and Priorities of the Department of Health and Human Services"
Tuesday, June 13, 2023
10:15 a.m.

Chairwoman Foxx (R-NC)

1. The *Inflation Reduction Act* (IRA) included $33 billion to expand subsidies for Obamacare plans for an additional three years. The President's budget calls for a permanent expansion of enhanced subsidies, at a cost of $247.9 billion over the next decade. Wouldn't it be better to strengthen employer-sponsored insurance, which is consistently more affordable and of higher quality?

2. Three out of four individuals in the *Affordable Care Act* (ACA) exchanges receive subsidies. Doesn't this demonstrate that these plans are unaffordable?

3. Premiums on the ACA exchanges are skyrocketing. Recently, health plans in New York requested rate bumps of up to 40 percent. What is the administration's plan to lower the cost of ACA premiums, or is the plan simply to continue to pump money into the system with tax hikes?

4. Our debt is about to hit $32 trillion. You have long been a proponent of Medicare for All, which would cost $32 trillion over 10 years. Do you think it's a good idea to double our federal debt for Medicare for All?

5. Telehealth, in many ways, was a silver lining of the COVID-19 pandemic. Many new patients gained access to these important services as the Department allowed employers to offer stand-alone telehealth coverage. However, telehealth excepted benefits will expire at the end of this plan year, as the declared Public Health Emergency came to an end on May 11. Do you believe this flexibility helped workers gain better access to care?

6. Medicare Part A is expected to go insolvent in 2031, and Medicare spending is expected to grow exponentially over the next few decades. The President's plan to address Medicare is simply to raise taxes and use accounting tricks to move money around. When will the President take the issue of health care costs seriously?

7. According to Congressional Budget Office estimates, ACA plans per enrollee are three times more expensive for taxpayers than employer-sponsored insurance. Do you believe that shifting enrollment from ACA plans to the employer-sponsored market would be beneficial for the federal budget? If so, what steps will the Department of Health and

Human Services (HHS) take to encourage migration?

8. Association Health Plans (AHPs) are an effective way to expand health care coverage options to small businesses and lower premiums. Virginia recently passed a law to allow realtors to join together to create AHPs. Unfortunately, HHS sent a notice to the state alleging it is violating coverage rules. Do you agree that Virginia's law would expand health coverage options and lower costs for realtors?

9. Small businesses rely on stop-loss insurance to provide affordable, higher quality health care coverage to their employees by self-insuring. Do you agree that stop-loss coverage is a necessary tool for many businesses to self-insure?

10. Is a rule to amend regulations governing short-term, limited-duration insurance (STLDI) currently being reviewed by the White House?

11. Does the Department expect to limit the duration of these plans to three months? How do you anticipate the changes to STLDI insurance will affect the rate of uninsured individuals?

12. Do you agree that STLDI is a useful tool for individuals to use if their coverage is interrupted by Medicaid redeterminations?

13. In the recent ACA regulation, the Department significantly weakens program integrity tools by requiring exchanges to wait two consecutive tax years before determining whether an enrollee is eligible for the advanced premium tax credits. Do you agree that this policy change will increase tax liabilities owed and increase debt for individuals erroneously receiving tax credits?

14. Your budget proposes to extend Medicare's $35 out-of-pocket cap for insulin to the commercial market, which will increase costs in the private sector by $2 billion a year. Will extending this cap to the commercial market raise premiums for individuals in small- and large-group plans?

15. The 340B program is intended to pass on savings and improve health outcomes for low-income patients. However, there are reports that hospitals and pharmacies are selling these drugs to commercially insured patients to help pad their bottom line, using employer-sponsored plans to subsidize the 340B program at the expense of workers' premiums. The President's budget includes funding for covered entities to report to the Health Resources and Services Administration on how the savings they achieve through the 340B program are passed on to patients. Can you provide an update on these oversight efforts?

16. According to a study from the University of Chicago, government price controls in the *Inflation Reduction Act* will result in 342 fewer cures reaching the market, which will take 330 million years off Americans' lives. What is the administration's plan to ensure that patients will not lose out on access to lifesaving cures and that America will continue

to be the world leader in medical innovation?

17. The Centers for Medicare and Medicaid Services' (CMS) implementation of the *Inflation Reduction Act*'s drug-pricing provisions has lacked transparency and public engagement. One step would be to ensure that the text of the Negotiation Program Agreement is made available for public comment well in advance, at least 60 days, of the first selected drug publication date. Will CMS take this reasonable step while also continuing to find other ways to engage with stakeholders and be more transparent?

18. Drug manufacturers are dealing with uncertainty as to whether their drugs will be selected for government negotiation. The negotiation process has the potential to upend each company's operations and research and development. It seems clear that CMS should have a pre-selection process where it notifies each manufacturer of each drug it intends to select for negotiation and solicits feedback from manufacturers. Will you commit to such a process?

19. For the prescription-drug negotiation process, CMS has proposed a requirement that manufacturers destroy all records related to the process and that would prohibit disclosing or otherwise publicizing information in the initial offer or subsequent offers. This essentially allows CMS to operate in secret and with no accountability. What is the logic behind CMS having one-sided information control, and doesn't this show the so-called negotiation process is not a true negotiation?

20. Do you think that patients should have the right to know how much a medical procedure is going to cost them before they obtain treatment?

21. CMS has not been enforcing the hospital price transparency rule. What will you do to ensure there is greater compliance with this rule?

22. Only four hospitals have been fined for violating the administration's hospital price transparency rule, while overall compliance is lacking. Why has the Department not done more to enforce the hospital price transparency rule?

23. Do you think that the fact that patients essentially never know how much a treatment will cost, and that doctors and patients generally assume that someone else—either the insurance company or taxpayer through the government is going to pick up the bill—makes our health care system more expensive?

24. Employers expect an increase in premiums of 5.4 percent this year. The RAND Corporation, the Congressional Budget Office, and other economists have identified provider consolidation as a main driver of health care cost increases. Perverse economic incentives have driven hospitals to acquire provider offices and then to bill incorrectly for services. Would you agree that this is a problem for employers and workers?

25. Price transparency is vital for employers to help them make better decisions in choosing and administering employee health plans. HHS is indefinitely deferring enforcement of a

rule requiring plans to make drug prices public and to submit them to HHS. Should Congress codify this rule to ensure proper implementation?

26. Prescription drug middlemen like pharmacy benefit managers (PBMs) are raking in profits while evading congressional scrutiny. An executive for one of the big three PBMs recently told investors to "not worry about Congress" and that it "would find ways to maintain its level of profit if those reforms to things like drug rebates went into effect." What actions can Congress take to increase oversight and accountability on PBMs?

27. CMS' Framework for Health Equity declares, "Each person CMS serves should receive … care that is responsive to their … cultural health beliefs and practice, traditions, and other communication needs."
    a. In light of that statement, why did CMS reject an appeal from St. Francis Hospital in Oklahoma, which was threatened with termination from Medicare for having a lit candle behind two layers of glass in a hospital chapel?
    b. How did this threat ensure Medicare beneficiaries are receiving care that is responsive to them?
    c. Why did CMS finally agree to a compromise, which incidentally coincided with the story hitting the media?

28. You were quoted as saying "Abortion is health care" when announcing a new rule to mandate coverage of contraceptive services at Planned Parenthood.
    a. What does this rule have to do with abortion?
    b. Do you plan on expanding the individual contraceptive arrangement to abortion services?

29. As I said in my opening statement, "The only health care experience you had before assuming office was litigating an appellate court case in which you attempted to strong-arm Catholic nuns into paying for others' contraceptives." Is the individual contraceptive arrangement a new way to circumvent the Little Sisters of the Poor's decision not to pay for abortifacients?

30. On March 2, 2022, in a statement released in response to concerns regarding gender reassignment surgery and child welfare investigations, you encouraged those who are being targeted by child welfare investigations to contact the HHS Office for Civil Rights to report their experience. Will you ensure that any parent who is investigated by Child Protective Services and who asserts a parental right to protect his or her child against sex change operations will receive support from the Office for Civil Rights?

31. In a memo released by your Department on March 2, 2022, the memo stated, "The Department of Health and Human Services and all leading national medical and pediatric associations confirm that providing gender-affirming medical care is in the best interest of children and youth who need it."[1] The memo goes on to suggest that child welfare services' funds under title IV-B of the *Social Security Act* should be used by states to

[1] HHS Administration on Children, Youth and Families, Log No: ACYF-CB-IM-22-01. https://www.acf.hhs.gov/sites/default/files/documents/cb/im2201.pdf.

"assist…in accessing gender-affirming health care." That is not an appropriate use of taxpayer dollars.

a. Does Title IV-B mention "gender-affirming" health care?
b. What are puberty blockers?
c. What effects do puberty blockers have on the brain development of children?
d. What about the effects of puberty blockers on fertility?
e. Are puberty blockers reversible?
f. Isn't it true that puberty blockers can cause permanent sterility in a healthy girl or boy?
g. Would providing puberty blockers be considered medical malpractice?

32. We know that the Centers for Disease Control and Prevention (CDC) closely consulted with teachers' unions such as the American Federation of Teachers (AFT) on school reopening guidance. The New York Post on April 25 of this year reported: "AFT and its fellow union, the National Education Association, also asked the White House and CDC for help shaping its press strategy to show the rank-and-file they and the Biden administration were on the same page."[2] Please tell us what communications advice the CDC gave to teachers' unions.

33. In February 2021, the CDC was planning to release new school reopening guidance. The guidelines would have advised schools that they could reopen regardless of community spread of COVID-19. But then the guidance changed. After consulting with the AFT, the CDC revised the guidance such that, according to CNN's Jake Tapper at the time, schools serving 99 percent of students could potentially close. We knew by then that COVID posed a low risk to school children. We also know that remote learning was a devastating experience for many children. Was it a mistake for the CDC to accept the AFT's edits to its reopening guidance?

34. On November 30, 2021, HHS issued an interim final rule for COVID-19 mitigation as a new provision to the Head Start Program Performance Standards. The rule required universal masking for all individuals two years of age and older, with immediate compliance, and vaccination for COVID-19 by January 31, 2022, for all Head Start staff, contractors providing services to children, and volunteers working with children. Although the CDC recommended in August 2022 universal masking only if there is a high community transmission rate, Head Start guidelines remained unchanged. Eventually, HHS, in a final rule, removed the universal masking requirement on January 6, 2023.[3] The vaccine mandate was struck down by a federal court on March 31 of this year on the grounds the mandate was arbitrary and capricious.[4] Why did HHS reverse course on universal masking so long after the CDC recommended otherwise, and why did it require a federal district court injunction to vacate the vaccine regulation on the

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[2] https://nypost.com/2023/04/25/teacher-unions-had-bigger-hand-in-cdc-school-reopening-plan/.
[3] https://www.federalregister.gov/documents/2023/01/06/2022-28451/mitigating-the-spread-of-covid-19-in-head-start-programs
[4] *Texas v. Becerra*, No. 5:21-CV-300-H, 2023 BL 110050, 2023 US Dist. Lexis 56119 (N.D. Tex. Mar. 31, 2023) (nationwide injunction).

grounds it was arbitrary and capricious?

35. It is disheartening to read widespread reports of unaccompanied children who enter through our borders and end up lost in the hands of human traffickers or become subject to dangerous and unlawful child labor.[5] According to the U.S. Customs and Border Protection, roughly 340,000 unaccompanied children have shown up at the United States border since 2021.[6] Data obtained by the New York Times, however, suggest that during the two years from 2021 through the present, the Department has lost contact with 85,000 unaccompanied children.[7] I am concerned about allegations that the Department may have lost track of some unaccompanied children.
    a. What specific means does the Department use to reach out to these children?
    b. What specific steps has the Department taken to remedy your inability to keep track of unaccompanied children?
    c. Are you using person-to-person contact to reach unaccompanied children?
    d. What other means do you use to reach unaccompanied children?

36. In a Department staff meeting last summer, you urged your staff to release minors into the United States at rapid-fire rates. You stated that the Department's efficiency in doing so was not meeting the standard of the assembly line that made Henry Ford rich and famous.[8]
    a. Do you disavow your "assembly line" comments?
    b. What is the administration doing to protect these children better and ensure that they do not become victims of trafficking or other crimes?

37. I am frankly shocked at the lack of coordination between the Department of Labor, HHS, and the Department of Homeland Security when it comes to protecting the health and safety of unaccompanied migrant children after they have entered the United States. It is the responsibility of HHS to ensure that these children are placed with responsible caregivers after they leave HHS. Yet, it appears as though many of these children were placed with human traffickers and were forced to work in jobs that are illegal for minors to hold. This was so prevalent that HHS stopped placing children with sponsors in certain zip codes.
    a. Did the Department of Labor warn HHS that these children were at risk for human labor trafficking at any point in 2021, 2022, or 2023?
    b. Do you believe that HHS properly vetted the sponsors of unaccompanied children who were found to be exploited by human labor traffickers?
    c. Did HHS follow all protocols when vetting sponsors for unaccompanied children?
    d. Did the Department's failure to vet sponsors contribute to the increase in child labor trafficking?

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[5] See Tara Rodas, Opening Statement, Health and Human Services Whistleblower, Federal Inspector General Employee, https://judiciary.house.gov/sites/evo-subsites/republicans-judiciary.house.gov/files/evo-media-document/rodas-testimony.pdf.
[6] https://nypost.com/2023/04/28/republican-senators-want-feds-to-explain-losing-85000-migrant-kids/.
[7] https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html.
[8] https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html.

e. If a child who was under the care of HHS' Unaccompanied Children Program is found to be a victim of human labor trafficking, is the sponsorship immediately terminated, and does the federal government reclaim custody of the child?
f. Are there circumstances under which the child will be returned to the original sponsor?
g. Are there circumstances under which the child will be returned to an immediate relative of the original sponsor? And, if so, what is the vetting process for these individuals?

38. Is it accurate to say that some human traffickers promise young children that they can go to school or work in the United States to lure them into being trafficked?

39. This seems to be a very lucrative business practice of cartels. Is HHS placing children with members of gangs and cartels, including MS-13?

40. Is it true that HHS would release multiple unaccompanied children to the same address or building?

41. One whistleblower recently testified that she saw "20, 30, and 40 unaccompanied children released in the same apartment building." What action is HHS taking to ensure that individuals are not sponsoring multiple children, and that multiple children are not being released to the same address?

42. In the HHS budget, you propose an outlandish 76 percent increase in the Title X Family Planning program from $286 million to $512 million. Would you agree that the proposed increase would be better directed to help low-income women and their families with prenatal care and supportive family services instead of providing taxpayer funds for taking the life of an unborn child?

43. Why is the FDA allowing the off-label use of cross-sex hormones to be used on children when there has been no long-term study on how this affects their physical and mental health?

44. Are you concerned that the medical community is essentially experimenting on children and may be condemning gender-confused children to lasting physical harm, including lost fertility and sexual health?

45. Do you think that parents today know the risks and lasting physical consequences of taking cross-sex hormones?
46. Do you have any comment about other nations, including the UK, Finland, Norway, France, and Sweden, recently limiting adolescent gender transition?

47. Why is the U.S. an outlier on this issue?

48. In the U.S., many lives were lost to COVID. However, many lives were also negatively impacted, and even shortened, due to our pandemic response. Substance abuse, domestic

abuse, and deaths of despair increased, and overall general health decreased, as people became more socially isolated and less active. What is the administration doing to measure the human and health costs of our COVID response?

49. Why did you enact the COVID-19 vaccine mandate for federally operated health care and clinical research facilities against employees, contractors, trainees, and volunteers?

50. Why did you mandate the COVID-19 vaccination without an option to test out of the mandate?

51. Why did you require that 300,000 educators in the Head Start program be vaccinated when scientific evidence was emerging that most children were not at grave risk of receiving or transmitting COVID?

52. Do you recognize the negative health or economic ramifications of this vaccine mandate on federal workers?

53. Did you ever consider the constitutionality of vaccine mandates before imposing them upon swaths of the federal workforce as well as those under your purview?

54. Did you express any concerns to President Biden and other agency heads regarding vaccine mandates?

55. Private health insurance is associated with superior health access and outcomes compared to Medicaid. What is the administration doing to ensure that patients who are not eligible for Medicaid have access to affordable private health insurance?

Rep. Suzanne Bonamici (D-OR)

1. The proliferation of fentanyl and other synthetic opioids among teenagers continues to have disastrous consequences around the nation. Two years ago, the Beaverton School District in NW Oregon developed "Fake and Fatal: One Pill Can Kill," an education and awareness campaign to teach students about the dangers of fentanyl. The school district also made Naloxone available in all secondary schools to reverse the effects of drug overdoses. Since the implementation of both policies, not one student in Beaverton schools has lost their life to a fentanyl overdose. This successful effort was made possible by coordination among the school district and local nonprofits, public health officials and organizations, and practitioners proficient in evidence-based solutions to the crisis of opioid abuse and misuse.
    a. How is HHS leveraging its resources through SAMHSA, CDC, and NIH to mitigate the effects of opioid abuse and misuse among youth, and how can Congress support the ability of HHS to forge stronger relationships with the Department of Education to make solving this urgent crisis a priority?

2. Many Head Start programs are facing staffing challenges because of low compensation and direct workforce competition from other early childhood programs and other

industries. Directors are continuing to recruit and train staff but are also working to change the scope of their grants, which may include converting Head Start slots to Early Head Start or reducing the number of children served. Change-in-scope applications are time-consuming and can take months to be resolved with the Office of Head Start. With summer being an essential time for planning for the upcoming program year, Head Start directors are eager to know the composition of the programs they will be running in the fall.

   a. What steps is the Office of Head Start taking to quickly resolve the large number of change-of-scope applications that are currently awaiting resolution?

3. The Preschool Development Grants Birth through Five (PDG B-5) program– which your agency recently awarded to 42 states – allows states to create more effective, efficient programs by collaborating across multiple systems and agencies. The PDG B-5 grants encourage states to focus on five major activities, including aligning existing programs, maximizing parental choice, building on the success of existing programs, fostering partnerships among stakeholders, and leveraging data for continued improvement.
   a. What progress have we seen in states that participate in the Preschool Development Grant Birth through Five program?

4. The Low Income Heating and Energy Assistance Program (LIHEAP) provides federally funded assistance in managing costs associated with home energy bills, energy crises, weatherization, and energy-related minor home repairs. The President's proposed budget would allow LIHEAP grantees to use up to 2.7 percent of their FY 2024 LIHEAP funds to assist low-income households with their water and wastewater utility bills. In my home state, Oregon Housing and Community Services worked effectively with Community Action Teams to deliver resources to Oregonians who needed assistance with their water bill during the pandemic. Despite the effectiveness of this program, it will end – but many people are still struggling with their water bills, especially in the rural communities I represent.
   a. How has the Low Income Household Water Assistance Program (LIHWAP) been successful, and why did the Department propose to continue allowing funding to support low-income people with their water and wastewater utility bills in their FY24 budget?

5. According to the 2021 report, GAO-21-540, from the Government Accountability Office (GAO), "about 1 in 10 young adults and 1 in 30 minors under age 18 experience homelessness without a parent or caregiver over the course of a year." As a Co-Chair of the Congressional Caucus on Homelessness, I want to emphasize that this is unacceptable.
   a. What has the Department done to implement the GAO's recommendations, and what has the Department done specifically to provide communities with additional information on strategies and promising practices for coordinating their programs on Continuum of Care (CoC) and Runaway and Homeless Youth (RHY)?
   b. How would the proposed FY24 budget combat homelessness among our nation's young people?

c. Additionally, how does HHS focus on the disproportionate rates of LGBTQI+ young people and BIPOC youth experiencing homelessness?

6. I'm very concerned about the shortage of behavioral health workers and the barriers that exist in recruiting and retaining a diverse and qualified behavioral health workforce. I am encouraged that HHS operates several loan repayment programs (LRPs) through HRSA's National Health Service Corps (NHSC), including the Substance Use Disorder Workforce LRP, NHSC LRP, Rural Community LRP, and Substance Use Disorder Treatment and Recovery (STAR) LRP. Despite these programs, I continue to hear from practitioners and providers that high student debt burdens are a prohibitive factor for graduates seeking to enter behavioral health professions.
    a. What more is HHS doing to expand access to these loan repayment programs and create opportunities for diverse, underrepresented students to pursue careers in the behavioral health workforce?

7. No one should have to worry about whether they will receive needed elder care support and services because of their identity or who they love. In June of 2022, President Biden demonstrated his commitment to this principle by advancing an LGBTQ+ Long Term Care Bill of Rights to protect at-risk LGBTQ+ elders in long-term care settings by Executive Order.
    a. What's the status of the drafting process and when we should expect to see concrete next steps on the LGBTQ+ Long Term Care Bill of Rights?
    b. By what date will the protections be put into place so LGBTQ+ older people in long-term care settings will know that the federal government is committed to their health and well-being?

Rep. Teresa Leger Fernandez (D-NM)

1. As you may know, I attended Head Start as a child and, to this day, I'm a strong advocate of the program. With that in mind, I was thankful to see that President Biden included $575 million for an increase in Head Start wages in his proposed budget for FY24. However, that only represents an increase of 4.8% which, if enacted, would still leave a significant difference between Head Start teacher wages and those earned by public school teachers. Question A
    a) How does HHS/OHS plan to address that discrepancy?

Rep. Glenn "GT" Thompson (R-PA)

1. In the 115th Congress, I was proud to champion the *Veterans E-Health and Telemedicine Support Act*, which allowed physicians at the Department of Veterans Affairs (VA) to treat veterans via telehealth across state lines. This simple fix greatly expanded access to care for our nation's veterans who could previously drive across state lines to see a VA physician but could not receive those services via telehealth. These services are particularly helpful in rural areas where the nearest in-person provider may be hours away. As you may know, there are certain specialties and practices in some states that allow providers to meet with patients via telehealth regardless of state boundaries.

Unfortunately, this patchwork of policies is not particularly effective, and it results in confusion and added layers of bureaucracy for patients and providers alike. How do you think we can build on the successful model at the VA to allow any physician to treat their patient via telehealth across state lines?

Rep. Gregorio Kilili Camacho Sablan (D-MP)

1. As Medicaid unwinds due to the end of the COVID-19 public health emergency, most States have been able to mitigate the loss of coverage by directing people to the Exchange. However, my district and the other territories do not have access to the Exchange.
    a) What support can your Department offer in developing a strategy for the establishment of Exchanges in the U.S. territories?

Representative Susan Wild (D-PA)

1. It was recently reported that call center workers at Maximus, one of the largest federal contractors for HHS, went on strike after the company announced surprise layoffs impacting over 700 workers. The workers impacted by the layoffs were customer service representatives who managed calls for millions of Americans reaching out with questions related to the Affordable Care Act and Medicare. The company attributed the layoffs to overstaffing; however, the company then recruited for many of these same positions at non-union organizing sites almost immediately after the layoffs were announced. In response to these surprise layoffs, the need for fairer wages, and the lack of career advancement opportunities, Maximus workers in four states went on their fourth strike.
    a. Secretary Becerra, does HHS intend to investigate Maximus' labor practices as it pertains to these seemingly unfair layoffs?
    b. If Maximus is found to have committed wrongdoing, how does HHS plan to remedy the harm done to laid-off workers and hold Maximus accountable?
    c. Will you call on Maximus to rehire laid-off workers?

Questions for the Record for
XAVIER BECERRA

Committee on Education and the Workforce
Full Committee Hearing:
"Examining the Policies and Priorities of the Department of Health and Human Services"
Tuesday, June 13, 2023
10:15 a.m.

Chairwoman Foxx (R-NC)

Question #1

1. The *Inflation Reduction Act* (IRA) included $33 billion to expand subsidies for Obamacare plans for an additional three years. The President's budget calls for a permanent expansion of enhanced subsidies, at a cost of $247.9 billion over the next decade. Wouldn't it be better to strengthen employer-sponsored insurance, which is consistently more affordable and of higher quality?

Question #2

2. Three out of four individuals in the *Affordable Care Act* (ACA) exchanges receive subsidies. Doesn't this demonstrate that these plans are unaffordable?

Question #3

3. Premiums on the ACA exchanges are skyrocketing. Recently, health plans in New York requested rate bumps of up to 40 percent. What is the administration's plan to lower the cost of ACA premiums, or is the plan simply to continue to pump money into the system with tax hikes?

Answer 1-3:

More than 16.3 million people selected an Affordable Care Act (ACA) Marketplace health plan nationwide during the 2023 Marketplace Open Enrollment Period (OEP) that ran from November 1, 2022-January 15, 2023 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2023 Marketplace OEP than ever before, and millions of working families saved an average of $800 on their health insurance premiums last year due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 3.6 million people (22% of total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from

people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year.

This year, individuals benefited from a highly competitive Marketplace. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans. Also, new standardized plan options were available in 2023 through HealthCare.gov, which helped consumers compare and select plans.

To build on this success, the FY 2024 budget invests in making private insurance even more affordable. The FY 2024 budget permanently extends the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget provides Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the Affordable Care Act, paired with financial incentives to ensure States maintain their existing expansions. The budget builds on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget extends the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

Question #4

4. Our debt is about to hit $32 trillion. You have long been a proponent of Medicare for All, which would cost $32 trillion over 10 years. Do you think it's a good idea to double our federal debt for Medicare for All?

Answer:
Medicare is a key pillar of our health care system and we are committed to strengthening the program both now and in the future. Thanks to our efforts, this year's Medicare Trustees Report estimated that the solvency of the Medicare Hospital Insurance (HI) Trust Fund has been extended by three years since last year's report. In addition, adoption of the proposals in the President's FY 2024 Budget would extend Medicare solvency by at least 25 years, without cutting benefits or raising costs for people with Medicare. The FY 2024 budget also includes a targeted package of Medicare proposals totaling $8 billion over 10 years that supports the Administration's priorities such as investing in mental health, strengthening nursing home oversight, and enhancing program benefits. We look forward to continuing to work with Congress to further strengthen this vital program that serves over 65 million Americans.[1]

Question #5

5. Telehealth, in many ways, was a silver lining of the COVID-19 pandemic. Many new patients gained access to these important services as the Department allowed employers to offer stand-alone telehealth coverage. However, telehealth excepted benefits will expire at the end of this plan year, as the declared Public Health Emergency came to an end on May 11. Do you believe this flexibility helped workers gain better access to care?

[1] FY 2024 HHS Budget in Brief

Answer:
In response to the COVID-19 public health emergency, which expired in May 2023, flexibilities for Medicare telehealth services were issued through legislative and regulatory authorities to increase access to care for patients and providers. The Consolidated Appropriations Act of 2023 recently extended many of these flexibilities through December 31, 2024. Extended telehealth flexibilities include waiving geographic and site of service originating site restrictions so that Medicare patients can continue to use telehealth services from their home and allowing audio-only telehealth services. Additionally, the expanded list of providers eligible to deliver telehealth services is also extended so Medicare beneficiaries can continue to receive telehealth services furnished by physical therapists, occupational therapists, speech language pathologists, and audiologists, as well as receive telehealth services from Rural Health Clinics and Federally Qualified Health Centers through December 31, 2024. If you are interested in drafting legislation to make these waivers permanent, CMS would be happy to provide technical assistance.

Additionally, recent legislative and regulatory changes made several telehealth flexibilities permanent. Federally Qualified Health Centers and Rural Health Clinics can furnish certain behavioral services via telecommunications technology. Medicare patients can continue to receive these telehealth services in their home as geographic restrictions on the originating site are eliminated for these telehealth services. Certain behavioral services can be delivered using audio-only communication platforms, and rural emergency hospitals can serve as an originating site for telehealth services.[2]

For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Medicaid and CHIP telehealth policies will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

Question #6

6. Medicare Part A is expected to go insolvent in 2031, and Medicare spending is expected to grow exponentially over the next few decades. The President's plan to address Medicare is simply to raise taxes and use accounting tricks to move money around. When will the President take the issue of health care costs seriously?

Answer:
Medicare is a key pillar of our health care system and we are committed to strengthening the program both now and in the future. Thanks to our efforts, this year's Medicare Trustees Report estimated that the solvency of the Medicare Hospital Insurance (HI) Trust Fund has been extended by three years since last year's report. In addition, adoption of the proposals in the President's FY 2024 Budget would extend Medicare solvency by at least 25 years, without cutting benefits or raising costs for people with Medicare. The FY 2024 budget also includes a targeted package of Medicare proposals totaling $8 billion over 10 years that supports the Administration's priorities such as investing in mental health and substance use disorder treatment, strengthening nursing home oversight, and enhancing program benefits. We look forward to continuing to work with Congress to further strengthen this vital program that serves over 65 million Americans.[3]

[2] FY 2024 HHS Budget in Brief (p. 69-70)
[3] FY 2024 HHS Budget in Brief

Question #7

7. According to Congressional Budget Office estimates, ACA plans per enrollee are three times more expensive for taxpayers than employer-sponsored insurance. Do you believe that shifting enrollment from ACA plans to the employer-sponsored market would be beneficial for the federal budget? If so, what steps will the Department of Health and Human Services (HHS) take to encourage migration?

Answer:

More than 16.3 million people have selected an ACA Marketplace health plan nationwide during the OEP that ran from November 1, 2022-January 15, 2023 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2023 Marketplace OEP than ever before, and millions of working families saved an average of $800 on their health insurance premiums last year due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 3.6 million people (22% of total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year.

This year, individuals benefited from a highly competitive Marketplace. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans. Also, new standardized plan options were available in 2023 through HealthCare.gov, which helped consumers compare and select plans. ACA plans are serving a demonstrated need for Americans who may not have the option to enroll in employer-sponsored coverage.

To build on this success, the FY 2024 budget invests in making private insurance even more affordable. The FY 2024 budget permanently extends the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget provides Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the Affordable Care Act, paired with financial incentives to ensure States maintain their existing expansions. The budget builds on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget extends the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

Question #8

8. Association Health Plans (AHPs) are an effective way to expand health care coverage options to small businesses and lower premiums. Virginia recently passed a law to allow

realtors to join together to create AHPs. Unfortunately, HHS sent a notice to the state alleging it is violating coverage rules. Do you agree that Virginia's law would expand health coverage options and lower costs for realtors?

Answer:
On May 31, 2023, CMS issued a preliminary determination pursuant to 45 CFR 150.217 that the Commonwealth of Virginia failed to substantially enforce certain specified federal market reforms. CMS's preliminary determination is based on implementation and enforcement of a state law, § 38.2-3521.1G of the Code of Virginia, as enacted by HB 768/SB 335 (2022), which allows an association of real estate salespersons to purchase health insurance coverage in the large group market in Virginia. The state law conflicts with and in some cases prevents the application of the specified federal market reforms. CMS made this preliminary determination after consulting with the Office of the Governor of the Commonwealth of Virginia and the Virginia Bureau of Insurance on April 7, 2023, and after corresponding with the Commonwealth.

An association of real estate salespersons described in the state law cannot establish or maintain a group health plan as an "employer" under the Employee Retirement Income Security Act (ERISA) section 3(5) and Department of Labor regulations and guidance. Therefore, each association member must receive coverage that complies with the requirements arising out of the member's status as an individual, small employer, or large employer. By treating health insurance coverage sold to self-employed individuals and small employers through such an association as coverage offered in the large group market, the state law conflicts with and in some cases prevents the application of the specified federal market reforms that apply to coverage offered in the individual and small group markets.

Question #9

9. Small businesses rely on stop-loss insurance to provide affordable, higher quality health care coverage to their employees by self-insuring. Do you agree that stop-loss coverage is a necessary tool for many businesses to self-insure?

Question #10

10. Is a rule to amend regulations governing short-term, limited-duration insurance (STLDI) currently being reviewed by the White House?

Question #11

11. Does the Department expect to limit the duration of these plans to three months? How do you anticipate the changes to STLDI insurance will affect the rate of uninsured individuals?

Question #12

12. Do you agree that STLDI is a useful tool for individuals to use if their coverage is interrupted by Medicaid redeterminations?

Answer 9-12:
The Administration has announced, in the Unified Agenda for Regulatory and Deregulatory Actions, an intent to propose amendments to the current regulatory definition of short-term, limited-duration insurance (STLDI). The rule's proposals would be designed to ensure this type of coverage does not undermine the Affordable Care Act, including its protections for people with pre-existing conditions, the Health Insurance Exchanges, or the individual, small group, or large group markets for health insurance in the United States.

Patients and their families deserve the security of knowing that the insurance they buy will be there for them when they need it. STLDI is a type of health insurance that is designed to fill temporary gaps in coverage when an individual is transitioning from one source of coverage to another. STLDI is excluded from the definition of individual health insurance coverage under the Public Health Service Act and, therefore, is generally not subject to the applicable federal individual market consumer protections and requirements for comprehensive coverage under the ACA. For example, STLDI is not subject to the prohibition on discrimination based on health status, prohibition of preexisting condition exclusions, and the prohibition on lifetime and annual dollar limits on essential health benefits. Thus, individuals who enroll in STLDI are not guaranteed these key consumer protections under the ACA.

With respect to the use of stop-loss insurance by employers with self-insured group health plans, the Department of Labor is the agency primarily tasked with administration of requirements applicable to private employer sponsored self-insured group health plans under Title I of ERISA.

With respect to individuals no longer eligible for Medicaid after the redetermination process, CMS established a Marketplace Special Enrollment Period (SEP) for qualified individuals and their families who lose Medicaid or CHIP coverage due to the end of the continuous enrollment condition, also known as "unwinding." The Unwinding SEP allows individuals and families in Marketplaces served by HealthCare.gov to enroll in Marketplace health insurance coverage outside of the annual open enrollment period. Consumers will be required to attest to a loss of Medicaid or CHIP coverage as part of their application but will not be required to submit documentation of a qualifying life event to be eligible for the Unwinding SEP. In addition to important consumer protections, ACA Marketplace plans offer consumers standardized plan options and the same deductibles and cost-sharing for certain benefits. These plans have the same out-of-pocket limits as other standardized plans within the same health plan category, making it easier for consumers to compare and choose plans. Most of these standardized plan options offer many services pre-deductible, including primary care, generic drugs, preferred brand drugs, urgent care, specialist visits, mental health and substance use outpatient office visits, as well as speech, occupational, and physical therapies.

Question #13

13. In the recent ACA regulation, the Department significantly weakens program integrity tools by requiring exchanges to wait two consecutive tax years before determining whether an enrollee is eligible for the advanced premium tax credits. Do you agree that this policy change will increase tax liabilities owed and increase debt for individuals erroneously receiving tax credits?

Answer:
In the 2024 Payment Notice, we finalized a proposal to amend the Failure to File and Reconcile (FTR) process

described so that an Exchange may only determine enrollees ineligible for advanced premium tax credit (APTC) after a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC for two consecutive years (specifically, years for which tax data will be utilized for verification of household income and family size). Under the previous policy, Exchanges determine an enrollee ineligible for APTC if the IRS, through data passed from the IRS to HHS, via the Federal Data Services Hub (the Hub), notifies an Exchange that the taxpayer did not comply with the requirement to file a Federal income tax return and reconcile APTC for one specific tax year. However, HHS has determined that the operational costs of the previous policy are significant and can be improved to provide a better consumer experience, while also preserving an Exchange's duty to protect program integrity. Exchanges have faced a longstanding operational challenge, specifically that Exchanges sometimes have to determine an enrollee ineligible for APTC without having up-to-date information on the tax filing status of households while Federal income tax returns are still being processed by the IRS.

Under this change, Marketplaces on the Federal platform will continue to send notices to consumers for any year in which they have failed to reconcile APTC as an initial warning to inform and educate consumers that they need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year and CMS recommends that SBMs take similar action. CMS is making this change as a result of analysis indicating that data lags in reporting from the IRS likely cause inappropriate coverage loss. CMS believes this change will help consumers avoid gaps in coverage by increasing retention in Marketplaces and will also help protect consumers from accruing large tax liabilities over multiple years. These changes will allow Marketplaces to maintain program integrity by denying APTC to consumers who have, over the course of two years, been given notification of their obligation to file and reconcile and failed to do so. This rule does not change the requirement for consumers receiving APTC to file taxes and reconcile their tax credits received.

Question #14

> 14.Your budget proposes to extend Medicare's $35 out-of-pocket cap for insulin to the commercial market, which will increase costs in the private sector by $2 billion a year. Will extending this cap to the commercial market raise premiums for individuals in small- and large-group plans?

Answer:
The Inflation Reduction Act limits Medicare beneficiary cost-sharing to $35 per covered insulin product for a month's supply. The President's FY 2024 Budget includes a proposal to extend the cap on patient cost-sharing to insulin products in commercial markets. This would allow more of the over 37 million Americans with diabetes to lock in this lower cost.

Question #15

> 15. The 340B program is intended to pass on savings and improve health outcomes for low- income patients. However, there are reports that hospitals and pharmacies are selling these drugs to commercially insured patients to help pad their bottom line, using employer-sponsored plans to subsidize the 340B program at the expense of workers' premiums. The President's budget includes funding for covered entities to report to the Health Resources and Services Administration on how the savings they achieve through

the 340B program are passed on to patients. Can you provide an update on these oversight efforts?

Answer:
HRSA places the highest priority on the integrity of the 340B Program and continually works to strengthen oversight of the Program within its current authority. Specifically, the FY 2024 President's Budget proposes to enhance program integrity by requiring covered entities to annually report to HRSA how savings achieved through the 340B Program benefits the communities they serve and provide HRSA with regulatory authority to implement this requirement. We look forward to working with Congress on these important issues, including opportunities to provide technical assistance on proposed statutory changes.

Question #16

16. According to a study from the University of Chicago, government price controls in the *Inflation Reduction Act* will result in 342 fewer cures reaching the market, which will take 330 million years off Americans' lives. What is the administration's plan to ensure that patients will not lose out on access to lifesaving cures and that America will continue to be the world leader in medical innovation?

Answer:
CMS supports continued drug innovation and believes it is vitally important that beneficiaries have access to innovative new therapies. The statute provides that drugs that have been approved by the FDA for at least seven years, or biologicals that have been licensed by the FDA for at least 11 years, are eligible for negotiation. Any drugs or biologicals selected for negotiation will have been on the market for quite some time.

The law requires CMS to exclude certain orphan drugs approved or licensed when identifying qualifying single source drugs, referred to as the orphan drug exclusion. To be considered for the orphan drug exclusion, the drug or biological product must (1) be designated as a drug for only one rare disease or condition by the FDA and (2) be approved by the FDA only for one or more indications within such designated rare disease or condition. As noted in the initial guidance, we are considering whether there are additional actions CMS can take in its implementation of the Negotiation Program to best support orphan drug development. The initial guidance can be accessed at: https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-initial-guidance.pdf.

CMS has been regularly engaging with members of the public to get their feedback so that we are implementing the Negotiation Program in a thoughtful way that both improves drug affordability and accessibility for people with Medicare and supports innovation. CMS has made public comment letters available for download at https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation. We plan to get public input throughout the implementation of the Negotiation Program to make sure that we know what is occurring in the market.

FDA remains strongly committed to doing what we can, such as through recommendations in guidance documents for industry and stakeholder engagement activities, to maintain and promote the robustness of the development pipeline for safe and effective drugs, including biological products to treat patients, including those with rare diseases. For example, FDA has published more than 18 guidances since 2018 on topics that are highly relevant to drug, including biological product development for rare diseases. Some recent examples of draft and final guidance documents include:

- 2023 Draft Guidance for Industry: *Clinical Trial Considerations to Support Accelerated Approval of Oncology Therapeutics* [4]
- 2023 Draft Guidance for Industry: *Considerations for the Design and Conduct of Externally Controlled Trials for Drug and Biological Products*[5]
- 2022 Guidance for Industry: *Human Gene Therapy for Neurodegenerative Diseases*[6]
- 2022 Draft Guidance for Industry: *Tissue Agnostic Drug Development in Oncology*[7]

Question #17

17. The Centers for Medicare and Medicaid Services' (CMS) implementation of the *Inflation Reduction Act*'s drug-pricing provisions has lacked transparency and public engagement. One step would be to ensure that the text of the Negotiation Program Agreement is made available for public comment well in advance, at least 60 days, of the first selected drug publication date. Will CMS take this reasonable step while also continuing to find other ways to engage with stakeholders and be more transparent?

Answer:
The initial guidance details the requirements and parameters of the Medicare Drug Price Negotiation Program, including requests for public comment on key elements of the program, and announces the next steps for how the agency will implement the new program for 2026, which is the first year in which the first set of negotiated prices will apply. In the initial guidance, CMS decided on key topics to seek comment, including the terms and conditions contained in the manufacturer agreement, including the manufacturer's and CMS' responsibilities, and where CMS would like specific input from the public to operationalize the new program. Due to timing constraints and the statutory requirement to publish the selected drug list for initial price applicability year 2026 by September 1, 2023, CMS issued guidance on topics related to drug selection as final, without a comment solicitation.

As always, CMS broadly welcomes input from the public at all times. In the initial guidance for the Medicare Drug Price Negotiation Program, CMS voluntarily solicited comment on a number of key topics related to implementation of the new program, and CMS is using this feedback to inform revised guidance. In the revised guidance, CMS may clarify policies that were previously issued as final, as well as make changes to any policies, including policies on which CMS has not expressly solicited comment, based on the agency's further consideration of the relevant issues. CMS has made public comment letters available for download at https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation. CMS is striving for an effective negotiation process with participating manufacturers that lowers prescription drug prices and ensures people with Medicare have access to innovative therapies,

[4] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-trial-considerations-support-accelerated-approval-oncology-therapeutics
[5] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/considerations-design-and-conduct-externally-controlled-trials-drug-and-biological-products
[6] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/human-gene-therapy-neurodegenerative-diseases
[7] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/tissue-agnostic-drug-development-oncology

while meeting the ambitious timeframes specified under the law.

Question #18

18. Drug manufacturers are dealing with uncertainty as to whether their drugs will be selected for government negotiation. The negotiation process has the potential to upend each company's operations and research and development. It seems clear that CMS should have a pre-selection process where it notifies each manufacturer of each drug it intends to select for negotiation and solicits feedback from manufacturers. Will you commit to such a process?

Answer:
CMS is implementing the Medicare Drug Price Negotiation Program in accordance with the law, including provisions that set forth the drug selection process for this program.

Question #19

19. For the prescription-drug negotiation process, CMS has proposed a requirement that manufacturers destroy all records related to the process and that would prohibit disclosing or otherwise publicizing information in the initial offer or subsequent offers. This essentially allows CMS to operate in secret and with no accountability. What is the logic behind CMS having one-sided information control, and doesn't this show the so-called negotiation process is not a true negotiation?

Answer:
CMS intends to implement a confidentiality policy that is consistent with existing requirements for promoting an effective negotiation process, protecting proprietary information, and that strikes an appropriate balance between (1) protecting the highly sensitive information of manufacturers and ensuring that manufacturers submit the information CMS needs for the Negotiation Program, and (2) avoiding treating information that does not qualify for such protection as proprietary. In the initial guidance released for the Negotiation Program, CMS sought comment on the confidentiality policies and intends to explore approaches for the revised guidance.

Question #20

20. Do you think that patients should have the right to know how much a medical procedure is going to cost them before they obtain treatment?

Question #21

21. CMS has not been enforcing the hospital price transparency rule. What will you do to ensure there is greater compliance with this rule?

Question #22

22. Only four hospitals have been fined for violating the administration's hospital price transparency rule, while overall compliance is lacking. Why has the Department not done more to enforce the hospital price transparency rule?

Question #23

23. Do you think that the fact that patients essentially never know how much a treatment will cost, and that doctors and patients generally assume that someone else—either the insurance company or taxpayer through the government is going to pick up the bill—makes our health care system more expensive?

Answers to 20-23:
CMS's ongoing efforts to increase transparency across the health care system will help to incentivize competition, improve consumer experience, and realize additional savings across the health care system, including for patients. Lack of accessible information on prices makes it challenging for consumers to shop for services and limits competition. Over the past several years, CMS has implemented—and is continuing to implement—numerous complementary policies to promote transparency across the health care system.

In November 2019, CMS finalized the Hospital Price Transparency regulations[8] establishing requirements for hospitals operating in the U.S. to establish, update, and make public a list of their standard charges for the items and services they provide in addition to prices for 300 shoppable services, effective January 2021. In 2021, CMS undertook additional rulemaking[9] to increase the penalty for noncompliance with these requirements. As a result, the maximum potential penalty amount was increased beginning in 2022 to $10 per bed per day, for hospitals with a bed count over 30, up to a maximum daily civil monetary penalty amount of $5,500. Therefore, the annual potential penalty amount increased from just over $100,000 annually per hospital to over $2 million annually per hospital in 2022. A comparison of the results of a sequence of CMS compliance studies[10] shows progress in hospitals' implementation efforts since the Hospital Price Transparency regulation first went into effect, with 82 percent of hospitals in the sample meeting consumer-friendly display criteria by late CY 2022, up from 66 percent in early CY 2021; 82 percent posting a machine-readable file that met the website assessment criteria by late CY 2022, up from 30 percent in early CY 2021; and 70 percent doing both by late CY 2022, up from 27 percent in early CY 2021.

As of April 2023, CMS has issued over 730 warning notices and 269 requests for corrective action plans. CMS has issued civil monetary penalties to four hospitals for noncompliance (posted on the CMS website).[11] CMS helps hospitals come into compliance by conducting extensive technical assistance with hospitals throughout the compliance process. CMS continues to collaborate and work with hospitals and stakeholders to increase and improve compliance with the hospital price transparency requirements. In April 2023, CMS made compliance review and enforcement process updates to increase compliance with the hospital price transparency requirements. Moving forward, CMS plans to take additional aggressive steps to identify and prioritize action

[8] "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public" https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf
[9] "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model" https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf
[10] HealthAffairs "Hospital Price Transparency: Progress And Commitment To Achieving Its Potential" https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential
[11] https://www.cms.gov/hospital-price-transparency/enforcement-actions

against hospitals that have failed entirely to post files. By taking these additional steps, we believe that, together with stakeholders and members of the public, we can further unlock the potential of hospital price transparency and achieve greater competition in the health care system and lower costs for patients.

Question #24

24. Employers expect an increase in premiums of 5.4 percent this year. The RAND Corporation, the Congressional Budget Office, and other economists have identified provider consolidation as a main driver of health care cost increases. Perverse economic incentives have driven hospitals to acquire provider offices and then to bill incorrectly for services. Would you agree that this is a problem for employers and workers?

Answer:
Medicare payment methodologies are specified in statute by Congress and generally based on settings of care. The Medicare statute does not allow for adjustments to account for differences in facilities where care is received unless provided by statute.

Section 603 of the Bipartisan Budget Act of 2015 requires applicable items and services furnished by certain off-campus hospital outpatient departments on or after January 1, 2017 to be paid under an applicable payment system, which CMS determined is the Physician Fee Schedule, rather than the Hospital Outpatient Prospective Payment System (OPPS). Section 603 of the Bipartisan Budget Act of 2015 addresses some of the concerns related to shifts in settings of care and overutilization in the hospital outpatient setting, which often has higher payments than what would have been made if a similar service had been furnished in the physician office setting.

We understand this is an increasing concern, particularly as consolidation and closures continue to impact cost and access to care. CMS is happy to provide technical assistance on any legislation you have to modernize Medicare payment policies.

Question #25

25. Price transparency is vital for employers to help them make better decisions in choosing and administering employee health plans. HHS is indefinitely deferring enforcement of a rule requiring plans to make drug prices public and to submit them to HHS. Should Congress codify this rule to ensure proper implementation?

Answer:

Stakeholders have expressed concern about potentially duplicative and overlapping reporting requirements for prescription drugs. For example, under the Transparency in Coverage Final Rule, plans and issuers must publicly post pricing information for all covered prescription drugs by January 1, 2022. Under the No Surprises Act, however, plans and issuers must also report some of the same prescription drug pricing information to the Departments. In response to this statutory enactment and stakeholder concerns, as an exercise of enforcement discretion, the Tri-Departments announced in August 2021, that they would defer enforcement of the requirement in the Final Rules that plans and issuers must publish machine-readable file related to prescription drugs while it considers, through notice-and-comment

rulemaking, whether the prescription drug machine-readable file requirement remains appropriate.

Question #26

26. Prescription drug middlemen like pharmacy benefit managers (PBMs) are raking in profits while evading congressional scrutiny. An executive for one of the big three PBMs recently told investors to "not worry about Congress" and that it "would find ways to maintain its level of profit if those reforms to things like drug rebates went into effect." What actions can Congress take to increase oversight and accountability on PBMs?

Answer:
HHS will be releasing a report which will include information on the impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs. The department looks forward to continuing to work with you on reforms to ensure that there are no unnecessary costs in our health care system.

In April 2022 CMS finalized a policy that requires Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale, so that the beneficiary can also share in the savings. Specifically, CMS is redefining the negotiated price as the baseline, or lowest possible, payment to a pharmacy, effective January 1, 2024. CMS is applying the finalized policy across all phases of the Part D benefit. This policy reduces beneficiary out-of-pocket costs and improves price transparency and market competition in the Part D program.

Question #27

27. CMS' Framework for Health Equity declares, "Each person CMS serves should receive … care that is responsive to their … cultural health beliefs and practice, traditions, and other communication needs."
    a. In light of that statement, why did CMS reject an appeal from St. Francis Hospital in Oklahoma, which was threatened with termination from Medicare for having a lit candle behind two layers of glass in a hospital chapel?
    b. How did this threat ensure Medicare beneficiaries are receiving care that is responsive to them?
    c. Why did CMS finally agree to a compromise, which incidentally coincided with the story hitting the media?

Answer:
CMS was made aware of a safety finding involving a fire risk, made by an independent accrediting organization, the Joint Commission, issued to St. Francis Hospital in Oklahoma. Patient safety is CMS's paramount concern. CMS adopts fire safety standards from the National Fire Protection Association – and lighted candles in proximity to patients with oxygen is a safety issue. CMS did not reject a formal appeal from St. Francis Hospital, because there never was an appeal. On May 4, 2023, CMS hosted a meeting with the hospital and the Joint Commission and granted a waiver allowing the hospital to mitigate the potential fire risk and correct the safety finding. The parties agreed on mitigation steps so the hospital can maintain the sanctuary candle, and the hospital did not lose its Medicare certification. We

were happy that we could work with the hospital to find a reasonable solution.

Question #28

28. You were quoted as saying "Abortion is health care" when announcing a new rule to mandate coverage of contraceptive services at Planned Parenthood.
    a. What does this rule have to do with abortion?
    b. Do you plan on expanding the individual contraceptive arrangement to abortion services?

Answer:
In January 2023, the U.S. Department of Health & Human Services (HHS) and the Departments of Labor and the Treasury (Departments) proposed a rule to strengthen access to birth control coverage under the Affordable Care Act (ACA). Under the ACA, most plans are required to offer coverage of birth control with no out-of-pocket cost. To date, millions of women have benefited from this coverage. The proposed rule would expand and strengthen access to this coverage so that all women who need or want birth control are able to obtain it. This rule is limited to contraception access and does not address abortion care.

HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question #29

29. As I said in my opening statement, "The only health care experience you had before assuming office was litigating an appellate court case in which you attempted to strong-arm Catholic nuns into paying for others' contraceptives." Is the individual contraceptive arrangement a new way to circumvent the Little Sisters of the Poor's decision not to pay for abortifacients?

Answer:
In January 2023, the U.S. Department of Health & Human Services (HHS) and the Departments of Labor and the Treasury (Departments) proposed a rule to strengthen access to birth control coverage under the Affordable Care Act (ACA). Under the ACA, most plans are required to offer coverage of birth control with no out-of-pocket cost. To date, millions of women have benefited from this coverage. The proposed rule would expand and strengthen access to this coverage so that all women who need or want birth control are able to obtain it.

HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question #30

30. On March 2, 2022, in a statement released in response to concerns regarding gender reassignment surgery and child welfare investigations, you encouraged those who are being targeted by child welfare investigations to contact the HHS Office for Civil Rights to report their experience. Will you ensure that any parent who is investigated by Child Protective Services and who asserts a parental right to protect his or her child against sex change operations will receive support from the Office for Civil Rights?

Answer:
HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question #31

31. In a memo released by your Department on March 2, 2022, the memo stated, "The Department of Health and Human Services and all leading national medical and pediatric associations confirm that providing gender-affirming medical care is in the best interest of children and youth who need it."[1] The memo goes on to suggest that child welfare

services' funds under title IV-B of the *Social Security Act* should be used by states to "assist…in accessing gender-affirming health care." That is not an appropriate use of taxpayer dollars.

a. Does Title IV-B mention "gender-affirming" health care?
b. What are puberty blockers?
c. What effects do puberty blockers have on the brain development of children?
d. What about the effects of puberty blockers on fertility?
e. Are puberty blockers reversible?
f. Isn't it true that puberty blockers can cause permanent sterility in a healthy girl or boy?
g. Would providing puberty blockers be considered medical malpractice?

Answer:
Health care is between a patient and their health care provider. Research demonstrates that gender-affirming care can improve mental health, reduce the rate of substance use disorder, and promote the overall well-being of gender-diverse youth when medically necessary.

[1] HHS Administration on Children, Youth and Families, Log No: ACYF-CB-IM-22-01. https://www.acf.hhs.gov/sites/default/files/documents/cb/im2201.pdf.

Question #32

32. We know that the Centers for Disease Control and Prevention (CDC) closely consulted with teachers' unions such as the American Federation of Teachers (AFT) on school reopening guidance. The New York Post on April 25 of this year reported: "AFT and its fellow union, the National Education Association, also asked the White House and CDC for help shaping its press strategy to show the rank-and-file they and the Biden administration were on the same page."[2] Please tell us what communications advice the CDC gave to teachers' unions.

Answer:

Throughout the COVID-19 pandemic, CDC received numerous requests from school officials (including school superintendents and school district representatives, principals, school boards, and others) as well as employers to help understand how they could ensure safe work environments for their employees.

CDC conducted extensive partner engagements to disseminate its COVID-19 school guidance and share additional tools and resources to support schools in providing safe, in-person instruction. CDC used existing partner engagements and long-standing relationships to compile a list of impacted groups relevant to school guidance. The Division of Adolescent and School Health in CDC's National Center for HIV, Viral Hepatitis, STD, and TB Prevention and the Division of Population Health/School Health Branch in the National Center on Birth Defects and Developmental Disabilities Home were particularly engaged in identifying stakeholders. Additionally, CDC supported schools and school districts with direct technical assistance, through numerous calls and virtual engagements, including listening sessions and "virtual school walk-throughs" to provide recommendations and feedback. These collaborations and engagements were essential in shaping CDC's understanding of challenges for schools and informing CDC's guidance to ensure it is feasible and meets the needs of educators and families.

Beginning in late January of 2021, CDC partnered with the Department of Education to coordinate the National Safe School Reopening Summit. The purpose of this event was to facilitate discussion about the importance of schools reopening across the United States. This event was also focused on dissemination of best practices in schools that had safely reopened across the United States and sharing the key recommendations from CDC's K-12 Operational Strategy. Held in March 2021, the event reached hundreds of participants and highlighted rural, urban, and suburban school districts and schools that had safely reopened using CDC-recommended strategies.

Question #33

33. In February 2021, the CDC was planning to release new school reopening guidance. The guidelines would have advised schools that they could reopen regardless of community spread of COVID-19. But then the guidance changed. After consulting with the AFT, the CDC revised the guidance such that, according to CNN's Jake Tapper at the time, schools serving 99 percent of students could potentially close. We knew by then that COVID posed a low risk to school children. We also know that remote learning was a devastating experience for many children. Was it a mistake for the CDC to accept the AFT's edits to its reopening guidance?

Answer:
Evidence emerged from early data on COVID-19 that persons with certain medical conditions were more likely to get sick and at an increased risk for hospitalization, intensive care use, and death from COVID-19. A person's risk of severe illness from COVID-19 increases with the number of underlying medical conditions. In particular, people who are immunocompromised or have a weakened immune system because of a medical condition or a treatment for a condition are at a very high risk for severe illness and death from COVID-19. This includes people who have cancer and are on chemotherapy, or who have had a solid organ transplant and are taking medication to keep their transplant. CDC used information about the risks of exposure and illness from COVID-19 among immunocompromised and other high-risk persons to consider ways to ensure guidance for schools and other settings addressed the needs of varied populations. Throughout the COVID-19 pandemic, CDC received numerous requests from school officials (including school superintendents and school district representatives, principals, school boards, and others) as well as employers to help understand how they could ensure safe work environments for their employees.

As communities planned safe delivery of in-person instruction in K-12 schools, it was essential for schools to decide when and under what conditions to help protect students, teachers, and staff and slow the spread of SARS-CoV-2 virus. CDC's school guidance emphasized that staff and students at increased risk of severe illness or death if infected with SARS-CoV-2 should continue to have options for online or virtual education and employment. This approach, when implemented at times when vaccination was not available or not yet widely available, would allow school officials to adjust their strategies based on the unique needs of the population of students and staff served by their schools. In this way, the information in CDC's guidance noted what steps schools could take to address the needs of immunocompromised teachers, helping school officials to develop a COVID-19 prevention strategy that best met the profile and needs of their school community.

Question #34

> 34. On November 30, 2021, HHS issued an interim final rule for COVID-19 mitigation as a new provision to the Head Start Program Performance Standards. The rule required universal masking for all individuals two years of age and older, with immediate compliance, and vaccination for COVID-19 by January 31, 2022, for all Head Start staff, contractors providing services to children, and volunteers working with children. Although the CDC recommended in August 2022 universal masking only if there is a high community transmission rate, Head Start guidelines remained unchanged. Eventually, HHS, in a final rule, removed the universal masking requirement on January 6, 2023.[3] The vaccine mandate was struck down by a federal court on March 31 of this year on the grounds the mandate was arbitrary and capricious.[4] Why did HHS reverse course on universal masking so long after the CDC recommended otherwise, and why did it require a federal district court injunction to vacate the vaccine regulation on the

[2] https://nypost.com/2023/04/25/teacher-unions-had-bigger-hand-in-cdc-school-reopening-plan/.
[3] https://www.federalregister.gov/documents/2023/01/06/2022-28451/mitigating-the-spread-of-covid-19-in-head-start-programs
[4] *Texas v. Becerra*, No. 5:21-CV-300-H, 2023 BL 110050, 2023 US Dist. Lexis 56119 (N.D. Tex. Mar. 31, 2023) (nationwide injunction).

grounds it was arbitrary and capricious?

Answer:
HHS has consistently taken an evidence-based approach to protecting the health and safety of adults and children in the Head Start program. When the CDC updated its guidance on mask use in January 2022, HHS notified Head Start grant recipients that they would not be monitored for compliance with mask requirements. HHS decided to remove the vaccine and testing requirements when the public health emergency declaration ended on May 11, 2023. As COVID-19 remains an ongoing public health concern, Head Start programs must have an evidence-based COVID-19 mitigation strategy in place to protect individuals in the program that relies on the latest science.

Question #35

35. It is disheartening to read widespread reports of unaccompanied children who enter through our borders and end up lost in the hands of human traffickers or become subject to dangerous and unlawful child labor.[5] According to the U.S. Customs and Border Protection, roughly 340,000 unaccompanied children have shown up at the United States border since 2021.[6] Data obtained by the New York Times, however, suggest that during the two years from 2021 through the present, the Department has lost contact with 85,000 unaccompanied children.[7] I am concerned about allegations that the Department may have lost track of some unaccompanied children.
    a. What specific means does the Department use to reach out to these children?
    b. What specific steps has the Department taken to remedy your inability to keep track of unaccompanied children?
    c. Are you using person-to-person contact to reach unaccompanied children?
    d. What other means do you use to reach unaccompanied children?

Answer: The 85,000 number cited by the New York Times is a misrepresentation of the Department of Health and Human Services' (HHS) Office of Refugee Resettlement's (ORR) work serving unaccompanied children. It represents a misunderstanding of Safety and Well-being calls and the role that they play in ORR's overall communication with and service provision to unaccompanied children, including Post Release Services, legal representation, and the ORR National Call Center (ORRNCC), which provides children discharged from ORR care 24/7 help line access.

ORR's custodial authority ends when a child is released from ORR care. However, ORR has policies in place to promote unaccompanied children's safety and well-being after they have been released from ORR care to the care of a sponsor who is typically a parent or other close family member. ORR has thorough sponsor screening and vetting processes in place for each category of sponsor and, pursuant to the Trafficking Victims Protection Reauthorization Act (TVPRA), ORR conducts a thorough assessment to determine if a sponsor is capable of providing for the child's physical and mental well-being. The TVPRA requires, among other things, that sponsor suitability assessments include verification of the sponsor's identity and relationship to the child and that the sponsor has not engaged in any activity that would indicate a potential risk to the child. All sponsors must complete a robust screening process that includes background checks, interviews, review of supporting documentation, and home visits as applicable. ORR takes its responsibility to care for and protect children in its custody seriously and works diligently to make sure every placement decision is made in the best interest of the

child. ORR's process for the safe and timely release of a child from federal custody includes several steps such as: separate interviews with the child and sponsor and speaking with the child's parents, if available; a sponsor application, address checks, and supporting documentation; background checks – which may include FBI fingerprint checks; and, home studies as applicable, including those required by the TVPRA, ORR policy, or at the discretion of ORR staff reviewing the facts of the case. Additional details on this process are available in ORR's Unaccompanied Children (UC) Program Policy Guide Section 2: Safe and Timely Release from ORR Case.

Per ORR policy, in ORR's network of funded grant or contract recipients, known as ORR care providers[12], are required to make at least three "Safety and Well-being" calls to speak with the child and sponsor individually to determine if the child is still residing with the sponsor, enrolled in and attending school, aware of any upcoming court dates, and otherwise safe, as well as to assess if either the child or the sponsor would benefit from additional support or services. Children and sponsors are not required to answer these calls. It is important to note that many sponsors and children may choose not to answer a call from an unknown phone number, may be fearful of government entities, or may simply miss the call. Despite the voluntary nature of the child's and the sponsor's participation in Safety and Well-being calls, in fiscal year (FY) 2022, ORR care providers made contact with either the child, the sponsor, or both in more than 81 percent of households. In addition, upon a child's release, ORR provides children with information on the ORRNCC, a 24-hour, seven days a week, resource not only for released children, but their family members, sponsors, legal service providers, Child Advocates, and other members of the community who can request assistance or report concerns to the ORRNCC on a child's behalf. The ORRNCC reports matters of safety concern to ORR and refers and reports to the appropriate law enforcement or other authority, such as child protective services.

In addition, ORR provides post-release services (PRS) to unaccompanied children who are required to receive follow-up services under the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA) and to children who, in the determination of a care provider, would benefit from ongoing assistance, including all children who are victims of trafficking in any form. PRS includes timely referrals and connection to community resources as well as intensive case management services in cases where additional support is necessary to address a child's specific needs or challenges. These referral and case management services are offered by a network of ORR-funded grant recipients across the United States. PRS can include help with school enrollment, support in finding and accessing health care, including for mental health and substance use disorder, connections with local organizations, and other supports to ensure children's well-being.

Further, if ORR care provider staff, such as a case manager or clinician, identifies or suspects any safety concerns at any point during their interaction with an unaccompanied child either while a child is in ORR care or post-release through a Safety and Well-being call, they are required to issue a Notification of Concern to ORR and notify appropriate investigative agencies, including local law enforcement and child protective services. This includes any suspicion that the child has run away, is at risk of or posing a danger to themselves or others, or is at risk of human trafficking, exploitation, or other abuse. ORR then conducts further review and determines what actions should be taken, which may include additional reporting and engagement with local law enforcement, state child welfare authorities, and/or referral to PRS.

Question #36

[12] A care provider is any ORR funded program that is licensed, certified or accredited by an appropriate State agency to provide residential care for children, including shelter, group, foster care, staff-secure, secure, therapeutic or residential treatment care for children.

36. In a Department staff meeting last summer, you urged your staff to release minors into the United States at rapid-fire rates. You stated that the Department's efficiency in doing so was not meeting the standard of the assembly line that made Henry Ford rich and famous.[8]
    a. Do you disavow your "assembly line" comments?
    b. What is the administration doing to protect these children better and ensure that they do not become victims of trafficking or other crimes?

Answer: Providing care for unaccompanied children in ORR custody is the priority in all decisions made by ORR, HHS, and the Administration. Given ORR's child welfare mission, ORR knows that the best place for a child is with a family in a community, not in a congregate care setting. In the prior fiscal year, more than 85 percent of unaccompanied children released to vetted sponsors were placed with a parent, legal guardian, or other close family member.

HHS engages in constant efforts to improve care and information-sharing efforts for better human trafficking prevention. For example, in February 2023, ORR entered into a data sharing Memorandum of Agreement (MOA) with OTIP and the National Center for Missing and Exploited Children (NCMEC) to increase information sharing and visibility on unaccompanied children who are referred to NCMEC and who may be at risk of trafficking or exploitation.

ORR has thorough sponsor screening and vetting processes in place for each category of sponsor and, pursuant to 235(c)(3) of the TVPRA (8 U.S.C. 1232(c)(3)(B)). ORR determines if a sponsor is capable of providing for the child's physical and mental well-being. The TVPRA requires, among other things, that sponsor suitability assessments include verification of the sponsor's identity and relationship to the child and that the sponsor has not engaged in any activity that would indicate a potential risk to the child. All sponsors must complete a robust screening process that includes background checks, interviews, review of supporting documentation, and home visits as applicable. ORR takes its responsibility to care for and protect children in its custody seriously and works diligently to make sure every placement decision is made in the best interest of the child. ORR's process for the safe and timely release of a child from federal custody includes several steps such as: separate interviews with the child and sponsor; speaking with the child's parents, if available; a sponsor application; verification of address; review and verification of supporting documentation; background checks – which may include FBI fingerprint checks; and home studies when required by the TVPRA, ORR policy, or at the discretion of the case manager and ORR staff reviewing the facts of the case. Additional details on this process are available in ORR's Unaccompanied Children Program Policy Guide Section 2: Safe and Timely Release from ORR Case.

ORR has zero tolerance for abuse or mistreatment of children. If an ORR care provider identifies or suspects any safety concerns at any point during their interaction with an unaccompanied child formerly in ORR care, they are required to issue a Notification of Concern to ORR and notify appropriate investigative agencies, including local law enforcement and child protective services. This includes any suspicion that the child has run away, is at risk of or posing a danger to themselves or others, or is at risk of exploitation, human trafficking, or other abuse. ORR then conducts further review and determines what action should be taken, which may include additional reporting and engagement with local law enforcement, state child welfare authorities, and PRS.

Should an ORR care provider or case manager suspect that a child is a victim of trafficking or is at risk of trafficking at any point during this process, they must also make a referral to HHS' Administration for Children and Families' Office on Trafficking in Persons (OTIP) and to the Department of Homeland Security's (DHS) Homeland Security Investigations and the DHS Center for Countering Human Trafficking for further investigation.

Further, this Administration is committed to expanding PRS tailored to the unique needs of each child. In FY 2022, ORR more than doubled the rate of children offered PRS, providing access to more than 40 percent of children compared to just over 20 percent in FY 2021. With continued funding from Congress, we continue to advance toward our goal of providing all children access to PRS by the end of FY 2024.

Question #37

37. I am frankly shocked at the lack of coordination between the Department of Labor, HHS, and the Department of Homeland Security when it comes to protecting the health and safety of unaccompanied migrant children after they have entered the United States. It is the responsibility of HHS to ensure that these children are placed with responsible caregivers after they leave HHS. Yet, it appears as though many of these children were placed with human traffickers and were forced to work in jobs that are illegal for minors to hold. This was so prevalent that HHS stopped placing children with sponsors in certain zip codes.
    a. Did the Department of Labor warn HHS that these children were at risk for human labor trafficking at any point in 2021, 2022, or 2023?
    b. Do you believe that HHS properly vetted the sponsors of unaccompanied children who were found to be exploited by human labor traffickers?
    c. Did HHS follow all protocols when vetting sponsors for unaccompanied children?
    d. Did the Department's failure to vet sponsors contribute to the increase in child labor trafficking?
    e. If a child who was under the care of HHS' Unaccompanied Children Program is found to be a victim of human labor trafficking, is the sponsorship immediately terminated, and does the federal government reclaim custody of the child?
    f. Are there circumstances under which the child will be returned to the original sponsor?
    g. Are there circumstances under which the child will be returned to an immediate relative of the original sponsor? And, if so, what is the vetting process for these individuals?

Answer:

HHS does not tolerate abuse or mistreatment of children and recognizes that unaccompanied children may be particularly vulnerable. Thus, consistent with its statutory authorities, HHS is working closely in partnership with the Department of Labor (DOL) in federal efforts to protect children against labor exploitation. HHS and DOL's joint efforts to conduct due diligence to prevent and respond to child labor issues have been ongoing and, as of March 23, 2023, have also been formalized in an MOA between DOL's Wage and Hour Division and the Department's ACF, which oversees ORR. The MOA expands collaborative work to help identify communities and employers where children may be at risk of child labor exploitation; aid investigations with information that could help identify circumstances where

children are unlawfully employed; and further facilitate coordination to ensure that child labor trafficking victims or potential victims have access to critical services.

[5] See Tara Rodas, Opening Statement, Health and Human Services Whistleblower, Federal Inspector General Employee, https://judiciary.house.gov/sites/evo-subsites/republicans-judiciary.house.gov/files/evo-media-document/rodas-testimony.pdf.

[6] https://nypost.com/2023/04/28/republican-senators-want-feds-to-explain-losing-85000-migrant-kids/.

[7] https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html.

[8] https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html.

In April 2023, HHS and DOL developed and distributed new materials and trainings to provide information to children and sponsors about child labor laws in the United States so that children and vetted sponsors understand the laws on labor rights and restrictions to working in the United States. The cross-training efforts of DOL and HHS staff have been successful and robustly attended, with approximately 800 HHS staff trained by DOL and 250 DOL managers trained by HHS.

Additionally, HHS launched an audit of individuals who have sponsored multiple unrelated unaccompanied children, to ensure all necessary safeguards were followed. On June 2, 2023, HHS released the results of its audit, which found that ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children with a vetted sponsor. The audit also identified areas for continued improvement. HHS announced additional efforts to protect the safety and well-being of unaccompanied children, including a new Program Accountability team in ORR that will be responsible for assessing and addressing potential exploitation risks faced by unaccompanied children. This new team will play a key role in working with an external entity to conduct an in-depth review of vetting and placement processes across all sponsor categories.

Further, HHS is committed to expanding PRS tailored to the unique needs of each child. In FY 2022, ORR more than doubled the rate of children offered PRS, providing access to more than 40 percent of children compared to just over 20 percent in FY 2021. With continued funding from Congress, HHS continues to advance toward its goal of providing all children access to PRS by the end of FY 2024.

When a child is released to a vetted sponsor, ORR's custodial authority ends. However, ORR takes reports of all forms of human trafficking, including labor trafficking, seriously and has put strong systems in place to support children who have been, or are at risk of, being trafficked. When ORR receives a report of suspected labor exploitation or trafficking, it takes a range of actions, which can include:

- Immediately halting discharges to specific neighborhoods (utilizing street information) as appropriate, or to individual sponsors until additional safety measures are put in place;
- Mandating home studies and/or supervisory reviews prior to case approval;
- Conducting welfare phone calls and/or in-person visits, and
- Flagging for the state's child welfare agency, local law enforcement, OTIP, and other relevant entities for certain locations and a geographically appropriate radius around those locations.

In addition, ORR requires care providers to create a Significant Incident Report for all suspected trafficking or exploitation concerns to notify ORR, OTIP, and investigative agencies within 24 hours. Further, the ORRNCC notifies local law enforcement and child welfare agencies, as the entities with the authority to determine whether to remove the child from their current home for their safety. ORR also recently engaged OTIP and NCMEC to enter into a Memorandum of Agreement where all parties share information on a weekly basis. The MOA also enables data-sharing between HHS and NCMEC to increase visibility on unaccompanied children who are referred to NCMEC and who may be at risk of trafficking or exploitation.

ORR identifies potential sponsors for unaccompanied children in different categories of cases: parents or legal guardians as Category 1; brothers, sisters, grandparents, or other immediate relatives as Category 2; distant relatives or unrelated individuals as Category 3; and unaccompanied children with a vetted sponsor yet to be identified as Category 4. ORR's

sponsor suitability assessment process includes verifying the sponsor's relationship to the child; speaking with the child's parents when possible; conducting separate interviews with the child and sponsor; collecting supporting documentation to verify the sponsors' information; and administering background and address verification checks—which include public records and sex offender registry checks, as well as FBI fingerprint checks in certain cases. Prior to placement, ORR also carries out home studies in certain circumstances, as required by the TVPRA and ORR policy. Home studies are in-depth investigations of a potential sponsor's ability to ensure the child's safety and well-being, which include background checks, not only of the sponsor, but also of adult household members, home visits, face-to-face sponsor interviews, and, if necessary, interviews with other household members. The conditions for which ORR will deny release to a potential sponsor are delineated in ORR policy, Unaccompanied Children (UC) Program Policy Guide Section 2.7.2.

In the event the sponsor is unable to provide care and custody for the child, and if they are not the child's parent or legal guardian, HHS provides instructions to contact the ORRNCC for support. The ORRNCC is a valuable resource where both sponsors and children can request assistance, report concerns, and be referred to essential community services to promote success and community permanence. The ORRNCC also reports to local law enforcement and the child welfare agencies in each state as appropriate.

Question #38

38. Is it accurate to say that some human traffickers promise young children that they can go to school or work in the United States to lure them into being trafficked?

Answer:
HHS's principal responsibility is to care for unaccompanied children while they are in HHS custody and to make sure the child is placed with a safe, vetted sponsor. Everyone at HHS takes reports of all forms of trafficking very seriously and have put strong systems in place to support children who have been or are at risk of being trafficked. ORR screens all unaccompanied children for indicators of abuse, including abuse on their journey to the United States, and for potential trafficking concerns during intake, assessments, sponsor assessments, and Significant Incident Reports. ORR refers potential concerns of human trafficking to OTIP within 24 hours in accordance with reporting requirements. OTIP reviews the concerns to assess whether the unaccompanied child is eligible for benefits and services. Concerns of human trafficking are also reported to OTIP by post-release service providers, the ORRNCC, legal service providers, law enforcement, child welfare entities, healthcare providers, other child-serving agencies, and child advocates. Children who have experienced abuse during their journey receive tailored services, and their cases are reported to the appropriate partners. ORR also provides PRS to unaccompanied children who are required to receive follow-up services under the TVPRA, and to children who, in the determination of a care provider, would benefit from ongoing assistance, including all children who are victims of trafficking in any form.

Question #39

39. This seems to be a very lucrative business practice of cartels. Is HHS placing children with members of gangs and cartels, including MS-13?

Answer:
ORR screens all unaccompanied children for potential trafficking concerns, including during intake, assessments, sponsor assessments, and Significant Incident Reports. Moreover, ORR takes its responsibility to care for and protect children in its custody seriously and works diligently to make sure every placement decision is made in the best interest of the child. ORR has thorough sponsor screening and vetting processes in place for each category of sponsor and, pursuant to 235(c)(3) of the TVPRA (8 U.S.C. 1232(c)(3)(B)). TVPRA, ORR conducts a thorough assessment to determine if a sponsor is capable of providing for the child's physical and mental well-being. The TVPRA requires, among other things, that sponsor suitability assessments include verification of the sponsor's identity and relationship to the child and that the sponsor has not engaged in any activity that would indicate a potential risk to the child. All sponsors must complete a robust screening process that includes background checks, interviews, review of supporting documentation, and home visits as applicable.

ORR's process for the safe and timely release of a child from federal custody includes several steps such as: separate interviews with the child and sponsor; speaking with the child's parents, if available; a sponsor application; address checks; review and verification of supporting documentation; background checks - which may include FBI fingerprint checks; and home studies when required by the TVPRA, ORR policy, or at the discretion of the case manager and ORR staff reviewing the facts of the case. Additional details on this process are available in ORR's Unaccompanied Children (UC) Program Policy Guide Section 2: Safe and Timely Release from ORR Case.

ORR's custodial authority ends when a child is released from ORR care, though ORR has policies in place to promote unaccompanied children's safety and well-being after they have been released from ORR care. Per ORR policy, ORR care providers are required to make at least three Safety and Well-being calls to speak with the child and sponsor individually to determine if the child is still residing with the sponsor, enrolled or attending school, aware of any upcoming court dates, and otherwise safe, as well as to assess if either the child or the sponsor would benefit from additional support or services. Children and sponsors are not required to answer these calls. It is important to note that many sponsors and children may choose not to answer a call from an unknown phone number or because they may be fearful of government entities, or they may simply miss the call. Despite the voluntary nature of the child's and the sponsor's participation in Safety and Well-being calls, in FY 2022, ORR care providers made contact with either the child, the sponsor, or both in more than 81 percent of households.

Question #40

40. Is it true that HHS would release multiple unaccompanied children to the same address or building?

Answer:
The safety and well-being of every child is at the forefront of every decision HHS makes. ORR's vetting policy and process is intensive, and there are multiple quality controls, including third-party review of cases and federal field specialists who sign off on each discharge. HHS has made numerous improvements to streamline the process without sacrificing child safety.

ORR policy (UC Program Policy Guide Section 2.4.2) requires a home study before releasing any child to a non-relative sponsor who is seeking to sponsor multiple children, or who has previously sponsored or sought to sponsor a child and is seeking to sponsor additional children.

Further, HHS launched an audit of individuals who have sponsored multiple unrelated unaccompanied children, to ensure all necessary safeguards were followed. On June 2, 2023, HHS released the results of its audit, which found that ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children with a vetted sponsor. HHS also announced additional efforts to protect the safety and well-being of unaccompanied children, including a new Program Accountability team in ORR that will be responsible for assessing and addressing potential exploitation risks faced by unaccompanied children. This new team will play a key role in working with an external entity to conduct an in-depth review of vetting and placement processes across all sponsor categories. HHS's ORR continuously reviews intensive vetting policies and procedures through ongoing individual case reviews and data analyses.

Question #41

41. One whistleblower recently testified that she saw "20, 30, and 40 unaccompanied children released in the same apartment building." What action is HHS taking to ensure that individuals are not sponsoring multiple children, and that multiple children are not being released to the same address?

Answer:
Per Office of Refugee Resettlement (ORR) policy, a home study is required for children being released to a non-relative sponsor who is seeking to sponsor multiple children or who has previously sponsored or sought to sponsor a child and is seeking to sponsor additional children. A home study consists of interviews, a home visit, and a written report containing the home study case worker's findings. More information about ORR's home study requirements is available in Section 2.4.2 of the Unaccompanied Children (UC) Policy Guide Section. In addition, in February 2023, ORR launched an audit as part of its iterative, continuous process to ensure that all necessary safeguards are in place without unnecessarily keeping children in government-funded congregate care settings. The audit focused on case reviews of children in 2021 and 2022 to non-relative sponsors who sponsored three or more unrelated children. ORR utilized these criteria because it determined that doing so would ensure the audit was focused on cases of highest potential concern. On June 2, 2023, HHS released the results of the audit and found that ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children with a vetted sponsor. The report also announced HHS' additional efforts to protect the safety and well-being of unaccompanied children, including a new Program Accountability team in ORR that will be responsible for assessing and addressing potential child exploitation risks associated with the UC Program. The new team will play a key role in working with an outside entity to conduct an in-depth review of vetting and placement processes across all sponsor categories.

Question #42

1. In the HHS budget, you propose an outlandish 76 percent increase in the Title X Family

Planning program from $286 million to $512 million. Would you agree that the proposed increase would be better directed to help low-income women and their families with prenatal care and supportive family services instead of providing taxpayer funds for taking the life of an unborn child?

Answer:
For over 50 years, Title X family planning clinics have played a significant role in ensuring access to equitable, affordable, client-centered, and high-quality preventive healthcare services for millions of low-income or uninsured women. The Title X family planning program is a critical part of the public health safety net and has served as a point of entry into care for nearly 195 million people in its history. Consistent with longstanding federal law, Title X funds cannot be used to pay for the provision of abortion services.

Despite the need for additional funding to support service expansion and mitigate inflation, the Title X program has been level-funded for over eight years. The proposed increase in funding is critical to meeting current demand and expanding much-needed access to Title X services such as pregnancy testing and counseling, access to contraceptives, STI testing, basic infertility services, cervical cancer screenings, and preconception care. Given women of reproductive age often visit their family planning provider as their primary source of health care, these providers often serve as an important linkage to other health care services, including for pregnant clients in need of prenatal care. The need for additional funding is even greater than what was proposed in the HHS budget, and the proposed increase would directly support the health and well-being of low-income women and their families.

Question #43

2. Why is the FDA allowing the off-label use of cross-sex hormones to be used on children when there has been no long-term study on how this affects their physical and mental health?

Answer:
If your question refers to Gonadotropin-Releasing Hormone (GnRH) agonists, FDA has approved such drug products for multiple indications. FDA approves drug products based on data and information submitted by a sponsor that establish the safety and effectiveness of the drug product for its proposed indication(s). You may review the approved labeling for individual drug products available at the FDA.gov website.[13]

FDA has not approved GnRH agonists to treat adolescents with gender dysphoria. If a sponsor submitted an application for such use, FDA would evaluate it under our statutory safety and effectiveness standards for approval. That said, FDA's regulatory framework recognizes the role of medical professionals in making treatment decisions for their individual patients. From FDA's perspective, healthcare providers generally may choose to use an approved drug for an unapproved use to treat a disease or medical condition if they determine that such use is medically appropriate for an individual patient (sometimes referred to as "off-label use").

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https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm

FDA monitors the safety of drugs once they are on the market, regardless of whether they were prescribed for an on-label use or off-label use. Important safety information is presented in the drug labeling for healthcare providers and their patients on, among other things, the drug's side effects. This information can help inform a prescriber's judgment as to whether the drug is appropriate treatment for a particular patient. After approval, FDA monitors the safety of drug products, including the frequency and severity of reported adverse drug experiences, through a variety of sources, including its MedWatch program. FDA regulations set forth requirements with respect to reporting, by manufacturers and certain other entities, of adverse drug experiences to FDA. In addition, MedWatch reports voluntarily submitted by healthcare providers and consumers can help FDA to detect problems with marketed drug products. Reports of adverse drug experiences in our FDA Adverse Event Reporting System (FAERS) database are continually monitored for emerging safety patterns. FDA may use this and other information to require updates to drug labeling if warranted.

Question #44

1. Are you concerned that the medical community is essentially experimenting on children and may be condemning gender-confused children to lasting physical harm, including lost fertility and sexual health?

Answer:
The CDC has found that 47% of teenagers who identify as LGBTQ+ seriously considered a suicide attempt, while one in four LGBTQ+ teenagers attempted suicide. Research demonstrates that gender-affirming care can improve the mental health and overall well-being of adolescents when medically necessary. Health care is between a patient and their health care provider. Parents also play an important role in these conversations.

Question #45

3. Do you think that parents today know the risks and lasting physical consequences of taking cross-sex hormones?

Answer:
Health care is between a patient and their health care provider. There are well-established guidelines to counsel families concerning the treatment of gender-diverse youth, in addition to the rules of medical ethics and legal requirements concerning informed consent.

Question #46

4. Do you have any comment about other nations, including the UK, Finland, Norway, France, and Sweden, recently limiting adolescent gender transition?

Question #47

47. Why is the U.S. an outlier on this issue?

Answer:
The CDC has found that 47% of teenagers who identify as LGBTQ+ seriously considered a suicide attempt, while one in four LGBTQ+ teenagers attempted suicide. Research demonstrates that gender-affirming care can improve the mental health and overall well-being of adolescents when medically necessary.

Question #48

48. In the U.S., many lives were lost to COVID. However, many lives were also negatively impacted, and even shortened, due to our pandemic response. Substance abuse, domestic abuse, and deaths of despair increased, and overall general health decreased, as people became more socially isolated and less active. What is the administration doing to measure the human and health costs of our COVID response?

Answer:
The toll of the COVID-19 pandemic was immense in terms of direct and indirect impacts. The April 2022 Memorandum on Addressing the Long-Term Effects of COVID-19 directed the Secretary of Health and Human Services to coordinate the Government-wide response to the long-term effects of COVID-19, including mental health and substance use challenges and bereavement. Since last April, HHS's Office of the Assistant Secretary for Health has led the efforts to address the longer-term impacts of the pandemic. Given the toll of Long COVID, these efforts have focused on the continuing health impacts that some face after initial SARS-CoV-2 infection. Actions are being taken across HHS and the federal government to study Long COVID with the ultimate goal of discovering the underlying causes that can lead to prevention, diagnosis and treatment. Various efforts are also underway to better understand the impacts of the pandemic itself, particularly on children and families, such as a recent report published by the National Academies of Medicine at the request of HHS's Administration for Children and Families on Addressing the Long-Term Impact of the COVID-19 Pandemic on Children and Families.

Question #49

49. Why did you enact the COVID-19 vaccine mandate for federally operated health care and clinical research facilities against employees, contractors, trainees, and volunteers?

Answer:
CMS implemented the staff vaccination requirements in the Omnibus COVID-19 Health Care Staff Vaccination interim final rule with comment period (IFC) to assure health and safety during the COVID-19 Public Health Emergency declaration. We know that the COVID-19 vaccine saves lives, and this Administration has made it a priority to continually work to protect our most vulnerable communities across the country. The health care staff vaccination requirement for covered Medicare- and Medicaid-certified providers and suppliers was enforced in all states beginning on February 20, 2022. Most providers and suppliers that were subject to the requirements surveyed by states were found to have been in substantial compliance with this requirement. However, on June 5, 2023, CMS issued regulations to withdraw the requirements in the IFC. CMS recognizes that the incidence of severe COVID-19 has declined significantly since the IFC was issued but continues to recognize that vaccines are important for preventing severe illnesses and promoting public health.

Question #50

50. Why did you mandate the COVID-19 vaccination without an option to test out of the mandate?

Question #51

51. Why did you require that 300,000 educators in the Head Start program be vaccinated when scientific evidence was emerging that most children were not at grave risk of receiving or transmitting COVID?

Answers to #51-#52:
At the time of the IFC's publication, November 30, 2021, the COVID–19 vaccine was the most effective risk reduction strategy available to avoid severe illness, hospitalization, and death, as well as the most important measure for reducing risk for SARS–CoV–2 transmission for the predominant variants of SARS–CoV–2. Vaccines remain an important component of a multi-layered strategy to reduce the risk of serious illness and death from COVID-19.

Question #52

52. Do you recognize the negative health or economic ramifications of this vaccine mandate on federal workers?

Question #53

53. Did you ever consider the constitutionality of vaccine mandates before imposing them upon swaths of the federal workforce as well as those under your purview?

Question #54

54. Did you express any concerns to President Biden and other agency heads regarding vaccine mandates?

Answers to #52-#54
Please refer to the OMB Executive Order on Moving Beyond COVID-19 Vaccination Requirements for Federal Workers[14].

[14] https://www.whitehouse.gov/briefing-room/presidential-actions/2023/05/09/executive-order-on-moving-beyond-covid-19-vaccination-requirements-for-federal-workers/#:~:text=Considering%20this%20progress%2C%20and%20based,safety%20protocols%20for%20Federal%20contractors.

Question #55

55. Private health insurance is associated with superior health access and outcomes compared to Medicaid. What is the administration doing to ensure that patients who are not eligible for Medicaid have access to affordable private health insurance?

Answer:

CMS aims to ensure that as many people as possible maintain a source of coverage as states unwind from the Families First Coronavirus Response Act Medicaid continuous enrollment condition. When an individual is found to be ineligible for Medicaid and CHIP at application, renewal, or following a change in circumstances, state Medicaid and CHIP agencies send account information to the Marketplace. Following receipt of information about an individual that has been determined ineligible for Medicaid or CHIP, Marketplaces on the Federal platform reach out to the individual and invite them to apply for coverage at the Marketplace. This account transfer process is particularly important during states' unwinding periods as it will serve to help make potentially eligible consumers aware that quality affordable coverage may be available to them through the Marketplace, and what steps they need to take.

We also have a robust plan in place to reach people with Medicaid coverage so that they are aware of the steps they need to take to maintain their Medicaid or CHIP coverage, or, if no longer eligible for Medicaid or CHIP, to smoothly transition to the other forms of coverage for which they might be eligible, such as Marketplace coverage. This plan includes new policy and operational flexibilities, such as a temporary Exceptional Circumstances Special Enrollment Period (SEP) available through HealthCare.gov for qualified individuals and their families who lose Medicaid or CHIP coverage following the end of the continuous enrollment condition; multi-pronged, large-scale national and local outreach and stakeholder engagement efforts; and investments and innovations in enrollment assistance.

More than 16.3 million people selected an ACA Marketplace health plan nationwide during the OEP that ran from November 1, 2022-January 15, 2023 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2023 Marketplace OEP than ever before, and millions of working families saved an average of $800 on their health insurance premiums last year due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 3.6 million people (22% of total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year.

This year, individuals benefited from a highly competitive Marketplace. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans. Also, new standardized plan options were available in 2023 through HealthCare.gov, which helped consumers compare and select plans.

To build on this success, the FY 2024 budget invests in making private insurance even more affordable. The FY 2024 budget permanently extends the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget provides Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the ACA, paired with financial incentives to ensure States maintain their existing expansions. The budget builds on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget extends the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

Rep. Suzanne Bonamici (D-OR)

Question #56

56. The proliferation of fentanyl and other synthetic opioids among teenagers continues to have disastrous consequences around the nation. Two years ago, the Beaverton School District in NW Oregon developed "Fake and Fatal: One Pill Can Kill," an education and awareness campaign to teach students about the dangers of fentanyl. The school district also made Naloxone available in all secondary schools to reverse the effects of drug overdoses. Since the implementation of both policies, not one student in Beaverton schools has lost their life to a fentanyl overdose. This successful effort was made possible by coordination among the school district and local nonprofits, public health officials and organizations, and practitioners proficient in evidence-based solutions to the crisis of opioid abuse and misuse.
    a. How is HHS leveraging its resources through SAMHSA, CDC, and NIH to mitigate the effects of opioid abuse and misuse among youth, and how can Congress support the ability of HHS to forge stronger relationships with the Department of Education to make solving this urgent crisis a priority?

Answer:
Adolescents develop a stronger sense of self, have a greater need for independence, and form important relationships with peers and people other than their parents.[15] During this stage, adolescents increasingly engage in risk-taking behaviors, including substance use. Negative relationships with family and an unsafe home environment can increase risk-taking and
substance use in adolescents.[16] Given these unique factors, substance use prevention and treatment for teenagers is a crucial part of SAMHSA's mission.

SAMHSA's national youth substance use prevention campaign - "Talk. They Hear You." – helps parents and caregivers, educators, and community members get informed, be prepared, and take action to prevent underage substance use. The aims to reduce underage substance use among youths under the age of 21 by providing

[15] Silvers, J. A., Squeglia, L. M., Rømer Thomsen, K., Hudson, K. A., & Feldstein Ewing, S. W. (2019). Hunting for what works: Adolescents in addiction treatment. Alcoholism: Clinical and Experimental Research, 43(4), 578-592.
[16] Otten, R., Mun, C. J., Shaw, D. S., Wilson, M. N., & Dishion, T. J. (2019). A developmental cascade model for early adolescent-onset substance use: the role of early childhood stress. Addiction, 114(2), 326-334. https://doi.org/https://doi.org/10.1111/add.14452

parents and caregivers with information and resources they need to address these issues with their children early and often.

While Medications for Opioid Use Disorder (MOUD) have been shown to be a safe and effective treatment for youth, access to MOUD for adolescents and young adults remains low. To enhance access to MOUD for youth who need it, adolescent health care providers must have the ability to prescribe these medications and must also have access to the latest resources and training to be able to prescribe MOUD safely and effectively. SAMHSA's Preventing Youth Overdose: Treatment, Recovery, Education Awareness and Training (PYO-TREAT) was a new grant program in FY 2023 that aims to increase access MOUD for adolescents and young adults and to train healthcare providers on the safe prescribing of MOUD.

The program aims for healthcare providers and other entities to create SUD treatment and prevention programs that include the appropriate use of MOUD for adolescents and young adults. SAMHSA intends to advance the goal of increasing integrated behavioral health access to children, youth, and families by allocating funding for FY 2023 to support the Youth Prevention and Recovery Initiative for Adolescents and Young Adults Program. The PYO TREAT new awards will address the overdose crisis that continues to endanger adolescents and young adults and has led to numerous preventable deaths.

In September of 2023, the Centers for Disease Control and Prevention (CDC) announced the new iteration of the Overdose Data to Action (OD2A) award to states and localities to expand harm reduction strategies, link people to life-saving care, and make the latest data available so that we can get ahead of the constantly evolving drug overdose crisis. For the first time, in addition to funding state health departments to prevent drug overdose, CDC has provided funding to directly support city, county, and territorial health departments, to help with collecting and using data to inform action, engaging with people with lived experience, and addressing health disparities. Funded recipients will be able to respond quickly and more equitably to the needs of their community, using and translating data to drive action that reduces overdose deaths and related harms in communities as fast as possible.

OD2A recipients use data to identify trends, gaps, and high-priority populations to focus targeted prevention activities. In many jurisdictions this includes a focus on adolescents at risk for overdose. For example, the OD2A jurisdiction in Riverside, California implemented youth overdose prevention training that addresses stigma surrounding opioid, overdose, help-seeking/treatment, and naloxone. They also piloted a youth-based curriculum package for overdose prevention and developed messages for those who use illicit drugs about fentanyl in the drug supply and harm reduction strategies.

Additionally, the Drug Free Communities (DFC) program, administered by the White House Office of National Drug Control Policy (ONDCP), and managed through a partnership between ONDCP and CDC, provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. The DFC program is aimed at mobilizing community leaders to identify and respond to the drug problems unique to their community and change local community environmental conditions tied to substance use. Currently, 750 community coalitions across the country receive funding up to $125,000 per year to strengthen collaboration among local partners and create an infrastructure that reduces youth substance use.

In 2023 ONDCP, CDC and NIH participated in a Department of Education (National Center on Safe and Supportive Learning Environments) webinars for educators concerning fentanyl and use of overdose reversal medicines called "Knowing the Facts About Fentanyl". This type of activity was helpful to orient school

personnel to the problem of pressed pills and the need for naloxone. Because many schools -- either because of school policy or state law -- forbid students to have any form of medicine on their person while on campus, schools could use financial support to provide overdose reversal medications to designated school staff so youth may have access to it in the event of an overdose on campus.

Question #57

57. Many Head Start programs are facing staffing challenges because of low compensation and direct workforce competition from other early childhood programs and other industries. Directors are continuing to recruit and train staff but are also working to change the scope of their grants, which may include converting Head Start slots to Early Head Start or reducing the number of children served. Change-in-scope applications are time-consuming and can take months to be resolved with the Office of Head Start. With summer being an essential time for planning for the upcoming program year, Head Start directors are eager to know the composition of the programs they will be running in the fall.
    a. What steps is the Office of Head Start taking to quickly resolve the large number of change-of-scope applications that are currently awaiting resolution?

Answer:
The Office of Head Start (OHS) is committed to partnering with grant recipients to expedite the process for Change in Scope applications. On July 25, 2023, OHS hosted a webinar to discuss Change in Scope application considerations and what to expect during the process for grant recipients, designed to help recipients strengthen their applications with the goal of shortening the approval process timeline. OHS also discussed common challenges, tips, and resources to aid grant recipients in submitting more complete and effective applications.

Since the date of the hearing, OHS has significantly expanded its capacity for processing Change in Scope applications, and will continue to process requests as quickly as possible. There are 251 actively pending Change in Scope requests, down from 443 requests as of the date of the hearing, with 70% of active requests pending under 180 days.

Question #58

58. The Preschool Development Grants Birth through Five (PDG B-5) program – which your agency recently awarded to 42 states – allows states to create more effective, efficient programs by collaborating across multiple systems and agencies. The PDG B-5 grants encourage states to focus on five major activities, including aligning existing programs, maximizing parental choice, building on the success of existing programs, fostering partnerships among stakeholders, and leveraging data for continued improvement.
    a. What progress have we seen in states that participate in the Preschool Development Grant Birth through Five program?

Answer:
The 42 PDG B-5 grant recipients are advancing stronger state early childhood systems by improving partnerships, collaboration, and coordination among existing birth through age five (B-5) programs and services focusing on advancing priorities based on state needs. With strengthened early childhood systems, states can leverage private, local, state, and federal funding and other resources to increase the quality of, and access to, early care and education (ECE), maximize parental choice and meaningful family engagement, improve and sustain quality in early childhood programs, support the ECE workforce, and improve state infrastructure to sustain system improvements. Examples from prior PDG B-5 recipients' efforts include:

- To support program alignment and improve the efficiency and effectiveness of the ECE system at the state level, Missouri transitioned 20 state programs serving children and families or providing professional development to providers into the Office of Childhood. By developing a cross-sector collaborative Early Childhood Career and Professional Development Network, Arizona increased collaboration among the many training and technical assistance programs and agencies across the state and improved their overall professional development system. Louisiana used PDG B-5 to expand community-based Ready Start Networks, which measure quality and coordinate enrollment across early childhood programs.

- To maximize parental choice and family engagement, the Connecticut Office of Early Childhood created its first Parent Cabinet, a diverse, parent-led advisory group that works directly with the state agency to improve child care, home visiting, licensing, and early intervention programs. To support families and connect them to the resources they need, North Carolina incorporated its Family Engagement and Leadership Framework throughout state and local early childhood education agencies, governance, and advisory bodies.

- To build on success of existing programs and expand access to high-quality ECE, Wyoming awarded infant-toddler sub-grants to improve the state's supply and quality of infant and toddler care and education. Rhode Island supported Health Equity Zones (HEZs), integrating funding from up to 20 sources to offer a range of services and programs to children and families living in that zone. HEZs use PDG B-5 funds to offer family navigators who use their extensive knowledge to support families and connect them with programs and services that meet their unique needs.

- To foster partnerships among stakeholders, Illinois enhanced an aligned, cross-systems approach for the infant and early childhood mental health consultant workforce serving child care, early intervention, preschool, and home visiting programs. Through PDG B-5 efforts, New Mexico was able to build and strengthen relationships between Housing Authority leadership and staff, and early childhood home visitors, case managers, and families receiving services.

- To better leverage data for continued improvement, South Carolina is developing a longitudinal data system that connects early childhood and K–12 data. Through PDG B-5, Kansas analyzed six years of historical, integrated

data on early childhood services funded by the Children's Cabinet to determine whether those services prevented foster care placement during the same period.

Question #59

59. The Low-Income Heating and Energy Assistance Program (LIHEAP) provides federally funded assistance in managing costs associated with home energy bills, energy crises, weatherization, and energy-related minor home repairs. The President's proposed budget would allow LIHEAP grantees to use up to 2.7 percent of their FY 2024 LIHEAP funds to assist low-income households with their water and wastewater utility bills. In my home state, Oregon Housing and Community Services worked effectively with Community Action Teams to deliver resources to Oregonians who needed assistance with their water bill during the pandemic. Despite the effectiveness of this program, it will end – but many people are still struggling with their water bills, especially in the rural communities I represent.
    a. How has the Low-Income Household Water Assistance Program (LIHWAP) been successful, and why did the Department propose to continue allowing funding to support low-income people with their water and wastewater utility bills in their FY24 budget?

Answer:
Since 2021, LIHWAP has helped households with low income with their water and wastewater bills. LIHWAP ensures water access by restoring services for households that have been disconnected, preventing service disconnections, and reducing rates so that households can maintain the continuous service that is critical for health and safety.

As of June 30th, 2023, LIHWAP has served over 1 million households across the country. LIHWAP funding has been used to:

- Reconnect water and wastewater services 84,514 times.
- Pay 565,273 past due bills for families and individuals with low incomes, preventing water shutoff.
- Reduce 486,628 household water bills.

In FY21 and FY22, LIHWAP served households with an average benefit of $415, weighted by number of services provided by comparing service amounts to benefits spent. Additionally, LIHWAP grant recipients have formed over 14,000 partnerships with water utilities across the county. Some of those utility providers are working to establish on-going assistance programs with local or state funding.

Many grant recipients have expended all or nearly all of their entire LIHWAP award. This includes North Carolina who has expended 99% of their award and served over 94,000 households. Another example is in the state of Kentucky. Kentucky received over $18 million in LIHWAP funding and exhausted all funding within seven months. The program restored water for 2,121 households, prevented 23,365 disconnections and provided a rate reduction for 19,322 households. LIHWAP was authorized as a temporary emergency program during the public health emergency, but continuous access to water and wastewater services is not

a temporary need. Research estimates that over two million people in the U.S. live without access to running water and basic indoor plumbing. In 2016, 1 in 20 households were disconnected from water services because of nonpayment, and in some cities, as many as 1 in 5 were disconnected. We know there are many people across the country who need the vital support that LIHWAP offers. Based on a calculation from 2021 American Community Survey 1-year estimates, there are 2,276,694 individuals with income below 150% poverty level that would be eligible annually for LIHWAP. LIHWAP grant recipient annual reports for fiscal year 2022 showed benefits went to households that need them the most; 55% of households served had vulnerable population members, 53% of households had incomes at or below 75% of the Federal Poverty Level.

Research also indicates that the cost of water is continuing to rise. The average residential water bill has increased almost 50% since 2010, and water rates are increasing at a rate that outpaces other utilities, including electricity and gas.

The need for ongoing LIHWAP funding has also been echoed by our grant recipients who administer the program at the state, tribal, and territorial level.

Additional information regarding how funds have been utilized can be found on the LIHWAP data dashboard. The Department has also highlighted the success of the program through spotlight videos which can be viewed on the OCS LIHWAP webpage.

Question #60

60. According to the 2021 report, GAO-21-540, from the Government Accountability Office (GAO), "about 1 in 10 young adults and 1 in 30 minors under age 18 experience homelessness without a parent or caregiver over the course of a year." As a Co-Chair of the Congressional Caucus on Homelessness, I want to emphasize that this is unacceptable.
    a. What has the Department done to implement the GAO's recommendations, and what has the Department done specifically to provide communities with additional information on strategies and promising practices for coordinating their programs on Continuum of Care (CoC) and Runaway and Homeless Youth (RHY)?
    b. How would the proposed FY24 budget combat homelessness among our nation's young people?
    c. Additionally, how does HHS focus on the disproportionate rates of LGBTQI+ young people and BIPOC youth experiencing homelessness?

Answer:
The Administration for Children and Families' (ACF) Family and Youth Services Bureau (FYSB) has convened several interagency meetings including with the Department of Housing and Urban Development (HUD) to strengthen its understanding of ways that communities address and serve the needs of unaccompanied minors experiencing homelessness, including the role of the Continuum of Care (CoC) program and other entities such

as Runaway and Homeless Youth (RHY) providers and child welfare agencies. These meetings have focused on identifying platforms to gather information and best practices across communities.

FYSB and HUD are working to identify programs that receive funding from both RHY and HUD's Youth Homelessness Demonstration Project (YHDP) or CoC programs, including programs that provide shelter or longer-term housing resources to youth under 18 years of age. This information will be used to better understand ways that organizations are leveraging funding across HUD and RHY resources and ways these organizations are serving minors experiencing homelessness. Information will be used to identify promising practices and share information across FYSB and HUD networks. Additionally, FYSB and HUD plan to host a joint webinar focused on ways communities and programs have leveraged RHY and HUD YHDP funds to prevent and respond to youth experiencing homelessness or housing instability.

FYSB has also engaged training and technical assistance providers in conducting listening sessions focused on support for minors experiencing homelessness or housing instability; identifying best practices from FYSB's RHY providers and HUD's YHDP grantees; educating youth services providers through national conferences; and other training opportunities. FYSB will continue to engage youth with lived expertise to help enhance services and improve outcomes for youth.

In addition, ACF is reviewing its 2014 Information Memorandum titled, *"Serving Youth Who Run Away from Foster Care"*[1] for potential updates. To support this work, in fall of 2023, FYSB and the Children's Bureau plan to conduct joint site visits in communities to discuss the roles and responsibilities of child welfare and RHY programs when youth and young adults experience homelessness or housing instability.

Further, FYSB participates in the Federal Regional Interagency Council on Homelessness (FRICH). FRICH meetings are also attended by HUD and several other federal agencies. FYSB has presented during FRICH convenings on ways the U.S. Department of Health and Human Services (HHS), HUD, and other federal agencies can coordinate and leverage existing resources to best support youth at risk of or currently experiencing homelessness or housing instability.

b. How would the proposed FY24 budget combat homelessness among our nation's young people?

Answer:
The FY 2024 President's Budget[2] request for the RHY program is $136.8 million, an increase of $11.5 million from the FY 2023 enacted level. These funds are estimated to support 562 awards, with an average award of $209,261 and a range of $70,000 to $350,000.

This additional funding will support the Whole Family Community-Based Demonstration project aimed at preventing and reducing youth homelessness, while also working to increase outcomes for youth and young adults experiencing or at risk of homelessness or housing instability. This human centric project will fund up to 20 grants to support organizations working with minors experiencing homelessness or housing instability. It will implement a whole-family, community-based prevention approach with the goal of supporting youth under 18 years of age to maintain safe and stable housing when appropriate or to seek alternative stability options to include connections to kinship support, caring adults, or other safe and stable housing. Grants will allow communities to create partnerships with schools, child welfare, youth justice systems, behavior health systems, housing and other youth systems to prevent youth homelessness. ACF will use this demonstration opportunity to identify effective strategies in preventing and stabilizing minors experiencing housing instability.

The funding will also support training and technical assistance and an evaluation component to support knowledge sharing and bridge a critical gap in services to improve whole-family, community-based prevention services. The budget includes legislative proposals to reauthorize and revise the Runaway and Homeless Youth Act (RHY Act) through 2026. In particular, the budget proposes to amend definitions and authorities to reflect current terminology and support youth at risk or victims of commercial sexual exploitation and human trafficking.

c. Additionally, how does HHS focus on the disproportionate rates of LGBTQI+ young people and BIPOC youth experiencing homelessness?

Answer:
Through FYSB, HHS continues to seek ways incorporate the voices of homeless youth. This includes continued coordination with the Runaway and Homeless Youth Training Technical Assistance and Capacity Building Center (RHYTTAC) and the National Runaway Safeline youth advisory boards to seek input from LGBTQIA2S+ youth on how to improve service delivery to better meet the needs of youth. RHYTTAC has developed a tip sheet that provides tools and resources for programs to implement to ensure that services comply with nondiscrimination requirements, are informed by the specific challenges faced by youth experiencing homelessness who identify as LGBTQIA2S+, and affirm the strengths and address the needs of the youth they serve.

Existing federal law and regulation establish non-discrimination requirements that apply to all RHY grant recipients. RHY's Final Rule (RHY Rule) (45 CFR Part 1351) reflects existing statutory requirements in the RHY Act and changes made via the Reconnecting Homeless Youth Act of 2008. Specifically, the RHY Rule established (1) non-discrimination protections for youth and young adults seeking to access RHY services, (2) expectations that RHY grant recipients implement non-discrimination and culturally and linguistically sensitive services and training, (3) expectations that services have a positive youth development approach, and (4) a specific ban on the use of RHY funding to support "treatment or referral to treatment that aims to change someone's sexual orientation, gender identity or gender expression." In addition, the RHY Rule developed program performance standards for RHY grant recipients providing services to youth and their families to be used as measures for successful outcomes and that the "standards […] be responsive to the complex social identities,"[3] such as the gender identity/expression and sexual orientation, of RHY clients.

While RHY grant recipients have the flexibility to serve specific populations of youth based on identified need, they must also have a plan to provide clear support in linking youth who do not meet the organization's eligibility criteria to a service which can accept the youth. For example, some Maternity Group Home recipients design specialized programs for pregnant and parenting youth and/or young adult females. These organizations must have a plan to support not only young men who are parents and experiencing homelessness, but also youth and young adults who identify as LGBTQIA2S+ who are experiencing homelessness and parenting.

Further, FYSB is finalizing an Information Memorandum (IM) to be disseminated to FYSB RHY Program Grant Recipients. This IM will reiterate program policy and offer practical strategies for how to best meet the needs of youth and young adults experiencing homelessness who identify as LGBTQIA2+.

Question 61

61. I'm very concerned about the shortage of behavioral health workers and the barriers that exist in recruiting and retaining a diverse and qualified behavioral health workforce. I am encouraged that HHS operates several loan repayment programs (LRPs) through HRSA's National Health Service Corps (NHSC), including the Substance Use Disorder Workforce LRP, NHSC LRP, Rural Community LRP, and Substance Use Disorder Treatment and Recovery (STAR) LRP. Despite these programs, I continue to hear from practitioners and providers that high student debt burdens are a prohibitive factor for graduates seeking to enter behavioral health professions.
    a. What more is HHS doing to expand access to these loan repayment programs and create opportunities for diverse, underrepresented students to pursue careers in the behavioral health workforce?

Answer:
In FY 2022, the National Health Service Corps (NHSC) provided scholarships and loan repayment assistance to more than 9,600 participants providing direct behavioral health services in communities identified as Health Professional Shortage Areas (HPSA), and more than a third of these providers were providing services in rural communities. The NHSC is not only an important recruitment tool for rural and underserved communities, but also is instrumental to keeping these providers in communities. Approximately 87 percent of NHSC clinicians who completed their service obligation between FY 2012 and FY 2021 still work in a HPSA or within the same community they served.

The President's Budget requests $965.6 million to extend and increase mandatory funding for the NHSC through FY 2026, which would allow the program to sustain its historic FY 2022 field strength levels of more than 20,000 clinicians serving in the field, along with another 3,500 in school or residency training to serve areas of greatest need. The request includes a total increase of $50 million in discretionary funding for loan repayment for behavioral health providers, including peer support specialists in crisis centers and clinicians providing opioid and other substance use disorder treatment.

The Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program provides loan repayment for individuals working in a full-time substance use disorder treatment job that involves direct patient care in a community where the mean overdose death rate exceeds the national average or a Mental Health HPSA. The demand for this program has been great. In FY 2022, HRSA was able to make only 208 awards from over 2,600 eligible applications with the funding available. The FY 2024 President's Budget request would sustain the increase in funding Congress realized in FY 2023 to support the program's potential as a tool to expand our response to the substance use disorder crisis. The President's Budget also proposes extending the tax-exempt status that is provided to NHSC Program recipients to similar workforce programs operated by HRSA, including the STAR Loan Repayment Program. The savings generated from this proposal would allow HRSA to make additional awards to grow and expand the behavioral health workforce.

Answer:
SAMHSA aims to increase the diversity in the behavioral health workforce through the Minority Fellowship Program, which provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, marriage and family therapy, mental health counseling, psychology; substance use/addiction counseling, marriage and family therapists and professional counselors. In

FY 2023, SAMHSA added addiction medicine as a component of the MFP. This program is jointly administered by SAMHSA's Center for Substance Use Services (CSUS), the Center for Substance Use Prevention (CSUP), and the Center for Mental Health Services (CMHS) at SAMHSA. Combined, this program will support fellowships for hundreds of students as well as support additional training through webinars on culturally appropriate services to thousands of students.

Question 62

62. No one should have to worry about whether they will receive needed elder care support and services because of their identity or who they love. In June of 2022, President Biden demonstrated his commitment to this principle by advancing an LGBTQ+ Long Term Care Bill of Rights to protect at-risk LGBTQ+ elders in long-term care settings by Executive Order.
    a. What's the status of the drafting process and when we should expect to see concrete next steps on the LGBTQ+ Long Term Care Bill of Rights?
    b. By what date will the protections be put into place so LGBTQ+ older people in long-term care settings will know that the federal government is committed to their health and well-being?

Answer:
The Biden-Harris Administration is committed to protecting and advancing the health and rights of LGBTQI+ people, including addressing discrimination, social isolation, and health disparities faced by LGBTQI+ older adults. You can find updated information about HHS's resources related to the health and wellbeing of LGBTQI+ individuals at https://www.hhs.gov/programs/topic-sites/lgbtqi/resources/index.html. This website includes information about HHS-funded programs through Services and Advocacy for GLBT Elders (SAGE).

The June 2022 Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals continues to expand the reach of this Administration's commitment to LGBTQI+ older adults and HHS is working diligently to finalize regulations cementing nondiscrimination on the basis of age. In a Notice of Proposed Rulemaking issued in August of 2022, both the Office for Civil Rights and the Centers for Medicare & Medicaid Services proposed strong regulations to protect LGBTQI+ older adults across federally funded health programs and activities, such as Programs of All-Inclusive Care for the Elderly. *See* 87 FR 47824, 47894 (August 4, 2022) (1557 NPRM). Such proposals will serve as the bedrock for continued development of guidance and resources.

Rep. Teresa Leger Fernandez (D-NM)

Question 63

63. As you may know, I attended Head Start as a child and, to this day, I'm a strong advocate of the program. With that in mind, I was thankful to see that President Biden included
$575 million for an increase in Head Start wages in his proposed budget for FY24. However, that only represents an increase of 4.8% which, if enacted, would still leave a significant difference between Head Start teacher wages and those earned by public school teachers. Question A
    a) How does HHS/OHS plan to address that discrepancy?

Answer:
We are aware of the significant discrepancy between Head Start teacher wages and those earned by public school teachers. Supporting the Head Start workforce is one of OHS's top priorities . Since the 2007 reauthorization of the Head Start Act, the share of Head Start Preschool teachers with a bachelor's degree has steadily increased, but the inflation-adjusted salaries of those teachers *decreased* by 2 percent and the gap between Head Start teacher salaries and kindergarten teacher salaries is considerably wide ($35,000 and $65,000, respectively). Meanwhile, Head Start enrollment is at the lowest level in 30 years primarily due to empty classrooms that cannot open due to a lack of qualified staff. Additionally, the Head Start teacher turnover rate reached an all-time high of 22 percent in 2022, compared to 10 percent teacher turnover in public schools. For context, in 2022, 63 percent of Head Start education staff were people of color. These trends lay bare that the Head Start model has long relied on women—primarily women of color—being willing to accept very low wages because they believe in the Head Start mission. This too often comes at the expense of their own well-being; many staff in Head Start receive wages that leave their own families below the federal poverty threshold. In 2019, one in four Head Start teachers nationally worked in programs that paid an average teacher salary below the poverty threshold for a family of four. This is why OHS is committed to investing in our workforce. The FY 2024 President's Budget includes a request for $574.6 million to invest in Head Start staff compensation, as a down payment toward achieving pay parity between Head Start educators and elementary school teachers.

In the meantime, OHS has several ongoing initiatives and supports for grant recipients that address this priority. In November, HHS announced a new proposed rule to strengthen Head Start's ability to recruit and retain qualified staff, raise teacher wages, and provide consistent quality programming for the children and families they serve. The new proposed rule follows President Biden's April 2023 Executive Order, which directed HHS to develop strategies to encourage comparability of compensation and benefits between staff employed by Head Start grant recipients and elementary school teachers and make child care and Head Start more accessible for those families most in need. If finalized, the new proposed rule would raise Head Start teacher annual wages by more than $10,000 on average. And it will put Head Start teachers on a path to parity with public school teachers by ensuring that their salaries are at least equivalent to preschool teachers in public school settings without impacting children currently enrolled in Head Start.

Last year, OHS published two Information Memorandums (IM) calling for grant recipients to improve compensation in order to be competitive with elementary schools (Competitive Bonuses for the Head Start Workforce and Strategies to Stabilize the Head Start Workforce). This guidance encourages grant recipients to consider restructuring their programs as a sustainable mechanism for providing increased compensation and other necessary support to staff. This may include consolidating grants, restructuring management or organizations, or requesting a reduction in the overall number of funded slots while continuing to prioritize services to the children and families who are most in need. The guidance outlines several areas programs could reinvest freed up funds, including permanently increasing compensation, offering bonuses, and supporting career advancement opportunities.

In response, OHS has seen a significant increase in change in scope requests from programs that propose to reduce enrollment in order to increase staff compensation. Many of these programs are already under-enrolled, primarily due to the workforce shortage. These programs are restructuring to ensure they have a stable, high-quality workforce that is able to consistently meet the needs of the children and families in their communities.

Rep. Glenn "GT" Thompson (R-PA)

Question 64

64. In the 115th Congress, I was proud to champion the *Veterans E-Health and Telemedicine Support Act*, which allowed physicians at the Department of Veterans Affairs (VA) to treat veterans via telehealth across state lines. This simple fix greatly expanded access to care for our nation's veterans who could previously drive across state lines to see a VA physician but could not receive those services via telehealth. These services are particularly helpful in rural areas where the nearest in-person provider may be hours away. As you may know, there are certain specialties and practices in some states that allow providers to meet with patients via telehealth regardless of state boundaries.

Unfortunately, this patchwork of policies is not particularly effective, and it results in confusion and added layers of bureaucracy for patients and providers alike. How do you think we can build on the successful model at the VA to allow any physician to treat their patient via telehealth across state lines?

Answer:
In response to the COVID-19 public health emergency, which expired in May 2023, flexibilities for Medicare telehealth services were issued through legislative and regulatory authorities to increase access to care for patients and providers. The Consolidated Appropriations Act of 2023 recently extended many of these flexibilities through December 31, 2024. Extended telehealth flexibilities include waiving geographic and site of service originating site restrictions so that Medicare patients can continue to use telehealth services from their home and allowing audio-only telehealth services. Additionally, the expanded list of providers eligible to deliver telehealth services is also extended so Medicare beneficiaries can continue to receive telehealth services furnished by physical therapists, occupational therapists, speech language pathologists, and audiologists, as well as receive telehealth services from Rural Health Clinics and Federally Qualified Health Centers through December 31, 2024. If you are interested in drafting legislation to make these waivers permanent, CMS would be happy to provide technical assistance.

Additionally, recent legislative and regulatory changes made several telehealth flexibilities permanent. Federally Qualified Health Centers and Rural Health Clinics can furnish certain behavioral services via telecommunications technology. Medicare patients can continue to receive these telehealth services in their home as geographic restrictions on the originating site are eliminated for these telehealth services. Certain mental telehealth services can be delivered using audio-only communication platforms, and rural emergency hospitals can serve as an originating site for telehealth services.

With regard to furnishing services across state lines, CMS' longstanding policy for Medicare is to defer to state law with regard to licensure issues. This is a permanent policy that was not limited to the public health emergency for COVID-19. While CMS did issue a blanket waiver of requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state during the PHE when certain conditions were met, this was not specific to telehealth. This waiver also facilitated the ability of physicians and practitioners to travel to states to furnish in-person services in areas that were overwhelmed due to COVID-19.

The waiver of Medicare requirements that the practitioner be licensed in the state where services are furnished worked in tandem with state waivers of their licensure requirements to permit care to be furnished to Medicare patients across state lines, either in person or through telehealth. The waiver of Medicare requirements ended with the PHE, and Medicare regulations continue to defer to state law as to whether a practitioner is authorized to practice in a state.

Data about Medicare fee-for-service beneficiaries who used telehealth services between January 1, 2020 and September 30, 2022, and a Medicare telehealth trends report, are available at https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-telehealth-trends. The data will be updated quarterly.

For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Medicaid and CHIP telehealth policies will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

Rep. Gregorio Kilili Camacho Sablan (D-MP)

Question 65

65. As Medicaid unwinds due to the end of the COVID-19 public health emergency, most States have been able to mitigate the loss of coverage by directing people to the Exchange. However, my district and the other territories do not have access to the Exchange.
    a. What support can your Department offer in developing a strategy for the establishment of Exchanges in the U.S. territories?

Answer:
Section 1323 of the Affordable Care Act (ACA) provided the territories the option of establishing a Marketplace and allocated funding to each territory for premium and cost-sharing assistance. In March 2011, the Department of Health and Human Services (HHS) awarded federal grants, known as "Territory Establishment Grants," to each of the territories that elected to establish a Marketplace for a variety of Marketplace-related implementation activities, including background research (such as market analysis, development of projected enrollment figures, capacity-building for consumer assistance, etc.,) and initial consultation with interested parties. In July 2014, HHS issued letters to each of the territories to clarify the applicability of certain ACA provisions to health insurance issuers in the territories. Ultimately, none of the five U.S. territories found that the option to establish a Marketplace was feasible at the time and instead received the funding allocated under section 1323 of the ACA for premium and cost-sharing assistance in the form of federal Medicaid matching funds during the time period of 2014 to 2019. Specifically, American Samoa received a total of $16.5 million; Guam received a total of $24.4 million; the Commonwealth of the Northern Mariana Islands received a total of $9.1 million; Puerto Rico received a total of $925 million; and the U.S. Virgin Islands received a total of $24.9 million.

As HHS implements the changes enacted under the Consolidated Appropriations Act, 2023 (CAA, 2023), we are working to protect beneficiaries and ensure states and territories follow Medicaid eligibility redetermination

requirements as they return to normal enrollment and eligibility operations after the end of the Medicaid continuous enrollment condition under the Families First Coronavirus Response Act (FFCRA). HHS shares your commitment to preventing coverage losses for eligible individuals, and we are already working to ensure state compliance with these requirements.

To support implementation of the CAA, 2023's changes, CMS has worked expeditiously to provide guidance and ongoing technical assistance to states. As this dynamic work continues, CMS will continue to provide states with additional guidance and support in complying with unwinding-related requirements, including those enacted in the CAA, 2023.

Even before states started unwinding from the Medicaid continuous enrollment condition, CMS met one-on-one with every state and territorial Medicaid agency to complete an initial assessment of compliance with federal eligibility redetermination requirements. Where necessary, CMS supported the development and approval of states' mitigation plans to redress areas of noncompliance in a manner that mitigates adverse consequences for and protects beneficiaries. As part of these mitigation plans, CMS is directing some states to delay procedural terminations until the state is able to implement such mitigations. During each state's unwinding period, CMS is reviewing data, state activities, and other information to ensure that states are complying with federal eligibility renewal requirements, and stepping in where necessary. CMS is closely monitoring to ensure that states claiming the temporary FMAP increase comply with the applicable conditions under the FFCRA (as amended by the CAA, 2023).

In addition, CMS is using a multi-pronged outreach approach to reach as many individuals and families as possible during the Medicaid and CHIP renewal process, and to make sure they know where to turn if they or their children lose coverage. This includes national and local public engagement, paid advertising, media engagement, toolkits and materials, and direct-to-consumer communications. CMS has conducted targeted outreach on unwinding to populations of color and at regular meetings with American Indian/Alaska Native tribes and tribal organizations, as well as via targeted campaigns in Spanish and other languages. State renewal forms, notices, and the fair hearing materials must be provided in a format that is accessible to individuals who have limited English proficiency.

Regulations implementing Section 1557 of the Affordable Care Act, which prohibits discrimination on the grounds of race, color, national origin, sex, age or disability in certain health programs and activities, require health programs, including Medicaid and CHIP programs, that receive federal financial assistance to take reasonable steps to provide meaningful language access to individuals with limited English proficiency. Reasonable steps to provide meaningful language access may include translating documents written in English, such as notices pertaining to renewals and other eligibility actions during the unwinding period, by a qualified translator. Meaningful access may also require provision of oral language assistance from a qualified interpreter, either in-person or using remote communication technology (e.g., telephone, internet, or video).

States are responsible for ensuring that eligible individuals maintain their coverage, and that those who are found ineligible for Medicaid are transferred to other insurance affordability programs for which they may be eligible. HHS appreciates the significant effort many states have put into protecting coverage for eligible individuals and supporting transitions to other forms of health care coverage where necessary, and we continue to work with states as they evaluate and address challenges they face during their unwinding periods. At the same time, the enforcement authorities Congress added in the CAA, 2023 provide HHS with important tools to ensure that states comply with federal requirements during a period that generally aligns with states' unwinding periods, and we will not hesitate to use them.

Representative Susan Wild (D-PA)

Question 66

66. It was recently reported that call center workers at Maximus, one of the largest federal contractors for HHS, went on strike after the company announced surprise layoffs impacting over 700 workers. The workers impacted by the layoffs were customer service representatives who managed calls for millions of Americans reaching out with questions related to the Affordable Care Act and Medicare. The company attributed the layoffs to overstaffing; however, the company then recruited for many of these same positions at non-union organizing sites almost immediately after the layoffs were announced. In response to these surprise layoffs, the need for fairer wages, and the lack of career advancement opportunities, Maximus workers in four states went on their fourth strike.
    a. Secretary Becerra, does HHS intend to investigate Maximus' labor practices as it pertains to these seemingly unfair layoffs?
    b. If Maximus is found to have committed wrongdoing, how does HHS plan to remedy the harm done to laid-off workers and hold Maximus accountable?
    c. Will you call on Maximus to rehire laid-off workers?

Answer:
CMS values and respects the contribution of the call center representatives and strongly supports the right of workers to voice concerns about working conditions. Recently, CMS has worked with Maximus to improve the working conditions for their employees:

- Increased pay ahead of required Executive Orders and Department of Labor Wage Determinations. Pay was increased above $15 in September 2021 ahead of the Biden Executive Order that went into effect in January 2022. Increased wages again in January 2023, in accordance with new Department of Labor wage determinations.
- Improved the health insurance options available to employees. In February 2022, Maximus offered health plans with lower deductibles for both employee-only and family coverage plans, reducing the total out of pocket costs for employees.
- Increased the amount of sick leave as a result of the CARES ACT and then increased the amount of paid sick leave, in accordance with recent Executive Orders
- Found positions on other contracts to transition workers that were laid-off as a result of our annual ramp down after Open Enrollment.

The call center annually must staff up to support increased call volumes for Open Enrollment for both Medicare and the Marketplace. To have the appropriate staffing to handle lower call volumes for the non-open enrollment period, the call center had to ramp down approximately 700 representatives that support Marketplace and Medicare to ensure appropriate staffing for the remainder of the year, until it begins to ramp up again for the next annual enrollment periods. Due to the nature of this work and to ensure the most efficient usage of Government resources and funding, this is a common challenge that the contractor has to manage.

Because Maximus Federal has other contracts with both state and federal call centers, they were able to offer employment on other contracts to those staff. This is not a requirement of the contract, but a benefit of

contracting with a vendor who has other state and federal work. Eligible staff did receive severance as well as opportunities to transition to other programs where positions may be available, and will be considered when additional staff is required in the future to support the annual enrollment period.

CMS recognizes the invaluable contribution of the thousands of call center representatives who ensure that those with Medicare or Marketplace questions receive accurate, high-quality information. One of CMS's top priorities is providing excellent customer service to people with Medicare and to Marketplace consumers as they navigate these programs.

[Whereupon at 1:21 p.m., the Committee was adjourned.]

