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**HEARING ON FISCAL YEAR 2026
DEPARTMENT OF HEALTH AND
HUMAN SERVICES BUDGET**

HEARING

[BEFORE THE]

**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS
UNITED STATES SENATE**

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

MAY 14, 2025

Printed for the use of the
Committee on Health, Education, Labor, and Pensions



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ON

EXAMINING THE PRESIDENT'S PROPOSED BUDGET REQUEST FOR FISCAL YEAR 2026 FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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MAY 14, 2025
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**HEARING ON FISCAL YEAR 2026
DEPARTMENT OF HEALTH AND
HUMAN SERVICES BUDGET**

Wednesday, May 14, 2025

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 1:31 p.m., in room 430, Dirksen Senate Office Building, Hon. Bill Cassidy, Chairman of the Committee, presiding.

Present: Senators Cassidy [presiding], Paul, Collins, Murkowski, Mullin, Marshall, Scott, Hawley, Husted, Banks, Moody, Sanders, Murray, Baldwin, Murphy, Kaine, Hassan, Hickenlooper, Markey, Kim, Blunt Rochester, and Alsobrooks.

OPENING STATEMENT OF SENATOR CASSIDY

The CHAIRMAN. I was waiting for the cameras to leave, and they weren't, so decided to rein them in. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

Secretary Kennedy, thank you for coming before the Committee. President Trump has taken on the mission to reform the Federal Government, making healthcare more affordable and making America healthy again. It is clear the status quo does not work. Bureaucratic bloat, regulatory hurdles at the Department of Health and Human Services have made it harder to deliver critical services.

HHS needs to work better for the American people. This means finding ways to speed up approvals for life-saving drugs, improving delivery of health care services so Americans who need these benefits can receive them, addressing the high levels of chronic disease, and holding bad actors accountable to lower health care costs for the American people.

I am encouraged that HHS is already working to address these issues. I want to note that this is the first time in at least two decades the HHS Secretary is testifying on the Department's budget before the HELP Committee. And I appreciate Secretary Kennedy for coming to answer our questions on the fiscal year 2026 budget.

Now, people fear change, even when it is from worse to better. But without a clearly defined plan or objective, people assume the worst. Much of the conversation about HHS's agenda has been set by anonymous sources in the media and individuals with a bias against the President.

Americans need direct reassurance from the Administration, and from you, Mr. Secretary, that these reforms will make their lives easier, not harder, and that is why I have invited you. No one can make that case better than you. These are the questions about how HHS will be able to preserve its primary functions and duties under this proposed budget.

Many offices and programs potentially seeing changes are essential for implementing bipartisan laws, including laws championed and signed into law by President Trump. Example, in 2018, Congress worked with President Trump to pass the *Support for Patients and Communities Act*, provide—protecting communities, saving lives through increased access to naloxone, and prevention and treatment for fentanyl addiction.

The HELP Committee and President Trump also worked together to pass laws to improve research into health disparities, address the needs of Americans with traumatic brain injuries, Alzheimer's, Lyme disease, support family caregivers, and help moms and babies live healthier lives, programs essential to achieving President Trump's goal of making America healthy again.

The proposed budget offices that are responsible for overseeing many of these initiatives, which were initiated by President Trump, will be consolidated or repurposed. Now, I agree with Secretary Kennedy that HHS needs reform. Over the past several years, I have engaged stakeholders and worked with colleagues to identify opportunities to modernize a wide array of HHS agencies and programs.

The Department needs to have an effective plan to fulfill statutory duties in tandem with efforts to increase transparency, accountability, to streamline programs, and to root out wasteful spending. Congress and the Administration should work together to ensure reform strike the right balance and deliver for all Americans.

Mr. Secretary, once more, no one can set the record straight better than you to explain how the Department will maintain its critical duties and implement change important to Americans' health.

By providing this clarity, we in Congress will be able to advocate for shared priorities in future legislation, and you will gain the trust of the American people, putting their minds at ease. I appreciate you being here.

I look forward to hearing how the proposed HHS budget will advance President Trump's mission. And with that, I recognize Senator Sanders for his opening statement.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you, Mr. Chairman. Mr. Secretary, thanks for being with us. Let me begin by quoting a sentence that came from your prepared remarks.

You state, and I quote, "The United States remains the sickest developed nation, and we spend \$4.5 trillion annually on health care, two to three times more per capita than comparable nations. Clearly something is structurally wrong with our approach." You

are right. The current healthcare system is broken. It is wildly expensive. It is dysfunctional.

What do we do, Mr. Secretary, to address it? Maybe for a start, we do what every other major country on earth does and recognize that health care is a human right guaranteed to every man, woman, and child.

Maybe we understand that the function of a rational health care system is not to make hundreds of billions of dollars in profit for insurance companies and drug companies who often engage in stock buybacks, pay their CEOs outrageous compensation packages. There was a guy from one of the major drug companies sitting exactly where you are sitting last year. The guy makes \$50 million a year. Meanwhile, we don't have enough doctors.

We don't have enough nurses. We don't have enough dentists, we don't have enough pharmacists, we don't have enough health care workers in general. You are right, the system is structurally broken. We spend far more, we have a shorter life expectancy than other countries.

This is an issue that I want to address with you. How in fact do we guarantee health care to all people and do it in an effective way? Let me say a word about prescription drugs. You and President Trump had a press conference earlier this week discussing an Executive Order that both of you claim would make sure that the American people pay the lowest prices in the world for prescription drugs, not the highest.

As you mentioned at your press conference, this is a concept that I personally strongly support, and I think you are aware of that. But as President Trump and you should know, this Executive Order, like Trump's previous Executive Orders on the subject, will likely be thrown out by the courts, and we will be back to exactly where we are today, paying by far the highest prices in the world for prescription drugs. In my view, the way forward is through Legislative action.

If you and President Trump are serious about significantly lowering the outrageous price of prescription drugs in this country, as I hope you are, I would very much appreciate both of you working with me and other people on this Committee and in the Senate on legislation that I will soon be introducing which accomplishes exactly the same goal as you and the President talked about, making sure that we pay no more for prescription drugs than people in other major countries.

If we are serious about that, let's work together and let's make that happen. And in fact, if Republicans and Democrats come together on this, if we prioritize it, we can pass that legislation in a couple of weeks. Thirdly, Secretary Kennedy, all of us want to make the Government more efficient and cost-effective, none fewer than I—there is too much bureaucracy.

But let me tell you also what we want and what the American people want. And that is we want the Federal Government to play a major role in continuing its efforts to combat such terrible diseases. There is cancer, Alzheimer's, diabetes, heart disease, and

others terrible illnesses that claim the lives of millions of Americans.

In that regard, I must tell you that I have heard from citizens, patients, and doctors in Vermont and all over this country who are deeply concerned that under the leadership of you and Mr. Musk, the Trump administration has terminated at least \$13.5 billion in health care funding, including more than 1,600 grants to conduct vital research into cancer prevention, Alzheimer's, diabetes, and cardiovascular disease, among many other medical research investments.

In the first 3 months of this year, the National Institute of Health has been effectively cut by \$2.7 billion, a 35 percent cut reversing over a decade of investment in medical research. Under your leadership, cancer research has been slashed by 31 percent.

Further, Secretary Kennedy, under your leadership, you have undermined the vital role vaccines play in preventing disease during the single largest measles outbreak in 25 years, which has led to over 1,000 cases of measles, over 125 hospitalizations, and 3 deaths.

Let me say a word about USAID. Elon Musk, the richest man on earth, who has led the effort to cut health and nutrition programs for the poorest people on earth, has absurdly suggested that no one, "no one" has died from the massive cuts to USAID. Mr. Musk is 100 percent wrong.

According to independent researchers, nearly 200,000 people have already died throughout the world as a result of the massive cuts in funding to prevent malaria, tuberculosis, HIV, malnutrition, and other serious diseases. Further, as a result of the elimination of U.S. funding for a global vaccine program, it has been estimated that over a million children will die because of the cuts that will save taxpayers very, very little money. So let me just conclude by saying this.

The United States of America is the wealthiest country on earth. We should have the best healthcare system in the world, not one of the worst. Given our purchasing power, we should be paying the lowest prices on earth for prescription drugs, not the highest.

Instead of giving hundreds of billions of dollars in tax breaks to the richest people in this country, we should be proudly investing in coming up with cures for cancer, Alzheimer's disease, diabetes, and other terrible illnesses. That is what we should be doing, but I am afraid that in too many ways, we are doing exactly the opposite. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Sanders. I will now introduce the witness. We are joined today by the Hon. Robert F. Kennedy, Jr., the 26th Secretary of the United States Department of Health and Human Services.

In his role as Secretary, Mr. Kennedy is responsible for overseeing the Nation's civilian Federal health agencies who serve over 150 million Americans. We look forward to hearing from you today, Secretary Kennedy. Again, thank you for joining us.

**STATEMENT OF HON. ROBERT F. KENNEDY JR., SECRETARY
OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Secretary KENNEDY. Thank you, Senator Sanders. I just want to begin by saying I know how determined President Trump is for us to have the lowest drug prices in the world as between Europe and the United States. And I also know that he doesn't care how we get there, that is where he wants Americans to be.

He has said I don't know how many times since I have been involved with him, about that. We shouldn't be paying or be able to go to London and buy GLP for \$88 that in this country cost us \$1,300. And I know it is something that you have been talking about for many years, and I look forward to working with you on legislation or—

Senator SANDERS. Thank you.

Secretary KENNEDY [continuing]. Any way that we can to get there. Thank you, Chairman Cassidy and Senator Sanders. I am honored to be before you today to present the Department of Health and Human Services Fiscal Year 2026 budget. Debilitating disease, contaminated food, toxic environments, addiction, and mental illness affect Americans across every race, class, and political belief.

When my team and I took the helm at HHS, we set out with clear goals. First, we aim to make America healthy again with a special focus on the chronic disease epidemic. Second, we committed to delivering more efficient, responsive, and effective service to over 100 million Americans who rely on Medicare, Medicaid, and other programs.

Third, we focus on achieving these goals by cutting costs for taxpayers. We intend to do more, a lot more, with less. The budget I am presenting today supports these goals and reflects—

[Public interruption.]

The CHAIRMAN. The witness will suspend. The Committee will come to order. Capitol Police are asked to remove the individuals from the hearing room. Members of the audience—are reminded disruptions will not be tolerated. Members of the audience are reminded disruptions will not be permitted while the Committee conducts its business.

Capitol Police are asked to remove the individuals from the hearing room. That was a made for C-SPAN moment. The Secretary will resume. Just a second, Mr. Secretary. Let's get the doors closed and the ruckus is totally clear. Got it. Okay. And we thank the Capitol Police for working with due diligence. Thank you very much. Mr. Secretary, please resume.

Secretary KENNEDY. The budget, I am—

The CHAIRMAN. Excuse me, Mr. Secretary. Will you reset the clock? The clock has been running. Whatever it would be. Okay, please.

Secretary KENNEDY. All right. The budget I am presenting today supports those goals and reflects two enduring American values, compassion and responsibility. I invite the Committee to unite around these ideals with me.

The United States remains the sickest developed nation in the world, and we spend \$4.5 trillion annually on healthcare. Two to three times more per capita than comparable nations. Clearly, something is structurally and systemically wrong with this system. Furthermore, healthcare costs are steadily increasing at a rate of 2 percent greater than the economy.

If we don't staunch this unsustainable hemorrhage, we will ransom our children to bankruptcy, servitude, and disastrous health consequences. Yes, an exploding debt is a social determinant of health. We won't solve this problem by throwing more money at it. We must spend smarter. We will shift funding away from bureaucracy and toward direct impact.

Some things at HHS will not change. We will preserve legacy programs like Medicare, Medicaid, and Head Start, as the foundation of the MAHA Agenda. Vulnerable populations, seniors, and veterans deserve consistent access to care, and I will ensure that they receive it.

Today, 83 million Americans, urban and rural, lack adequate access to primary care physicians. We will prioritize these families, especially Native American and Alaskan communities. We will protect IHS funding, streamline its operations, and give the tribes more autonomy in managing their resources.

Let me be clear, we intend to make the Trump HHS not just the most effective, but also the most compassionate in U.S. history. Our official budget statement outlines many priorities, but I want to highlight a few. First, we will consolidate programs to better tackle mental health and addiction.

These issues now rival chronic disease and their impact. HHS will aggressively combat the opioid crisis, especially the spread of synthetic drugs like fentanyl. We will empower state, local, and tribal leaders to create effective solutions. Second, we will address nutrition, physical activity, and healthy lifestyles.

The President's budget requests \$94 billion in discretionary funds to support these priorities, including the Administration for a Healthy America. We will emphasize healthy eating in Head Start, and ensure the program continues to serve its 750,000 children and parents effectively.

Third, we will equip FDA to expand its food safety efforts through research, regulation, inspection, and education, remove harmful chemicals from food and packaging. Fourth, we will fund cutting edge research at NIH while cutting risky or non-essential studies. That includes ending gain-of-function experiments and research based upon radical gender ideologies.

At the CDC, we will return to core missions, tracking disease, investigating outbreaks, and sustaining public health infrastructure while cutting waste. Fifth, we will eliminate DEI funding and redirect resources toward real poverty reduction. We will move beyond lip service to communities of color and take meaningful action to meet their needs.

Six, we will strengthen cybersecurity and health IT. The AI revolution has arrived, and we are already using new technology to manage health data more efficiently and securely. Finally, we will

rebuild public trust, a trust that eroded through years of industry capture, corruption, waste, and misplaced priorities.

We will launch a new era of transparency in public service, creating an honest science-driven HHS that answers to the President, to Congress, and to the American people. I look forward to working with Congress to pursue this mission together as a bipartisan cause.

Let's work side by side to make America healthy again. Thank you.

[The prepared statement of Secretary Kennedy follows.]

PREPARED STATEMENT OF ROBERT F. KENNEDY, JR.

The mission of the Department of Health and Human Services (HHS or Department) is to enhance and protect the health and well-being of the American people.

President Trump and all of us at HHS take that charge seriously. So, when a program is not as effective as it can be, or costs more than it ought to, or fails to deliver on its promise—change and reform are necessary.

The President's Fiscal Year (FY) 2026 Budget applies this mindset to the work of the Department, making thoughtful and strategic decisions to transform HHS and better protect the health and well-being of the American people. The budget invests in methods to address chronic disease; protect American families from environmental toxins; promote nutrition as well as food and drug safety; strengthen services for American Indians and Alaska Natives; encourage innovation in America's healthcare future; and focus resources toward proven and effective initiatives. This budget, likewise, recognizes the fiscal challenges our Country faces today, and the need to update and redirect our investments to meet the needs of a rapidly changing world.

The Fiscal Year 2026 Budget request includes reforms to put healthcare spending on a sustainable fiscal path. We must remake the government to maximize efficiency and productivity in order to fulfill the President's promise to Make America Healthy Again (MAHA). HHS has made progress toward these goals, promoting the health of Americans while instituting significant workforce reductions and identifying over \$13 billion anticipated in contract savings—and there is more to come. Over the next few months, we will work together with Congress to restructure the Department and improve how we deliver services to the American people. HHS takes seriously our role as responsible stewards of taxpayer dollars, and we look forward to working with you to implement the President's agenda while continuing to cut government bloat and rescope the Federal role. Protecting the health of Americans has to be done hand in hand with protecting our Nation's fiscal health—they rely on each other. The Fiscal Year 2026 Budget will reduce duplication of programs and services, increase accountability, and work with state and local governments to improve flexibility.

The Fiscal Year 2026 Budget protects key programs that Americans rely on that keep us competitive with our enemies, and fulfill promises made to Tribal Nations. This budget allows us to do our part to restore fiscal responsibility to the Federal Government while optimizing HHS's ability to improve and save American lives. The reductions made are necessary to right-size the Department's budget, which has ballooned by about 40 percent since the COVID-19 pandemic.

The Fiscal Year 2026 Budget focuses on restructuring efforts to transform HHS to Make America Healthy Again. I look forward to working with you on our vision to Make America Healthy Again. The President's Budget for HHS also reflects proposals to meet the President's comprehensive Government-wide Transformation Plan through a sweeping restructuring that aims to identify opportunities to improve the work HHS does for the American people, in terms of its efficacy, efficiency, quality, and cost-effectiveness.

The HHS restructuring will serve multiple goals without impacting critical services. First, beginning in fiscal year 2026 it could save taxpayers an estimated \$1.8 billion per year through a reduction in workforce. Our reductions have focused on aligning HHS staffing levels to reflect the size of HHS prior to the COVID-19 pandemic which saw around a 15 percent increase in the number of employees.

Second, it will streamline the functions of the Department. Currently, the 28 divisions of HHS contain many redundant units. The restructuring plan will consolidate

them into 15 new divisions, including a new Administration for a Healthy America, or AHA, and will centralize core functions such as Human Resources, Information Technology, Procurement, External Affairs, and Policy. The restructuring plan intends to reduce regional offices from 10 to 5 by planning to close regional offices in high-cost cities. This restructuring will reduce the number of full-time employees to approximately 62,000, while preserving critical staff such as FDA food safety inspectors.

Third, the overhaul will implement the new HHS priority of ending America's epidemic of chronic illness by focusing on safe, wholesome food, clean water, and the elimination of environmental toxins. These priorities will be reflected in the reorganization of HHS.

Finally, the restructuring will improve Americans' experience with HHS by making the agency more responsive and efficient, while ensuring that Medicare, Medicaid, and other essential health services remain intact.

In summary, these changes will allow us to act more nimbly and focus on the core mission of improving the Nation's health. Without duplication of resources, and reduced bureaucracy, HHS can use Federal dollars to more directly impact the lives of those served by HHS programs. HHS will be prepared to share additional information with Congress in the coming weeks. We look forward to congressional collaboration in this process.

Making Americans Healthy

One of the Department's top priorities is fighting the scourge of chronic disease facing our Country. Today, Americans' overall health is in a grievous condition. Over 70 percent of adults and a third of children are overweight or obese. Diabetes is ten times more prevalent than in 1960. Cancer among people 50 and under is rising by one or 2 percent a year. Autoimmune diseases, neurodevelopmental disorders, asthma, Alzheimer's, ADHD, depression, addiction, and a host of other physical and mental health conditions are on the rise.

The United States has worse health than any other developed nation, yet we spend far more on healthcare—at least double; in some cases, triple. Last year we spent \$4.9 trillion, not counting indirect costs like missed work. That's almost 17.6 percent of our Nation's GDP. But more than that, it's a human tragedy—today, over half of all Americans are chronically ill.

The President's Budget requests \$94 billion in discretionary funding to combat these challenges. This budget includes strategic investments in the new Administration for a Healthy America (AHA). It is my vision for this new agency to better coordinate programs targeted to improve chronic care, disease prevention, and other health resources.

The Fiscal Year 2026 Budget provides resources to the Department of Health and Human Services that would allow the Secretary to tackle issues related to nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety.

CMS

Medicare, Medicaid, and the Children's Health Insurance Program remain a cornerstone of the MAHA agenda to improve outcomes for our seniors and children. This budget continues CMS program funding to maintain beneficiary service levels, streamline program administration, and move toward improved health outcomes while eliminating non-statutory and wasteful spending. The Trump administration remains committed to protecting these programs by ensuring that Federal taxpayer dollars are protected against waste, fraud, and abuse.

Mental Health and Substance Use

It is estimated that one in five adults in the United States lives with mental illness—that's nearly 20 percent of the adult population. Approximately 16 million Americans with mental illness had serious thoughts of suicide. As the number of deaths by suicide continues to increase, it is more important than ever that HHS expand access to the care people need when they need it. An estimated 49.5 percent of adolescents have had a mental health disorder at some point in their lives. As child and youth mental health declines, HHS is dedicated to providing resources to children and youth in their communities.

The Fiscal Year 2026 Budget invests in behavioral health by streamlining programs to avoid duplication and supporting block grant funding for these critical services. The Administration is committed to combating the scourge of deadly drugs, especially synthetic opioids like fentanyl, that have ravaged American communities, as President Trump did during his first term. The President has made reducing the initiation of drug use, particularly among young people, and increasing the number of individuals receiving evidence-based treatment, leading to long-term recovery from substance use disorders, a top priority. The Budget also proposes to refocus activities that were formerly part of the Substance Abuse and Mental Health Services Administration, by eliminating funding for programs that duplicate block grant funding, or are too small to have a national impact.

Primary Care

Under the President's Executive Order to establish the Make America Healthy Again Commission, I am committed to investigating any potential root causes of the chronic disease epidemic. As part of AHA, programs related to primary care will be streamlined, and focused on needs of all Americans no matter where they may live and at what income level. The Budget and the transformation at HHS support these efforts and ensures that primary care includes prevention and addresses the root causes of chronic disease.

Head Start

For Americans to be healthy, we must start when they are children. The President's Budget recommends Head Start continue to receive funding equal to the Fiscal Year 2025 Enacted level. In exchange, Head Start needs to be consistent with Administration priorities. This includes increasing parental choice; improving health, education, and employment outcomes; increasing program delivery efficiency; and promoting parental engagement. Head Start directly supports local-level institutions, including faith-based centers, empowering them to oversee care. Head Start also enables parents to find dignity in work when their children are enrolled in a safe and secure Head Start program.

Make Americans Safe

I am committed to making Americans safer. I am working to make sure our tax dollars support healthy foods—and we are scrutinizing the chemical additives in our food supply.

Wholesome food is a key component of the MAHA agenda and maintaining FDA activities that enable the United States to identify harmful ingredients, and overall make the food supply safer, will be a key component to the Department's ability to realize a healthy future.

Protecting Our National Security and Sustaining Scientific Competitiveness

This budget also supports the Nation's public health infrastructure and capacity to respond to existing and emerging public health threats, with a focus on infectious diseases, preparedness, and outbreak response.

While we need to rescale our biomedical research budget, HHS will continue to prioritize America's national security and competitiveness. Biomedical research continues to be one of our Country's biggest exports. NIH is the largest single public funder of biomedical and behavioral research in the world. This budget includes \$27.5 billion for NIH, a rebalancing that will focus on essential research at a more practical cost and invest in security infrastructure. We will focus only on Gold Standard science at NIH and across HHS, increasing transparency for research done there.

NIH has broken the trust of the American people with wasteful spending, misleading information, risky research, and the promotion of dangerous ideologies that undermine public health. The Administration is committed to restoring accountability, public trust, and transparency at the NIH.

Supporting and encouraging scientific research is a longstanding Federal priority, one that results in both a growing economy and Americans living longer lives. Executing this responsibility demands that the Federal Government regularly considers how to organize this support in the most efficient manner possible. HHS is committed to safeguarding taxpayer resources so that institutions are adequately supported at a sustainable level, and that we are only funding essential costs, in line

with private-sector standards. The budget proposes to consolidate major HHS research institutions in NIH to maximize the effectiveness of their research.

The proposed budget shifts NIH's focus away from foreign interests and reforms its efforts on the core research activities that align with the President's commitment to Make America Healthy Again. NIH will no longer issue grants to promote radical gender ideology to the detriment of America's youth, or fund dangerous gain-of-function research, though related research will continue consistent with Administration policy and oversight. Our Administration is committed to eliminating radical gender ideologies that poison the minds of Americans.

Restoring Trust

At HHS, we're committed to empowering states, localities, and Tribal communities by supporting science-based policies, rebuilding trust in public health, and protecting future generations from harmful exposures. We are committed to restoring a tradition of gold-standard, evidence-based science—not one driven by politicized DEI, gender ideology, nor sexual identity. We are removing the financial conflicts of interest in our agencies—to create an honest, unbiased, science-driven HHS, accountable to the President, to Congress, and to the American people.

Americans do not want their tax dollars going to initiatives that espouse radical ideologies. We are proposing to eliminate programs like the Community Services Block Grants that have been hijacked from true poverty reduction to fund DEI initiatives, saving taxpayers \$770 million. Americans need to trust that we are good stewards of the dollars they entrust to us, and this budget shows our commitment to pursuing pathways to gain back taxpayers' trust.

We have also ended HHS as the principal vector for child trafficking. The Budget re-focuses the Unaccompanied Alien Children (UAC) program on its core mission of sheltering unaccompanied alien children while also protecting them from child trafficking and labor exploitation. During the Biden administration, HHS became a collaborator in child trafficking for sex and slavery. The Biden administration operated the UAC program like an assembly line, prioritizing the quick release of children to insufficiently vetted sponsors over the children's safety. And we have ended that. We are very aggressively going out and trying to find these children that were lost by the Biden administration.

The Budget refocuses the Centers for Disease Control and Prevention mission on core activities such as emerging and infectious disease surveillance, outbreak investigations, and maintaining the Nation's public health infrastructure, while streamlining programs and eliminating waste. The Budget proposes merging multiple programs into one grant program that will address Sexually Transmitted Diseases, Viral Hepatitis, and Tuberculosis giving States more flexibility to address local needs.

Strengthening the Indian Health Service

Through the Indian Health Service (IHS), HHS is responsible for providing quality healthcare services to more than 2.2 million eligible American Indians and Alaska Natives.

HHS has a unique trust responsibility to provide healthcare for Tribes, including on remote reservations and other vulnerable communities in Indian Country. Without this support, many of these communities truly have no other options for care. The budget prioritizes and preserves funding for this agency.

Looking forward, and consistent with our statutory authorities, we recognize that our provision of quality healthcare in Indian Country and beyond must change to achieve and ensure the high quality of these services. As more Tribes have assumed the responsibilities of providing healthcare for their members with support from the IHS, investments in the budget reflect our support for the growth of Tribal self-governance in the provision of healthcare.

* * *

The President's 2026 budget for HHS recognizes the importance of focusing government spending on programs that work and reforming our Nation's healthcare programs for a fast-changing world. This Budget recognizes that securing America's future demands sound fiscal management and responsible decisions about our priorities. If we are serious about fulfilling HHS's mission of enhancing and protecting the well-being of all Americans, we must adopt the bold innovation and direction espoused by the President's Budget to Make America Healthy Again.

[SUMMARY STATEMENT OF SECRETARY KENNEDY]

Thank you, Mr. Chairman, Members of the Committee.

I'm honored to appear before you today to present the Department of Health and Human Services' Fiscal Year 2026 budget.

Debilitating disease, contaminated food, toxic environments, addiction, and mental illness affect families across every race, class, and political belief. When my team and I took the helm at HHS, we set out with clear goals. First, we aimed to make America healthy again, with a special focus on the chronic disease epidemic. Second, we committed to delivering more efficient, responsive, and effective service to the over 100 million Americans who rely on Medicare, Medicaid, and other programs. Third, we focused on achieving these goals while cutting costs for taxpayers. We intend to do more—a lot more—with less.

The budget I'm presenting today supports these goals and reflects two enduring American values: compassion and responsibility. I invite the Committee to unite around these ideals with me.

The United States remains the sickest developed nation, and we spend \$4.5 trillion annually on health care—two to three times more per capita than comparable nations. Clearly, something is structurally wrong with our approach.

Furthermore, health care costs are steadily increasing at a rate 2 percent greater than the economy. If we don't staunch this unsustainable hemorrhage, we will ransom our children to bankruptcy, servitude, and disastrous health consequences. Yes, an exploding debt is a social determinant of health.

We won't solve this problem by throwing more money at it. We must spend smarter. The 2026 budget cuts costs through restructuring—not by eliminating essential services. We will reduce 28 divisions to 15, eliminate redundant units, and centralize functions like HR, procurement, and policy. These changes will return us to pre-COVID-19 staffing levels and yield immediate savings of \$1.8 billion per year, with more savings ahead.

We will shift funding away from bureaucracy and toward direct impact.

Some things at HHS will not change. We will preserve legacy programs like Medicare, Medicaid, and Head Start as the foundation of the MAHA agenda. Vulnerable populations, seniors, and veterans deserve consistent access to care, and I will ensure they receive it. Today, 83 million Americans—urban and rural—lack adequate access to primary care physicians. We will prioritize these families, especially Native American and Alaskan communities. We will protect IHS funding, streamline its operations, and give tribes more autonomy in managing resources.

Let me be clear: We intend to make the Trump HHS not just the most effective, but also the most compassionate in U.S. history.

Our official budget statement outlines many priorities, but I want to highlight a few:

First, we will consolidate programs to better tackle mental health and addiction. These issues now rival chronic disease in their impact. HHS will aggressively combat the opioid crisis, especially the spread of synthetic drugs like fentanyl. We will empower state, local, and Tribal leaders to create real solutions.

Second, we will address nutrition, physical activity, and healthy lifestyles. The President's budget requests \$94 billion in discretionary funds to support these priorities, including the Administration for a Healthy America (AHA). We will emphasize healthy eating in Head Start and ensure the program continues to serve its 750,000 children and parents effectively.

Third, we will equip the FDA to expand its food safety efforts—through research, regulation, inspection, and education—to remove harmful chemicals from food and packaging.

Fourth, we will fund cutting-edge research at the NIH while cutting risky or non-essential studies. That includes ending gain-of-function experiments and research based on radical gender ideology. At the CDC, we will return to core missions: tracking diseases, investigating outbreaks, and sustaining public health infrastructure—while cutting waste.

Fifth, we will eliminate DEI funding and redirect resources toward real poverty reduction. We will move beyond lip service to communities of color and take meaningful action to meet their needs.

Sixth, we will strengthen cybersecurity and health IT. The AI revolution has arrived, and we must use new technology to manage health data more efficiently and securely.

Finally, we will rebuild public trust—trust that eroded through years of industry capture, waste, and misplaced priorities. We will launch a new era of transparency and public service, creating an honest, science-driven HHS that answers to the President, to Congress, and to the American people.

I look forward to working with Congress to pursue this mission together—as a bipartisan cause. Let’s work side by side to make America healthy again.

The CHAIRMAN. Thank you, Mr. Secretary. I will start with questions. Mr. Secretary, I appreciate that NIH wants to recalibrate its research portfolio to address conditions not previously attended to sufficiently, nutrition, conditions such as a rise after viral infection like myalgic encephalomyelitis or chronic fatigue syndrome.

But this is happening in tandem with reports that HHS is closing the office for long COVID research and practice. And I talk to people for whom long COVID is seriously impacting their life.

To what extent will HHS continue to support research, data collection, and other programs focused on understanding ongoing health impacts of long COVID?

Secretary KENNEDY. Senator, I am 100 percent committed to finding treatments for long COVID. I am deeply involved in that personally. I have a son who is really dramatically affected by long COVID.

I have many, many friends who are affected by that, and by Lyme disease, incidentally, which we also—is also a priority. The COVID office was cut by an Executive Order from the White House, but we have—everybody at NIH and at CDC is committed to these kind of studies. And I can tell you personally, I will make sure that they happen.

The CHAIRMAN. Thank you. The NIH is the largest public funder of biomedical research in the world, given us an edge over countries like China with whom we are obviously a geopolitical rival.

But it takes a long time to develop this. And the rising prevalence of neurodegenerative disease is one area in which we have an impending crisis if we don’t support the research and advanced cures. And my concern—and now I will speak as a guy from Louisiana. If NIH funding is substantially reduced, they have folks at my universities, at Tulane and LSU, who are doing work on these sorts of things.

Knowing that the NIH budget is getting squeezed, and the indirect cost likewise, how will the NIH successfully do more with less? How will we build those new scientists to find these cures and to compete with geopolitical rivals?

Secretary KENNEDY. Well, for one thing, Senator Cassidy, you are talking about neurodegenerative disease. Now—

The CHAIRMAN. For example, ALS or Alzheimer’s.

Secretary KENNEDY. ALS, right. The Chinese are not spending a lot of money on DEI. And there are—and we are cutting those studies.

We are cutting studies on gain-of-function studies, and we are cutting grants to foreign scientists from adversarial countries, and particularly the Chinese, which have the Thousand Talents Pro-

gram, which is openly trying to exploit U.S. research and take our IP.

We spend more than any country in the world on biomedical research. We spend—NIH controls about 70 percent of the global funding for biomedical research. The cuts we have made today are cuts—are administrative cuts.

As far as I know, we have not fired any working scientist. Of the working scientists, the people who are actually doing science, there are some people who were—scientists that were doing IT or administration. But in terms of—who did lose their jobs. But in terms of working scientists, our policy was to make sure none of them were lost and that research continues.

The CHAIRMAN. Let me—thank you. Let me ask you, the budget proposes to eliminate several large block grants for hospital and health Department emergency preparedness, and other core public health capabilities, explaining states are better equipped. To fund these activities.

Now, I agree that frontline public health happens at the local level, but what works well in say Louisiana may not work well in a State like New York. But rural under-resourced states especially rely upon Federal funding to support public health.

How do you propose we balance competing interests, returning power to states because there is a difference in how different states do it, but replace the funding necessary to combat these public health problems?

Secretary KENNEDY. Well, I think it is a balance, Mr. Chairman. And we have a legal obligation, CDC has a legal obligation, to do national pandemic response, and we will meet that obligation.

In fact, we are going to improve it, and particularly if we can get support from this body, to refund, reappropriate the PAHPA, which is critical for a pandemic response. But there are some functions that are local in nature. And in those cases, we will be supporting local infrastructure to respond.

They know better than we know, and we saw this during some of the hurricane response with Governor DeSantis's response, which was really Florida localized. There was no deaths and very little destruction to a hurricane that was as bad as the one that followed that relied on Federal response and was really a catastrophe for the state.

I think experience shows that the locality is going to often do better with some functions, particularly with the hospitals and infrastructure. But we are not relinquishing our responsibility at CDC to manage national emergencies.

The CHAIRMAN. Thank you.

Senator Sanders.

Senator SANDERS. Thank you, Mr. Chairman. Let me start going back to prescription drugs. Mr. Secretary, did I hear you correctly to state that your goal is to have Americans pay the lowest prices in the world or equivalent to what is paid in other major countries? That is my goal. That you are prepared to work with us on legislation to achieve that goal?

Secretary KENNEDY. Absolutely.

Senator SANDERS. All right. And I believe there's bipartisan support for it. I believe that if the leadership here prioritizes that, we can do that in a very short period of time. Look forward to that. Let me ask you this, as Secretary of HHS. We have in America today some 85 million Americans who are uninsured or underinsured.

We spend more per capita as you have indicated than any other country. Is healthcare a human right? Are we making America healthy when so many people cannot afford to go to a doctor, when 68,000 people a year die because they don't get to a doctor when they should? Is healthcare a human right? Will you work with us to guarantee health care to every man, woman, and child in America?

Secretary KENNEDY. Well, I think you are asking two different questions. You are asking a philosophical question about whether it is a human right, like a Constitutional right.

As an attorney, I would say that it is not a right of a kind that we otherwise enshrined in the Constitution, because healthcare costs your neighbor money. If I smoke cigarettes for 20 years, I make that choice, which is my choice—

Senator SANDERS. I don't have a lot of time, so I just—what I am get—

Secretary KENNEDY. If you ask a question—if you are asking me a philosophical question, I got to give you a thoughtful answer.

Senator SANDERS. Within 30 seconds.

[Laughter.]

Secretary KENNEDY. It is not like freedom of speech, which costs everybody—

Senator SANDERS. But every other country, Mr. Secretary, every other country guarantees health care to all people as a right. Should we as Americans?

Secretary KENNEDY. The objective is to get Americans the level of the health care that they want, the choice, which Americans want.

Senator SANDERS. They don't want the choice to be uninsured. They don't want the choice to die because they don't get to a doctor on time.

Secretary KENNEDY. Americans prefer private insurance to other insurance sources.

Senator SANDERS. Do you believe—Okay.

Secretary KENNEDY. What I would say is I want to find a solution to this. I want every American to have insurance. President Trump wants every American to be insured and have access to health care. The question is, how do we get there? Obamacare is not working. It is not working. And this is the—

Senator SANDERS. We can—sorry to interrupt you. All right, the reconciliation—

Secretary KENNEDY. My job is to try to make it work.

Senator SANDERS. All right. I have limited time. The piece—the reconciliation bill that is now being worked on in the House will come to the Senate. As it stands right now, cuts Medicaid in the *Affordable Care Act* by more than \$715 billion, which the CBO has estimated would eliminate health insurance for 13.7 million Americans.

Also raise those payments for millions of others. Is throwing 13 million Americans off of the health care they have, poor and working class people, keeping America healthy?

Secretary KENNEDY. I haven't seen that number. I have seen the number 8 million. And you are the people—the cuts are not true cuts. The cuts are eliminations of waste, abuse, and fraud. And I can go through—I can go through with the people who will lose it. A million people—there are million people—

Senator SANDERS. Mr. Secretary, I really don't mean to be rude, but as you know, I have a very limited amount of time.

Secretary KENNEDY. You asked the question. I am going to answer it.

Senator SANDERS. Well—yes, I have got a bunch of questions that I would like you to answer as well. All right. We talk about austerity, doing more with less, but in that very same bill that is being worked on in the House right now, there are \$235 billion in tax breaks for the top two-tenth of 1 percent. Do you think that makes sense, when that same bill would throw 13 million people off of Medicaid? Should we give tax breaks to billionaires and throw kids and others off of Medicaid?

Secretary KENNEDY. You are conflating the Congressional bills with proposals from the President. The President—

Senator SANDERS. No, I am talking about the Congressional bill. I am talking about the bill, the reconciliation bill.

Secretary KENNEDY. I mean the President is not trying to do tax cuts for billionaires. He is trying to have no tax on tips and no tax for overtime.

Senator SANDERS. \$235 billion by—through the estate tax.

Secretary KENNEDY. How many people—how many billionaires do you know that are making overtime or making any—tips—

Senator SANDERS. \$235 billion—look, it is a big bill. There are a lot of provisions in it. But you cannot deny, the top two-tenths of 1 percent will get \$235 billion in tax rates while we cut Medicaid.

The CHAIRMAN. Okay.

Senator Paul.

Senator PAUL. Thank you. I want to commend Secretary Kennedy and the Administration for putting forward less spending. And one of the reasons I think we need to look at NIH and other grant-making organizations is, if you keep giving them the same amount, you will keep getting the same frivolous grants.

I will recite a couple of them so people can remember. 660,000 was given to study the impact of microaggressions on obesity-related eating in Latino Americans. Really maybe heart disease, diabetes, obesity, but eating disorders in Latino Americans. Here is another one.

\$419,000 to study if lonely rats seek cocaine more than happy rats. Maybe we could eliminate that and that could go to a real disease. Most recently, NIH recorded a \$620,000 grant for LGBTQ+ inclusive teen pregnancy prevention program for transgender boys. And what they discovered was that girls who think they are boys are at least as likely to get pregnant as girls who thinks they are girls.

Amazing, the science. But we should all agree that is just left-wing ideology. That is not science. We should study obesity, and cancer, and diabetes. I commend you for shifting the balance. I have a specific question about closing down Fort Detrick recently. My understanding is that a contractor intentionally slashed the hazmat suit or the biosafety suit of someone who was handling Ebola.

You were immediately attacked in the press by saying it was just anti-science. Once again shutting down science. Was this a serious breach, and is it being investigated?

Secretary KENNEDY. We brought in the FBI to investigate it. And as you say, it appears like it was a deliberate criminal act to try to—that was a kind of—that is equivalent to attempted murder because the kind of microbe, the pathogens that they were handling have a very, very high case fatality rate—up to 50 percent.

The disturbing thing about it is that there are three leaks a week globally from BSL4 labs, and any of those could be cataclysmic for humanity. And as a result, we not only closed Fort Detrick, and we brought the FEI in to investigate that. We also declared the end of gain of function studies, again, that will allow those kind of leaks to continue.

Senator PAUL. I commend you for that. I think ultimately legislation will be needed because the next Administration could reverse it. I think there is bipartisan support for some controls on gain of function. As you shut down gain of function though, you have to decide what it is, and then you have to look for it.

I would suggest that at both Fort Detrick and at the NBAC lab that is nearby run by the DHS, that we look at experiments involving Ebola, avian flu, Marburg virus, to determine one, whether they are gain a function, but also just determine whether the experiments are wise. I am told in public records that they are doing experiments or have done experience to aerosolize Ebola at the NBAC lab. That is the DHS lab nearby to Fort Detrick.

My hope is that when you investigate whether to do gain of function or what is gain of function, what is being done, that you will compile that and at least give us a report in Congress, and we are going to ask for it. But so there can be public scrutiny of these things. You will help scrutinize it, but the whole public needs to know how dangerous some of these things are and whether we should be doing them.

The idea of aerosolizing Ebola, I think, is a—and, or training Ebola to be aerosolized is incredibly dangerous, probably goes against the biological weapons convention, and I would like to hear a little bit about whether or not as you investigate this, you plan on bringing information back to Congress or to the public.

Secretary KENNEDY. Yes, we are going to be absolutely transparent. I am—I have a trip planned to Fort Detrick with Kristi Noem, the Director of DHS, and with Jay Bhattacharya and other people in my agency, or experts on bioweapons, or experts on gain-of-function research and we are going to be absolutely transparent.

We have also proposed a methodology for regulating and for determining which—what is dangerous gain of function and what is legitimate scientific investigation, and how to bring the public into that debate, which I think as you point out is absolutely critical.

That is where we messed up last time, and as you know, we have some of the Democrats here who are talking about the great science from NIH, but now we have a major agency, intelligence agency, the CIA, the FBI, the DOE, and the State Department have all agreed that NIH research almost certainly led to the pandemic, the COVID pandemic.

That is not the kind of the result that we should be allowing or enabling, and we are going to end that now.

Senator PAUL. If possible—the trip to Fort Detrick and to NBAC, we would like to be included or invited on that trip, if possible.

Secretary KENNEDY. Absolutely.

The CHAIRMAN. Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman. Mr. Secretary, one of my constituents, her name is Natalie Phelps. She is a mom of two from Bainbridge Island in Washington State. She has been fighting aggressive stage four colorectal cancer for nearly 5 years now. Her best hope now is a clinical trial she is participating in at the NIH Clinical Center. She flew out to NIH a few weeks ago for her first appointment, and her care team there wanted her to come back in 4 weeks to start treatment.

But because of the thoughtless mass firing of thousands of critical employees across NIH and HHS that you have carried out, Natalie's doctors at that clinical center have told her they have no choice but to delay her treatment by an additional 4 weeks.

Now, an extra 4 weeks may not sound like a long time, but I will tell you, for stage four cancer patients like Natalie, this could mean the difference between life and death. Secretary Kennedy, how many staff have been cut from the NIH's Clinical Center? I want a specific number.

Secretary KENNEDY. I can't tell you that now, Senator Murray. But what I can tell you is that if you contact my office tomorrow, I will look specifically into that.

Senator MURRAY. Well, that is not acceptable. I want an answer back on that. She deserves it. I do—she doesn't have much time. She deserves an answer back.

Secretary KENNEDY. Wouldn't you rather get her into that clinical trial as fast as you can?

Senator MURRAY. Absolutely. I wanted—

Secretary KENNEDY. If you contact my office tomorrow, this is a—if that happened—

Senator MURRAY. You are here to defend your budget. I am here to ask you questions about the impact of that.

Secretary KENNEDY. You asked me—you asked me about a specific case that I want to help with. I don't think anybody—I don't think that should happen to anybody.

Senator MURRAY. Okay. Well, what have you, and I mean you personally, done to assess how those staff cuts are impacting patient care? She is one of many. What have you done to assess that?

Secretary KENNEDY. I provided the guidelines that said we shouldn't—no clinical trials should be affected by the cuts. I have—Matt—

Senator MURRAY. Mr. Secretary, I just have a short amount of time. They are impacting clinical trials.

Secretary KENNEDY. You asked me a question. Do you want me to answer it?

Senator MURRAY. I want to tell you. You need to know this. You are here to defend the NIH budget which you are—

Secretary KENNEDY. Senator, do you want me to answer your question? Do you want me to answer your question, Senator?

Senator MURRAY. I want to tell you that Natalie is sitting there waiting for treatment and you are here to—

Secretary KENNEDY. I am offering to help her, but you don't care. You don't care about Natalie. I've offered to help Natalie.

Senator MURRAY. I am asking you a question and it is critical. You are here to defend cutting NIH by half. Do you genuinely believe that won't result in more stories like Natalie's?

Secretary KENNEDY. I think the cuts that we are—that are now proposed by the NIH are going to hurt. I think that President Trump, listen, there is no agency head in the Government, like myself, that wants to see their budget cut. And—

Senator MURRAY. Well, and I asked you, have you personally assessed what this is doing to patients? And I am telling you one story of one person. It is an impacting life or death situation. I think it is pretty—

Secretary KENNEDY. You want me to answer your question, Senator?

Senator MURRAY. Well, you did.

Secretary KENNEDY. Okay. I have not. You have not allowed me to answer it.

Senator MURRAY. Well, I will just say that it is my job to be a voice for people like Natalie and countless other patients who are like her. So, you have got to fix this. I want to know, and I want a personal update on Natalie's case. And you have offered that. Please give that to me in the next 24 hours. And I expect details and transparency about the state of NIH clinical care.

Secretary KENNEDY. You contact my office, Senator, and I will do everything in my power to try to get Natalie into that—

Senator MURRAY. Let me—I have got 1 minute left, and I want to ask you about the NIOSH cuts. I am really alarmed by your decision to essentially eliminate the National Institutes for Occupational Safety and Health. You have already fired nearly 90 percent of the staff.

That includes the staff in my state at the Spokane Research Lab. Those are experts. They do essential work to protect miners, and firefighters, and farm workers. People who work in dangerous conditions. I am told that after backlash you are reinstating some of those, mainly in the West Virginia office.

But there doesn't—nobody in the Western United States. And there doesn't seem to be any rhyme or reason to how you have made these decisions. And how do you explain this to my constituents in Spokane who are out of a job, and the workers that are being impacted by that?

Secretary KENNEDY. The work in NIOSH will not be interrupted. We are going—I have brought back 328 workers, mainly in the Cleveland office, and the Morgantown office, and for the World Trade Center site.

That work will continue. The work on mine safety will continue. The epicenter of that work has been Cleveland, and it has been Morgantown. We understand it is a critically important function, and I did not want to see it end.

Senator MURRAY. Mr. Chairman, I would just say you can't fire 90 percent of the people and assume the work gets done.

The CHAIRMAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. Mr. Secretary, nearly seven million Americans are living with Alzheimer's disease. And caring for people with this devastating chronic disease costs us some \$360 billion a year. I am the author of the law that is known as the *BOLD Act*.

It takes a public health approach to Alzheimer's. It educates providers, promotes earlier diagnosis. It helps caregivers, and it also promotes lifestyle changes. I have worked very hard to make sure that HHS has the resources to carry out this law, which was just recently extended. I am concerned that the reductions in force of approximately 10,000 staff across HHS will completely undermine this Act.

This Act in many ways is very consistent with your approach of looking at public health issues for chronic diseases. For example, the Healthy Aging branch administers the *BOLD Act* for Alzheimer's. It has lost all of its staff.

How can you ensure that the CDC continues to implement the *BOLD Act* and the Alzheimer's programs under it when all of the staff responsible for that administration have either been placed on administrative leave or let go?

Secretary KENNEDY. I Don't know enough about that program. I know that under the—that division has been folded into the America—the Agency for Healthy America. And a lot of the reports that whole divisions have been liquidated were just wrong. They were divisions that were being reassigned under the reorg.

Now, I am under a constrain here because at 4 o'clock yesterday afternoon we were told that there was—that a Federal judge granted a TRO in our case on the reorg. And my attorneys have asked me not to talk about any details of the reorg today. So I—but on that budget line, I will work with you. I am committed, Alzheimer's has run in my family.

As you know my cousin Maria Shriver who is deeply involved in it. The NIH had a very, very checkered history on studying Alzheimer's because of the amyloid plaque scandal. And we have an opportunity now to do really good science and find a cure very quickly.

Also find out equally, importantly, why so many people are getting Alzheimer's in this generation. I want to make that happen. I want to work with you, Senator, to make sure that happens and that those programs continue.

Senator COLLINS. Thank you. I chaired recently the first Appropriations Committee hearing of the year, and we have focused on biomedical research and how important it is that America not lose its global edge in innovation that is producing life-saving and life-enhancing discoveries.

Among the many issues that we covered, as you might expect, the hearing explored the 15 percent arbitrary, one size fits all percent cap that NIH has imposed on indirect, but still research-related costs for its grants. What we heard is that this cap will mean less basic research, fewer clinical trials, and that it will also cause our scientists and researchers to leave the United States and go to other countries.

I believe strongly that this proposed cap is poorly thought out, that it is harmful, and I know that it violates current law because since 2018, we have included in the Appropriations bill specific language that prevents NIH from imposing such a cap.

I know the system needs to be looked at, but are you reviewing how NIH's approach of this one size fits all 15 percent on indirect costs would affect laboratories, whether they are private, nonprofit labs, or whether they are in universities, as far as doing crucial biomedical research?

Secretary KENNEDY. Senator, we are. And you and I have talked about this issue. And I think that the impetus for the cap was that there were a lot of private universities with giant endowments like Stanford and Harvard that were getting indirect payments of 78—70, 78 percent.

What that means if you get a million dollar grant, NIH then has to pay you an extra \$780,000, or administrative costs. And a lot of those costs weren't even going to anything to do with science. They were going to the university budget. And in order to curb that abuse, we adopted a 15 percent which is the industry standard. That is what the Gates Foundation or any other foundation would pay.

But I understand the University of Maine, University of Alabama, many other universities, state universities were not abusing it. We lost about \$9 billion a year in those kind of costs. And so, we have a plan for how to address.

Issues like what is happening at the University of Maine. I am being gaveled out, so I will talk to you privately about that.

Senator COLLINS. Thank you.

The CHAIRMAN. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. Secretary Kennedy, you run a Department that touches the lives of almost every

American. Yet for this budget hearing, these are the six pages that we have gotten in terms of your budget request.

We are also seven and a half months into this fiscal year, and yet you are not telling the American public anything about how you are spending the billions in taxpayer dollars right now. You had to submit an operating plan to the Congress, and this is just a sample page. But 530 programs simply have asterisks. Secretary Kennedy, this isn't about your hiding information from me.

This is about your hiding information from the American public. And if you are going to cut cancer research or gut mental health support at least stand by your work and explain it to the American people.

Now, Secretary Kennedy, I want to start with what I hope is an easy question for you. Do you think lead poisoning in children is a significant concern?

Secretary KENNEDY. Is lead poisoning—?

Senator BALDWIN. In children a significant concern.

Secretary KENNEDY. Is an extremely significant concern.

Senator BALDWIN. Thank you. Then I would like to know why your Department has effectively shut down the very program to address lead poisoning in children. The city of Milwaukee requested assistance from the CDC to help the city respond to lead poisoning cases tied to public schools.

Six schools have been closed, displacing more than 1,800 school children. The request for Federal assistance was denied because of lack of staff. The entire childhood lead poisoning branch has been fired. In the words of a Milwaukee mom, it really sends a message of, you don't matter.

I don't know what you would say to parents who must now test their children for lead and deal with school closures. But do you intend to eliminate this branch at CDC, yes or no?

Secretary KENNEDY. No, we do not.

Senator BALDWIN. Okay. Because you cannot tell us that you want to make America healthy again when you are willfully destroying programs that keep children safe and healthy from lead poisoning. Congress dedicated \$51 million in funding for this particular program.

But when a community asks for help to prevent lifelong complications for children, and there was no one there to pick up the phone—and it is not because this program is ineffective. It is because you fired the entire team whose job it is to support communities like Milwaukee.

Secretary KENNEDY. If that money has been appropriated, we will spend that money. If it has been appropriated to Milwaukee, we will spend it in Milwaukee. I have spent a lot of time in Milwaukee working on that—

Senator BALDWIN. It is to provide expert—the entire staff has been fired. Secretary Kennedy, I did note in your opening testimony, although we wouldn't know it from the skinny budget that we have, that you plan on funding the Head Start program.

But I want to tell you about the ramifications of what has happened to date with regard to Head Start. I have heard from families across the state. People who are terrified about these uncertainty and instability surrounding Head Start. Just 1 week into President Trump's administration, Head Start programs in Wisconsin suddenly couldn't access their grant funding.

It forced one Head Start in Waukesha, Wisconsin to temporarily close, leaving 250 families without care. Over the last 4 months, HHS has provided roughly \$1 billion less to Head Start programs across the country than during the same period last year. The delays in funding have exacerbated uncertainty for programs needing to make payroll. And in some instances, like the one I cited in Waukesha, programs have had to shut their doors until the payments came through.

Now, I don't know what you would say to a parent who is unable to drop their child off at preschool because you failed to get already appropriated money out the door. Or maybe I should ask you, what would you say to a parent who shows up for childcare or for Head Start and the doors are closed?

Secretary KENNEDY. I would be very sad if somebody showed up—I fought very, very hard to make sure that there would be no cuts.

Senator BALDWIN. What is causing the delays in Head Start funding? That is my question.

Secretary KENNEDY. I fought very hard to make sure that Head Start gets all of its funding next year.

Senator BALDWIN. Well, we need it this year. And why are there delays now?

Secretary KENNEDY. I don't know that there are, Senator, and I will look into it. But I don't know—there should not be any delays. The funding is there. We are spending it. It is allocated. I don't know why there would be those kind of problems.

There were—I can tell you that within the agency, there were, there were people who wanted to make the Trump administration look bad and that there were checks held up that shouldn't have been. I will have to look into that, Senator.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. Mr. Secretary, welcome. Good to see you. I want to talk a little bit about the HHS reorganization on some of the programs that impact Alaska's most vulnerable populations. I sent you a note letting you know that just after this hearing, I am going to be chairing a Senate Committee on Indian Affairs, specifically examining HHS tribal programs that are outside of IHS.

I really thank you for your early efforts to exempt IHS health care providers from the RIFs. That was very important. But I have also heard concerns from tribal leaders on the impacts of RIFs to key HHS programs serving their communities.

I know you are going to have some of your folks tuning in on that, and I really appreciate that. But some of the other reductions that we are looking at within your budget do have significant consequences to a state like mine.

One is the LIHEAP program, the Low Income Energy Assistance. For us, it is not a budget line item. You have been to Alaska. You know that the temperatures there can get really, really tough. Keeps people from freezing to death in their homes. Another program is NIOSH.

I know that HHS had rescinded a number of those employees. That was great news. But the employees that received RIF notices for the program were not rescinded in the NIOSH Center for Marine Safety and Health Studies. So this is—this is a big deal for our commercial fishing safety.

It could effectively leave our fishing fleet out of compliance with Coast Guard safety regs, so we are watching that very, very carefully. And then, again, shared focus here on making sure that our children are as healthy as they possibly can be.

I want to look to ways that we can strengthen and not eliminate the Head Start program. But I wanted to ask you—

Secretary KENNEDY. You are talking about the NIOSH program.

Senator MURKOWSKI. NIOSH, yes.

Secretary KENNEDY. You should talk to me about that. And as you know, that is something that I am deeply concerned with the commercial fishery. So, we should talk about it and let's, and let's work for a solution.

Senator MURKOWSKI. Got it. I am with you right there. Let me ask about domestic violence and sexual assault funding. Right now I am talking—I am receiving a lot of incoming from our community based domestic and sexual violence program operators.

They are really concerned about the delayed release of Fiscal Year 2025 funding, the absence of notices of funding opportunities, as well as proposed cuts or consolidations that might threaten the Office of Family Violence Prevention and CDC's Division of Violence Prevention.

You have got some programs there that are really foundational to domestic and sexual violence. They have been reauthorized with bipartisan support, so. I am going to enter into the record a letter from the National Task Force. And it basically—was sent to you, I guess, yesterday. Just urging the communication of concrete plans for releasing some of these funds.

[The following information can be found on page 55 in Additional Material:]

You are—I am going to raise that to your level. But I want to make sure that we are sending the right signal to so many who are just really on the edge with, again, these community based services that are helping the most vulnerable of the most vulnerable. So we have got the funding that is out there. It is just delayed. We need help releasing that.

Secretary KENNEDY. My understanding is that the domestic violence funding was not cut, so I don't know. I mean, I have to go back and check, but I specifically asked about that program last night and was told that there was no cuts. That President Trump is committed to it. And so, I don't know why people would be experiencing even delays.

Senator MURKOWSKI. It may be that it is—with the RIFs, you don't have people that are processing these things. So again, I want this to be at the top of your screen.

Secretary KENNEDY. That could be.

Senator MURKOWSKI. Last question for you. I mentioned LIHEAP. The budget proposal, the skinny budget proposes to eliminate LIHEAP. And the proposal says that it is unnecessary because states have policies preventing utility disconnection for low-income households, effectively making LIHEAP a pass-through benefiting utilities in the Northeast.

Further, LIHEAP rewards States like New York and California, two of the top recipients for LIHEAP funding, which have implemented anti-consumer policies. I am just telling you, we are not in the Northeast. We are not in that bucket. We are cold. There are other places that are hot. LIHEAP is a lifesaver.

I did see your statement from yesterday saying that OMB was thinking that President Trump's energy policy is going to reduce costs dramatically. It may. It may be a while. Right now folks in Alaska still need those ugly diesel generators to keep warm, so I would ask—

Secretary KENNEDY. I know. I was on a Navajo—first of all, I have heard that my whole life because my family was involved in providing low-cost energy to the poor in New England. And there are people in New England who suffer from—if energy prices are high and you have a cold winter.

I was on the Navajo Reservation a couple of weeks ago and the Navajo President, Buu Nygren, said to me, if we cut LIHEAP, people will die on this reservation. I know the same is true in Alaska.

The presumption behind the budget cuts were that the energy prices were going to drop dramatically in which case these payments would just become a subsidy to the oil industry. If that doesn't happen, I would expect Congress would then still appropriate the money and I will spend it.

I have already spent \$400 million between January and now on this program, and we have made to get it out—made sure to get it out to all the families that needed it, so—

Senator MURKOWSKI. I think you are going to find a lot of support on this Committee for that.

Senator Murphy.

Senator MURPHY. Thank you very much, Madam Chair. Secretary Kennedy, I want to talk to you about your relationship with this Committee and this Congress. I want to talk to you about the statements that you made to the Chairman of this Committee and to Members of this Committee during your confirmation hearing about vaccines.

You didn't tell the truth. I find that to be really dangerous for our relationship. If I were the Chairman, who believes in vaccines and voted for you because he believed what you said about supporting vaccines, my head would be exploding.

In the hearing, you told us, "I will not work to impound, divert, or otherwise reduce any funding appropriated by Congress for the

purpose of vaccination programs.” That is not the truth. You have done exactly—

Secretary KENNEDY. I have—

Senator MURPHY. Let me finish my question.

Secretary KENNEDY. I didn’t hear what you said. I am just asking you to repeat it so I can understand your question.

Senator MURPHY. During the hearing—during the hearing—I will repeat it. During the hearing, you said to this Committee and to the Finance Committee, “I will not work to impound, divert, or otherwise reduce funding appropriated by Congress for the purpose of vaccination programs.”

That is not what happened. You have done the opposite. You canceled \$12 billion in grants to the states, including my state, that are used to administer and track vaccines. You promised Chairman Cassidy—

Secretary KENNEDY. When did I do that?

Senator MURPHY. Madam Chair, would you allow me to finish my question?

Secretary KENNEDY. When did I do that?

Senator MURPHY. Let me—let me finish my question—

Secretary KENNEDY. You are making accusations. Just tell me when I did it so I can understand what the question is.

Senator MURPHY. You have canceled \$12 billion in public health grants to states. Whether you know this or not, that funding is used by the states in part to be able to administer and dispense information about vaccines. Let me give you—

Secretary KENNEDY. Which programs?

Senator MURPHY. Mr. Secretary, let me give you the full panoply of the things you have said before this Committee that didn’t turn out to be true. You also promised Chairman Cassidy that the FDA would not change vaccine standards from “historical norms.” But what happened as soon as you were sworn in?

You announced new standards for vaccine approvals that you proudly referred to in your own press release as a radical departure from current practice. And experts say that departure will delay approvals. You also said specific to the measles vaccine that you support the measles vaccine, but you have consistently been undermining the measles vaccine.

You told the public that the vaccine wanes very quickly. You went on the Dr. Phil Show and said that the measles vaccine was never fully tested for safety. You said there is fetal debris in the measles vaccine.

Secretary KENNEDY. All true.

Senator MURPHY. This morning—

Secretary KENNEDY. All true. All true.

Senator MURPHY. This morning in front of—

Secretary KENNEDY. Do you want me to lie to the public?

Senator MURPHY. That is not—none of that is true.

Secretary KENNEDY. Of course it is true. Of course it is true, Senator. Senator, begging your pardon, you do not know what you are talking about.

Senator MURPHY. I will submit for the record——

Senator MURKOWSKI. Let's have a little bit of order so that you can get your question, and he can get his statement.

Senator MURPHY. Madam Chair, I didn't ask for a response yet.

Senator MURKOWSKI. I understand.

Senator MURPHY. I would like to lay out the predicate of my question before I am interrupted by the witness. He should have some respect for this Committee.

Senator MURKOWSKI. Go ahead. Go ahead.

Senator MURPHY. Just this morning in front of the House of Representatives, you also said that you, in fact, would not recommend that kids get vaccinated for measles. You said you would just lay out the pros and cons.

Okay, so this is the summation of everything that you have said to compromise people's faith in the measles vaccine in particular. It is contrary to what you said before this Committee. You said you support the measles vaccine, but then you have laid out a set of facts that are contested.

I will submit information for the record from experts who can contest what you have said about the vaccine. And the result is to undermine faith in the vaccines. Kind of like saying, listen, I think you should swim in that lake, but the lake is probably toxic, and there is probably a ton of snakes and alligators in that lake, but I think you should swim in it. Nobody is going to swim in that lake if that is what you say.

I want you to acknowledge that when you say you support the measles vaccine, and then go out and repeatedly undermine the vaccine with information that is contested by public health experts, that is not supporting the vaccine. And so, I guess I have two simple questions for you.

One is, can you clarify what you said in the House this morning? Are you or are you not recommending that families get their children vaccinated, or are you just giving people the pros and cons? And do you understand that when you say these things about the measles vaccine, what ends up happening is less people get the vaccine. That may be what you want.

But do you understand that the result of constantly questioning the efficacy or safety of the vaccine results in less people getting the vaccine. So, I don't necessarily want to spend the remaining 20 seconds in an argument over the science, but you at least understand that is the consequence of what you are saying? And are you actually still recommending people get the vaccine or are you not?

Secretary KENNEDY. If I advise you to swim in a lake that I knew there to be alligators in, wouldn't you want me to tell you there were alligators in it?

Senator MURPHY. Are you recommending the measles vaccine or not?

Secretary KENNEDY. What I have said, and what I said in the——

Senator MURPHY. It doesn't sound like you are if that is——

Secretary KENNEDY. Are you going to let me answer? Are you going to keep——

Senator MURPHY. Are you or are you not?

Secretary KENNEDY. Are you going to let me answer? What I pledged before this Committee during my confirmation is that I would tell the truth—that I will have radical transparency. I am going to tell the truth about everything we know, and we don't know about vaccines.

Senator MURPHY. Are you recommending the measles vaccine or not?

Secretary KENNEDY. I am not going to just tell people that everything is safe and effective if I know that there is issues. I need to respect people's intelligence.

Senator MURPHY. I think you are answering the question. I think you are answering the question. That is really dangerous for the American public and for families in this country.

Senator MURKOWSKI. We are going to—we are going to move to Senator Marshall.

Secretary KENNEDY. The reason they have lost faith in this program is because they have been lied to by public officials for year, after year, after year.

Senator MURPHY. The Secretary of Health and Human Services is no longer recommending the measles vaccine——

Senator MURKOWSKI. Senator Marshall.

Secretary KENNEDY. By the way, I said at the hearing this morning that I was recommending the measles vaccine. You can go look at the transcript.

Senator MURKOWSKI. Senator Marshall.

Senator MARSHALL. Madam Chairman. Thank you so much for being here, Mr. Secretary. We are glad you are here. Let's stay on the measles vaccine just for a second. Let me catch my breath after that—all that. I am an obstetrician. If a 25-year-old pregnant woman asked me if she should take the measles vaccine, the MMR, I would have—give her the answer, no you shouldn't.

But if she was 25 and trying to get pregnant, I would give her different advice. I have always valued the sanctity of the physician-patient relationship. I went to medical school for 4 years. I did 4 years of residency. I delivered thousands of babies.

It is my job to give that recommendation. What is the role of the Secretary of HHS as far as recommendations of vaccine, and just discuss it a little bit further.

Secretary KENNEDY. Well, the vaccine recommendations, Senator, are normally made through ACIP, the Advisory Committee of Immunization Practices, which is an outside consulting committee at the CDC.

There is another committee called FERPAC which is within FDA that actually recommends whether the vaccines get licensed or not. And so, that is where the recommendations come from.

Traditionally, they have not done evidence-based medicine. They only adopted evidence-based medicine about 12 years ago. And what we have said during our Administration is we want to have safety studies prior to the licensure and recommendation of vaccines.

Vaccines are the only medical product that is exempt from pre-licensing safety testing. So the only vaccine that has been tested in a full-blown placebo trial against an inert placebo was the COVID vaccine.

The other 76 shots that children in this country receive between birth and 18 years old, none of them have been safety tested in pre-licensing studies against the placebo, which means we don't understand the risk profile for those products. And that is something that I intend to remedy.

Senator MARSHALL. Okay. You said earlier you couldn't talk about the reorganization, and maybe you cannot answer this question, but I—maybe you can at least confirm these facts for me or not.

Isn't it true that under Joe Biden's White House, they added 20,000 employees to HHS? When you were nominated, there was 28 divisions with HHS. 100 communication offices, 40 IT Departments, 9 H.R. units as well. Is that—can you answer that question?

Secretary KENNEDY. Yes, that is right there. There are dozens of IT Departments. There are eight senior finance officials.

There are nine separate offices on women's health. Eight separate offices for minority health. Twenty-seven separate offices for HIV. Fifty-nine behavioral health programs. Forty opioid programs.

What we are trying to do is consolidate, streamline, eliminate the redundancies, eliminate all those administrative costs for each one of those little Departments, consolidate them, and make them make sense and make them accountable to the American people.

Senator MARSHALL. I don't—or I suppose all those IT systems communicate with each other? You all are on one IT system?

Secretary KENNEDY. There is 40—as you pointed out, there is 40 procurement Departments with four separate computer systems that don't talk to each other. So and as you pointed out, this—my Department grew by 38 percent over the last 4 years. I would say that is great if Americans got healthier, but they didn't. It got worse.

What we are trying to do is go back to the pre-COVID levels, and to start making the Department function as it would if you, in a rational universe. And to bring in modern AI and telemedicine and all the opportunities we have now. These new efficiencies, and for medical delivery to the American people and for patient care.

We are not able to take advantage of any of them because there is so much chaos and disorganization in this Department and everybody who has gone up against it in the past has thrown their hands up and given up. What we are saying is let's organize in a way that it can quickly adopt and deploy all these opportunities.

We have to really deliver high-quality health care to the American people.

Senator MARSHALL. If I could—this was going to be a question. I am just going to make a statement. All the research that we do on MAHA, on soil health, on nutrition, in my heart, that is research on cancer. It is research of Alzheimer's.

At the end of the day as well, we should be spending as much money at the front side of this as we are trying to cure the end of it. We are seeing epidemics of colorectal cancer. Young age Alzheimer's. All these things, and I think the research at the front end is every bit as important at the hind end.

Secretary KENNEDY. Senator Murphy made a good point. We have—the NIH has made all these extraordinary breakthroughs, and particularly in treating cancer reducing mortalities for colorectal cancer, but my question is, wouldn't it be—isn't it as important to find out why kids are getting colorectal cancer.

When you and I were a kid, there were zero kids with colorectal cancer. It is epidemic now. So it is not really a badge for us when we say, oh, we can make it less lethal. Why don't we go figure out what is causing it and eliminate that exposure?

With all of these, with Alzheimer's, with heart disease. Something is making Americans very, very sick. And our response should not be just, Okay, we will develop a pharmaceutical fix for it, or a medical fix. Let's figure out what it is and get rid of it so we can have healthy kids again.

Senator MURKOWSKI. Thank you.

Senator Kaine.

Senator Kaine. Thank you. Mr. Kennedy, I want to ask you some questions about staff reduction and kind of the timing of it. You were confirmed by the Senate on February 13, so I am sort of assuming that things happened before you were confirmed where other people's work.

On January 28th, the fork in the road letter came out to people across the Federal employment space. Widely attributed to OPM and Elon Musk and DOGE. But that was before you were confirmed, so you had nothing to do with the fork in the road letter, correct?

Secretary KENNEDY. Correct.

Senator Kaine. Okay. You were confirmed on February 13. On February 14, 1 day later, HHS announced that 3,500 probationary employees were going to be laid off. I know you are a hard worker, but am I right to assume that in the 1-day between your confirmation and the next day, you weren't the primary decision maker about laying off probationary employees at HHS?

Secretary KENNEDY. I was aware of it, and I could have blocked it.

Senator Kaine. Yes. You were aware of it. So, you weren't the primary decision maker. Was that a decision that was made like OPM or DOGE? And because it wasn't just HHS, it was all Federal agencies who would lay off probation. Do you know where that decision was made?

Secretary KENNEDY. I had my full upper staff in place before I got there.

Senator KAINE. Right, but did they make the decision or was it White House and DOGE to lay off probationary employees.

Secretary KENNEDY. They made the decision. My staff made the decision.

Senator KAINE. Okay.

Secretary KENNEDY. Although, DOGE came in and DOGE gave us information that we wouldn't otherwise have had access to.

Senator KAINE. Okay. Next we go to April 1st.

Secretary KENNEDY. I can also say this—

Senator KAINE. No, all I asked was if you made it and you answered the question. And I appreciate it. April 1, HHS RIFs 10,000 employees effective June 2. Now, by this point you had been Secretary for about 6 weeks.

A few days after that announcement, HHS staff briefed our staff at the Senate HELP staff, and basically just here are some highlights. In that 10,000 RIF, 467 staff at the Administration for Children and Families, 2,473 at the Centers for Disease Control, 322 at CMS, 400 at HRSA, 1,312 at National Institutes of Health, 197 at SAMHSA, 2,019 at the Food and Drug Administration.

By now, you have been Secretary for 6 weeks, so this was RIFs, not the forks, but you were involved in the decision about these 10,000 RIFs, correct?

Secretary KENNEDY. Yes.

Senator KAINE. In tandem with your leadership team, correct?

Secretary KENNEDY. Yes. And as I said before, I pushed back on certain ones and canceled certain ones.

Senator KAINE. Yes. I think yesterday, it might have been earlier today, you confirmed that 20,000 employees have been let go—at HHS. 10,000 RIF-ed and 10,000 forked. Do you know how many of the 20,000 were veterans?

Secretary KENNEDY. No, I don't know.

Senator KAINE. That is a fact that is very easy to determine from someone's personnel file, so I am going to ask that question for the record. We are finding across the Government that Veterans are disproportionately being let go, (A), because they are a higher percentage of the Federal workforce and (B), there a dramatically higher percentage of probationary employees because they leave military service after 10 or 25 years, and then they are probationary new employees when they join the civilian service.

I want to find the answer to that question. Where does the rubber meet the road on 20,000 RIFs, and layoffs, and forks? In people not getting cancer trials—and I appreciate your willingness to help Senator Murray's constituents. In state grants being canceled. In Virginia losing \$425 million in funding to the Virginia Department of Health. But here is a small example.

All of our offices do case work. All of them do casework. And we get requests from constituents all the time. CMS is the largest agency in the Federal Government. Its budget is nearly twice the

size of the Pentagon. And people who depend on Medicaid, Medicare, and the S-CHIP program really, really depend on.

It is the most consistent in the top three or four in terms of constituent requests to my office. Answer this question about Medicare, or Medicaid, or the S-CHIP program. In every Administration I have served with, Obama, Trump one, Biden, I get answers to questions on behalf of constituents.

I may not get them as fast as I like, and sometimes I like the answer and sometimes I don't. But let me show you what CMS is now doing to answer constituents' questions. I have omitted the name of the constituent, and I have omitted the name of my staffer. This was very recent.

A hard-working retiree, patriotic, taxpaying American who is on Medicare wrote to ask CMS a very simple question about Medicare. Couldn't get an answer. Asked us to reach out. We reached out to the Medicare Part C and D Congressional Liaison Office, and here was their answer to our basic question. Unfortunately, there is not an update to provide. With the recent change of Administration, we are unable to provide any information related—on matters related to Mr. X's request. Congressional casework team.

I mean, if you are just an everyday, hard-working American retiree on Medicare and you have a basic question about it, you ought to be able to get an answer. And I am just going to say, I have shared this with my colleagues, and many of us are having the same experience where our constituents can't get a basic question answered. I wonder if 20,000 fewer employees is connected to this. I yield back, Mr. Chair.

The CHAIRMAN. Senator Husted.

Senator HUSTED. Thank you, Mr. Chairman. Secretary Kennedy, thank you for being with us today. I appreciate the work that you have done in trying to raise awareness about making America healthy again, particularly as it relates to our dietary consumption. How food can be medicine, and food can make us sick. You have raised a great deal of awareness.

When we talk about public education campaigns, I think you have done more to shine the light on things that average American can do to make themselves healthier than almost any Secretary I can recall. So, thank you for that service. I also have listened to a lot of the conversation today where somehow we think that spending more is somehow compassionate.

On every single thing, like you have to spend more to do it even though every single person in this Congress knows that they are spending borrowed money that our children will have to repay. \$106,000, their share of the national debt when you are a child born into this Nation right now. And everything that you can do to create savings and improve the quality of services that American taxpayers get from your agency, I commend you on it. I encourage you to do so.

I want to give you the opportunity to share a couple points that you might want to share some of the work that you are doing in this budget is going to help people become healthier, generate some better outcomes for them, and savings that you think can be cre-

ated that would not harm somebody's health, but actually preserve the fiscal future of this Nation, so that those children can grow up and have access to the American dream that we all had access to when we were born in this Nation. So, share your thoughts.

Secretary KENNEDY. I appreciate you raising that about the debt issue because the point I was making earlier was that there is no agency head that wants to reduce the size of their agency. I would rather have as much money and power as I can possibly have.

I recognize that President Trump and the OMB Director have a larger duty and a larger vision, which is we are spending \$2 trillion a year that we don't have, and we are billing our children, and that is a moral deficiency. Senator Sanders asked me about the morality of universal health.

You can—there is a good moral argument for that, but there is also a moral argument—and, when we are spending \$1 trillion a year just to service that debt, within 5 years, half of every dollar collected in taxes is going to go to servicing the debt and within 10 years it could be 100 percent and then our kids are doomed.

That is a, the debt is a social determinant of health. We are trying to reverse that, and we are doing it in a way that it is not just throwing more money at the problem. We are revising the GRAS standards.

Twenty years of Democrats have said, we need to revise the GRAS standards. I have done it in 100 days. We are getting rid of nine synthetic—petroleum-based synthetic dyes in our food. Twenty years the Democrats have been saying we want to do this, and I have done that in 100 days.

I am—we are rewriting the dietary guidelines. The dietary guidelines that President Biden gave us, 453 pages long, and it is just an industry-generated document. The same industry impulse that put Froot Loops at the top of the food pyramid.

We are creating a four-page document that can be locally sourced that will drive the school lunch program. We have called on and inspired Governors and Legislatures across the country to ask for exemptions to the SNAP program to get soda and candy off of SNAP. We have—am I getting—is that a timer?

Senator HUSTED. You are good. Thank you for the work on SNAP, by the way, because getting unhealthy foods out of that program—if you are at the bottom quartile of income, you are almost twice as likely to be obese as if you are for the top cohort.

Secretary KENNEDY. Also diabetic.

Senator HUSTED. It is costing people their productivity, their quality of life. It is costing the American taxpayer more money through Medicare, Medicaid, and other health services we provide.

I just would say, we talked about kids. I want to give you a moment to share a thought. In 2022, we had a shortage of infant formula. There is a look at children now about how—what they should have in that infant formula. You are doing that with the—

Secretary KENNEDY. Operation Stork Speed.

Senator HUSTED. Yes, exactly. Tell us a little bit about that and just—if you have a moment.

[Technical problems.]

Senator HUSTED. Well, I will just say, Mr. Chairman, thank you for doing that. How about that? There we go.

The CHAIRMAN. But the Secretary made the statement that no vaccines except for COVID have been evaluated against placebo. For the record, that is not true. Coronavirus, measles, and HPV vaccines have been.

Some vaccines are tested against previous versions. So just for the record to set that straight.

Next, Senator Hassan.

Senator HASSAN. Thank you, Mr. Chairman. And Secretary Kennedy, thank you for being here. I would like to start by talking about the current measles outbreak, which I know is a concern for all of us here today.

Two children in Texas have tragically died from measles this year, the first children to die from measles in our Country in more than 20 years. Measles is almost completely preventable with the measles vaccine. As you know, it is critical that families hear directly and clearly from healthcare leaders about how they can best protect their children.

Mr. Secretary, I would like to give you an opportunity to state clearly here today to any parents who are watching that the best way to protect their children from measles is to vaccinate them.

Secretary KENNEDY. I have said that the best way to stop the spread of measles is through vaccination. I would say this, we have handled this measles outbreak—we get a measles break every year. We have handled this measles outbreak better than any other nations affected—

Senator HASSAN. What I was interested in—I am just—you can say you—what I asked you to do was to say straight to the camera as you did on social media that it is your position that the best way for parents to prevent their kids from getting measles is to vaccinate them, and that is your statement today—

Secretary KENNEDY. I said that to you.

Senator HASSAN. All right. Well, that is great. Thank you. Now, you lead the Nation's health department, so let me ask you a couple of questions. Do you think HHS should employ anyone who has endangered the health of children?

Secretary KENNEDY. No.

Senator HASSAN. You hired David Geier to lead autism research at HHS, an individual who fraudulently posed as a doctor and gave dangerous medications and medical tests to children with autism.

According to the State of Maryland's investigation, David Geier, who has no medical license or training gave hormone blocker injections to children with autism who were as young as 8 years old, which the Maryland Board of Medicine said poses a substantial risk of harm. Secretary Kennedy, yes or no, will you fire David Geier?

Secretary KENNEDY. First of all, what you are saying is not true. And we did not hire David Guyer to manage autism research at HHS. And—

Senator HASSAN. What is his job—what is this job then?

Secretary KENNEDY [continuing]. They have just said some very defamatory things—

Senator HASSAN. Well, no, I—

Secretary KENNEDY [continuing]. About a person who, by the way—

Senator HASSAN. Let me just be clear for the record—

Secretary KENNEDY. Those charges, Senator. I am going to correct the record on this because you have defamed—

Senator HASSAN. No, let me tell you what the record says and then I will hear from you. Last week when Mr. O'Neill was here in his confirmation hearing, I submitted for the record the charge that the State of Maryland laid out.

Now, if you would like also for me to submit to the record with unanimous consent today the findings of the State of Maryland, which fined him \$10,000 for practicing medicine without a license—he does not have a medical license—and for providing and instructing and giving children hormone blockers.

That is what the finding of the Maryland Department—the State of Maryland, its medical licensing board was. And I will submit that for the record I hope with unanimous consent.

Secretary KENNEDY. I am assuming that you don't know what I am about to tell you, or you wouldn't say something that was so dishonest. You may or may not know that David Geier sued the American—

Senator HASSAN. Oh, I do know that. I do know that. That doesn't change the findings, nor does it change the experience of the parents who testified.

Secretary KENNEDY. That finding was reversed by court, and he was awarded \$5 million.

Senator HASSAN. That is not true. Now, let me ask you, so I just want confirmation. David Geier is still at HHS. I wrote you a letter about this a month ago and you have not responded.

Secretary KENNEDY. Well, I apologize for that. That is our bad, and I will respond. But David Geier is not managing autism research at my agency, and we never said that he was.

Senator HASSAN. What is his job at HHS? This is somebody who gave parents the impression that he was a doctor and gave hormone blockers to children as young as eight, telling them that hormone blockers would somehow magically help their kids with autism.

Senator HASSAN. His father was—

Secretary Kennedy. His father is a doctor, but he is not. And his father was not in the room and did not—and he faked his father's signature according to the State Board of Medicine.

Secretary KENNEDY. That ruling was overturned by a court. So what you are saying is just wrong. It is just a lie. And they were

actually—the court said that the Maryland Board of Physicians was guilty of actual malice in fabricating those charges against David Geier.

Senator HASSAN. Well, we will pursue this. Last—and I will submit for the record—

Secretary KENNEDY. Do you want to know why we brought David Geier in?

Senator HASSAN. Sure.

Secretary KENNEDY. Because it wasn't to run autism research. In 2002, the CDC runs a vaccine safety data link, which is supposed to be the vaccine information, were the biggest HMOs that are supposed to allow CDC to have a surveillance system for vaccine injury. It is a backstop system. The CDC will not let any physicians in there to look at it, or any scientists, independent scientists.

Senator HASSAN. He is neither a scientist nor physician.

Secretary KENNEDY. The Congress ordered. CDC to open it to the Geiers. So they are the only scientists who have ever been in there.

Senator HASSAN. Yes, but again, Mr. Geier is not a scientist. Thank you.

Senator HAWLEY. Okay. Senator Hassan's time has expired. But before we move on, did you have a unanimous consent request that I heard in there, Senator?

Senator HASSAN. Senator Hawley, I have a unanimous consent request for the web—the printout of the Web site that shows Dr. Geier is—not Dr. Geier, that is his father. Mr. Geier is employed. And also a unanimous consent request for the finding from the Board of Licensing in Maryland.

Senator HAWLEY. Without objection to both of those.

[The following information can be found on page 58 in Additional Material:]

Senator HAWLEY. Now, Mr. Kennedy, before we get to my time, do you want—if you would like to finish your response, go ahead and I will recognize myself.

Secretary KENNEDY. Yes. Let me say that David Geier is the only living independent scientist who has seen the VSD inside. There has been a lot of monkey business with the VSD, including allegations of fraud.

He was hired by an independent contractor, not as an HHS employee, but by an independent contractor to look at the documents that we were getting from the VSD to see if they conformed with what he saw between 2002 and 2016. And that is the only reason that he was brought in, to see if there was—there is so much information that has disappeared from that data base.

The only way we could find out what information disappeared was because he was the one guy who saw it.

Senator HASSAN. Just let the record show he is not a scientist. Thank you very much.

Senator HAWLEY. All right. Secretary Kennedy, different subject—on a different subject. You and I have talked before, and when you have been before this Committee and you, and I have talked in person a number of times about Mifepristone.

I just want to follow-up with you because since the last time you were before the Committee the last time you and I spoke, there has been a major study by the Ethics and Public Policy Center of 865,727 prescribed cases of Mifepristone abortions, chemical abortions between 2017 and 2023. Have you seen this study? Are you familiar with this? Do you know what I am saying?

Secretary KENNEDY. Yes, I am.

Senator HAWLEY. You will remember then that this data shows the biggest study on Mifepristone done, I think, ever. And it showed that nearly 11 percent of women experience very serious adverse health effects, to include sepsis, hemorrhaging, infection, of course, emergency room visits.

Now, and by the way, that is 22 times higher, that rate is 22 times higher than the FDA's current label, which says it is just 0.5, the incidence of serious adverse health events. So my question to you is this. You previously testified to the Committee that you would do a top to bottom review of mifepristone.

Mifepristone is subject to a REMS currently. You have said you will do a top to bottom review. Do you continue to stand by that? And don't you think that this new data shows that the need to do a review is, in fact, very pressing?

Secretary KENNEDY. I think the new—first of all, it validates the CAS study, which is previously probably the most comprehensive data that we have seen on it. And it is—and it is alarming. And clearly it indicates that at very least the label should be changed. I have asked Marty Makary, who is the Director of FDA, to do a complete review and to report back.

Senator HAWLEY. Good. Do you have any sense of timeline, Mr. Secretary, on that?

Secretary KENNEDY. I do not.

Senator HAWLEY. It will be a top priority though for you, is that safe to say?

Secretary KENNEDY. Yes.

Senator HAWLEY. You say that it probably indicates the label needs to be changed. Do you think it is also important as part of your review to consider whether it is necessary now to put back in place the long-standing safety protocols that always accompanied Mifepristone until the last Administration, in-person dispensing, doctor visits, screening for ectopic pregnancies?

Secretary KENNEDY. I know that Marty Makary will make a recommendation. I feel that the policy changes will ultimately go through the White House, through President Trump.

Senator HAWLEY. But you will make a recommendation based on the data?

Secretary KENNEDY. Yes.

Senator HAWLEY. Good. On a different subject.

Talking about the advertising that is routinely done by pharmaceutical companies. You have been a long-time critic of direct to consumer pharmaceutical advertising. You wrote, I think in the Wall Street Journal a little over a year ago, about the need to re-

visit guidelines around pharmaceutical advertising. Is that still your view? I mean, has your view changed?

Secretary KENNEDY. Yes. Pharmaceutical advertising is particularly insidious because commercial advertising has some level of First Amendment protection, not as great as political speech. It doesn't have the kind of strict scrutiny applied to political speech. It still has a level of protection.

But pharmaceutical advertising is unique because if a company is advertising, for example, Coca-Cola, the consumer has a choice whether to buy it, and then he is spending his own money on it, so he has got skin in the game. With pharmaceutical advertising, the consumer is purchasing the product, and it is usually the most expensive form of the product.

They are usually advertising because they want to vary the existence and the availability of generic drugs that are much cheaper and equally effective. And the consumer is spending not his own money but most often our money—taxpayer money. Furthermore, the pharmaceutical ad is getting tax deduction, so we are funding it.

Senator HAWLEY. I want to ask you just about that. Under current law, pharma companies can deduct their advertising cost as a business expense. Do you think it is time to change that?

Secretary KENNEDY. I actually have a call in to Scott Bessent about that, but I am working very hard on this issue, and we expect to come out with a policy within the next few weeks.

Senator HAWLEY. Well, let me propose that we work together. Today, I am introducing legislation to repeal the tax deductibility of these advertisements. It is a bipartisan bill with Senator Shaheen on the other side of the aisle here.

It is a bicameral bill with both the Democrat and Republican sponsors in the House of Representatives. And my view is it is time to get rid of these tax breaks for these companies and to end this practice. Can you support that?

Secretary KENNEDY. 100 percent support it.

Senator HAWLEY. Fantastic. I look forward to working with you on that. Alright, let the record reflect I am giving up Senator Hickenlooper 15 seconds—

Secretary KENNEDY. I assume Senator Sanders will also support that.

Senator SANDERS. Absolutely. I will go further. I mean, the idea—

Senator HAWLEY. This is coming out of your time now, John.

Senator SANDERS. All right. The answer is yes.

[Laughter.]

Senator HAWLEY. All right. Senator Hickenlooper.

Senator HICKENLOOPER. Senator Sanders can finish your thought, please.

Senator SANDERS. We are the, I think along with New Zealand, the only countries on earth that allow for pharmaceutical advertising. I think it is time we ended that.

Senator HICKENLOOPER. Thank you, Mr. Chairman. And thank you, Mr. Secretary, for taking the time and for your willingness to come into public sector. I am not going to try and play got 'cha, but it is an opportunity to spend a little bit of philosophical time. And I guess one question is, do you think our Country spends too much on scientific research?

Secretary KENNEDY. No.

Senator HICKENLOOPER. Okay. And so, obviously the NIH is the largest—in terms of biomedical research, there is the Howard Hughes Institute, but the NIH—

Secretary KENNEDY. 70 percent of the world.

Senator HICKENLOOPER. Exactly, 70 percent the world. And I guess when you look at the level of cuts that we are facing over there—and I recognize that a lot of these cuts are imposed upon you, so. But there is a gap in basic fundamental research that is going to have to be filled somehow. And have you got any ideas of how we can do that, given the scale, the dimension of the loss we are facing?

Secretary KENNEDY. Well first of all, my job is to support the President on this and to support OMB. But the reality is that, as I have said, no agency head wants to see cuts to his agency.

I love scientific research, so I want to do as much as possible. But I think because of the—we are very, very aggressively implementing AI, and I think we are going to do it faster and better than anybody else in Government, any other agency. We brought very, very high caliber people from Silicon Valley.

Senator HICKENLOOPER. I get that. And that will accelerate and help us do more research—

Secretary KENNEDY. We can shorten clinical trials. We can get rid of animal trials, which we are already doing.

Senator HICKENLOOPER. I am in support of all that, and we have talked about that for years.

Secretary KENNEDY. We can do—we can now do—

Senator HICKENLOOPER. But the research I am talking about is not that so much as the fundamental science, basic science research.

Secretary KENNEDY. Like bench science, or epidemiological studies, or whatever. And I think we can do a lot of that stuff quicker. I will take as much money as you give me, and I will spend it well.

Senator HICKENLOOPER. I just want to make sure to urge you to be a fighter for more of that research because there is a questioning of science right now within many in the White House—not everyone, but many in White House. It really needs to be pushed back. Senator Hawley, I will sign on to that bill as well. Second question I have got.

We have a lot of issues around wildfires in Colorado right now, and with the—I will just go back to the NIOSH, the National Institute of Occupational Safety. You mentioned that they kept them in Cleveland, and I think somewhere in Pennsylvania. Pretty much everyone was laid off in Colorado.

Secretary KENNEDY. In Morgantown, yes.

Senator HICKENLOOPER. Yes. Everyone is laid off in Colorado. And the question really—and I think a couple have been ordered to be reinstated. But all the West is dealing with these—I mean, thousands, tens of thousands, probably hundreds of thousands of people out fighting fires.

These are people risking their lives. Walk away from their families every day. And the basic research that needs to be done, I don't think the replacements are going to be—in many cases, they are new onto the job.

They are not going to be sufficient to address and really make sure the specific health needs of these workers, these outdoor workers are addressed. So, questions. How can we, how can you make sure that folks in Colorado like firefighters are able to do their job safely?

Secretary KENNEDY. I think a lot of the cuts there we are implementing now are painful cuts. And that they are cuts that are going to—are going to be difficult.

But I think the President's position is that we are spending two trillion dollars that we don't have, that we are taking from our children. And we have got to protect their rights to prosperity, to enrichment, to dignity, to choice. And—

Senator HICKENLOOPER. Again, I have heard that argument and I appreciate it. And I am a great frugal—a voice of frugality, at least in my office, and try to push around the Senate where it is allowed.

But we are looking at a budget that is going to increase the deficit by who knows how much, \$4 to \$5 trillion. To take things like this that we know are successful—and not just for Colorado, but for almost every Western state essentially, and we are cutting receiving such a small amount of money for something that is so important.

I just hope that you can push back on that a little bit. And someone has got to take a stand for these things that are minor financial benefits, but significant losses to how we provide safety for workers and our citizens.

Secretary KENNEDY. I am happy to work with you on that, Senator.

Senator HICKENLOOPER. Okay. Great. I yield back to the Chair.

The CHAIRMAN. The Committee will be adjourned for 5 minutes subject to the call of the Chair.

[Recess.]

The CHAIRMAN. The Committee will come to order.

Senator Banks, you are next.

Senator BANKS. Thanks, Chairman.

Secretary KENNEDY. Senator, can I just say one word?

The CHAIRMAN. Yes, sir.

Secretary KENNEDY. I want to clarify an issue that we talked about before. Senator Murray had raised the issue of a constituent of hers who she said had been denied a place in a clinical trial in Washington due to the RIF. We have been able to run down that case. The patient was medically ineligible for that trial.

The CHAIRMAN. Ineligible?

Secretary KENNEDY. Medically ineligible, and nothing to do with the RIF. And NIH had been trying to get her into another clinical trial, but none of our clinical trials were shut down because of the RIF. That was a canard.

The CHAIRMAN. Thank you for the clarification.

Senator Banks.

Senator BANKS. Thank you, Mr. Chairman. Secretary Kennedy, you have—[technical problems]—compassion for Americans with autism and their families. There is still so much that we don't know about the conditions, and there are many questions to be answered.

That is why I was glad that you recently announced an autism research data base similar to a registry that you created. The NIH has more than 80 registries for different diseases, and they are a critical tool to understand disease progression.

But even in spite of all of that, you were immediately attacked for privacy violations and accused of ulterior motives. Can you tell us today how will this data base handle protected health information, and is it an opt-in or an opt out database?

Secretary KENNEDY. This is like—thank you for that, Senator—for asking that. This is a database—as you say, there is actually 190 disease databases at my agency. Almost every important disease has a registry.

Arthritis has a registry, for example. Heart disease, cancer, various kinds of cancers. And the registry is intended to help scientists research what causes the etiology of disease and also what the cures are. It is entirely voluntary.

Patient privacy is protected. The data is digitalized and depersonalized so that people cannot find out who the patient is. And patients have an absolute right to opt out of it. So, it is entirely voluntary.

But it is a very important tool for scientists to use who want to understand how to treat diseases. If there is a number of people who have used, for example, chelation therapies on autism. And you can look at that. You can see what the outcomes were—or other kinds of therapies.

Microbiome treatments, all these other—these various treatments that physicians and frontline treatment nurses and doctors are using across the country to address disease and find out which ones work and which ones don't.

Senator BANKS. You have also been accused of assuming an environmental cause of autism and rejecting a genetic cause. Can we say that your critics are misrepresenting what you really believe?

Secretary KENNEDY. Well, I don't believe—I don't think—I think if my critics are saying that I reject a genetic cause, I think they are correct in the sense that autism is an epidemic, and the genes do not cause epidemics. They can contribute vulnerability, but you need an environmental toxin.

It is like cigarettes and smoking. Smoking cigarettes was killing one out of every five of its customers, the tobacco industry. That

meant four out of five survived. So there is a genetic component to the ones who got lung cancer and died.

That is a genetic vulnerability, but you also need an environmental toxin. You cannot have a sudden epidemic without an environmental exposure.

Senator BANKS. Have you halted or redirected funding away from any pre-existing autism research?

Secretary KENNEDY. I am told, and I haven't done this calculation myself, but I am told that there was a 20 to 1 research ratio for genetic cause of autism over the past 20 years at NIH.

If you ask me, I believe that was because they did not want to look at the environmental exposures because they were scared of what they found. So, I don't think we should be funding that genetic work anymore. I think we know a lot about the genes, the upper fold-field vulnerabilities, high testosterone, low glutathione on the MTHFR gene, the genes that control methylation.

All of these are involved, and we know that. And what we really need to do now is to identify the environmental toxins.

Senator BANKS. I appreciate greatly your attention and effort on that. Secretary Kennedy, we are importing a third of our medicines from China. It is a public health risk, as well as a national security risk, and you and I discussed this in your confirmation hearing. I asked you at that point about reshoring medicine production from China during that hearing. I wonder if you could give us any updates on how that is happening.

Secretary KENNEDY. Yes. I think there are very exciting things happening, and some of them as a direct result of President Trump's tariffs. And I have been working very closely with David Ricks of Eli Lilly.

I think they have been the most aggressive of any of the pharmaceutical companies about answering President Trump's summons to onshore production. They have nine facilities now that are breaking ground. And one of them, the API facility, that they are breaking ground on will be, I believe, the biggest API facility in the world. These are ingredients active pharmaceutical ingredients.

China controls that market right now, and this single facility could give us back dominance of that market. So I am very, very optimistic about what is happening. And I am grateful to Eli Lilly, which has not always been a big ally of mine.

I am grateful, and we have been working very closely with the leadership of Eli Lilly to make sure they get what they need to onshore production because we saw during COVID that for essential medicines, we cannot afford to have the ingredients offshored.

Senator BANKS. Thank you for your leadership. I yield back.

The CHAIRMAN. Senator Markey.

Senator MARKEY. Thank you. Mr. Secretary, all I have been hearing from you today is your defense of and advocacy for brutal cuts to Medicaid, brutal cuts to NIH research to find the cure for Alzheimer's and cancer or other diseases, brutal cuts to community health centers, brutal cuts to the CDC, the early warning system for diseases.

All to find the funding for tax cuts for billionaires and millionaires. That is all I have been hearing. And it is absolutely unbelievable that the Secretary of Health and Human Services can sit before the HELP Committee and make such an argument.

Secretary Kennedy, for months I have been hearing from people about the impact that you and Donald Trump have had on them. And for months I have been sharing their stories. And I have compiled them here. And Mr. Chairman, I would like to include my Make America sick agenda—included in the record.

The CHAIRMAN. Without objection.

[The following information can be found on page 115 in Additional Material:]

Senator MARKEY. Thank you. This is a set of stories that are being told to me that I would like to relate. Jennifer is from Massachusetts, is a stage four cancer patient. There is no cure for her diagnosis. Her life depends on Federal investment in research and for clinical trials to continue uninterrupted to find a cure for Jennifer—with NIH funding. She is right to be worried.

I heard from Henry in Rhode Island who wants a—continued funding for cancer research, where he works. He is worried about getting fired because the labs NIH grants, under new leadership, were cut. He wants to work on cancer research to find the cure for Jennifer. You have already terminated \$1.8 billion in NIH funding, which for Jennifer should really stand for National Institutes of Hope. She is losing hope.

You are defending a 40 percent cut, Mr. Secretary, in research for Alzheimer's, for cancer, for stroke, for diabetes, for mental health. They are being slowed. They are being slashed. And I understand streamlining, but this is not streamlining. It is a bludgeoning of our health's future and a giveaway of our global scientific leadership. And it will be people like Jennifer who will pay the price.

Lou from Massachusetts, he wrote to me about his son who died of an overdose. He said his son, Zach, was “a loving and loved family member who had the illness of addiction.” He wants research to cure this disease, funding for treatment without stigma, support for health workers serving people with addiction to prevent any other family member from suffering from the same fate.

Can you honestly tell us, or tell him, actually, that you can cut \$1 billion—\$1 billion from the Substance Abuse and Mental Health Administration, including funding for programs to teach First Responders how to use naloxone to help to guarantee that other parents not lose their children?

Can you honestly tell me that the cuts you have already made to addiction treatment across the country will make anyone healthier? How can you justify a \$1 billion cut to substance abuse and mental health, Mr. Secretary?

Secretary KENNEDY. Senator Markey, you weren't here when I was talking earlier, but one of the things that I have talked about is that the budget for my agency increased by 38 percent over the Biden administration, and Americans got sicker, and more Americans overdosed, and more American died from cancer.

We have now an epidemic of colorectal cancers in our children. And the chronic disease rate has now gone up to 60 percent. The autism rate has dropped to 1 in 31 children. And all that money that was supposed to cure those diseases or revert them, none if it worked.

All we need is leadership and a new vision, and I am bringing that to my agency. And I am realigning my agency—

Senator MARKEY. Okay. President Trump is negotiating with the Chinese about keeping fentanyl out of our Country.

Secretary KENNEDY. Well, that is a good thing, isn't it?

Senator MARKEY. In the meantime, we can't be cutting the programs for the people who are already suffering from opioid related diseases. We can't cut the programs. Yes, it would be great if we could cut it.

Be great if we can reduce it. While we are waiting for that to happen, why would we cut \$1 billion from the programs that go to the families that have the substance abuse issues right now? Why would we cut it now, before we get a solution to the problem. They need things right now.

Secretary KENNEDY. First of all, most of the programs that support addiction, including naltrexone, narcan, suboxone, methadone, housing, we operate under SAMHSA 500. Are rehabs that give people access on their Medicaid. We are keeping those intact.

We have—President Trump, because of his leadership, has dropped the fentanyl imports from this country because of leadership at the border by 40 percent.

We are actually doing more with less, and we are going to continue to do that. And what I am doing at my agency is I am realigning all these perverse incentives that have driven up cost and driven down health. I am realigning so that people can make money in this country and markets can make money at the same—

Senator MARKEY. Look—80,000 people died last year. This is not about efficiency. This is about cruelty. Cutting these programs—these people are already addicted. These people already need help. You are slashing the programs that families need right now.

The CHAIRMAN. Senator Markey—Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moody.

Senator MOODY. Thank you, Mr. Chairman. And thank you for being here. I think it is wonderful that we are doing this hearing. Thank you, Mr. Chairman.

I believe this is the HELP Committee's first HHS budget hearing in more than two decades. And certainly, I don't think this afternoon has been easy on you. And we are grateful that you are willing to answer the hard questions.

Secretary KENNEDY. Thank you, Senator Moody.

Senator MOODY. Have the difficult discussions because if I heard you correctly the 60 percent, 50 percent, whatever increase in the last 5 years in your agency, you said, reflected or resulted in people getting sicker and more people dying.

We have to do more than just think of throwing money at something is going to solve a problem. And I am grateful for everyone that is stepping up on the cabinet and saying, I want to do this job in a deliberate way that is going to deliver for the people that means more than just coming here to Washington, and throwing money at problems, and spending taxpayer moneys without giving a lot of deliberate forethought to results.

I think that is what you have been trying to say here today. And I appreciate you tackling this because not many people would want to brave this job, certainly at this moment in time, and as our Nation is spiraling out of control, and more and more debt, and more and more spending.

We have got to be responsible for the future stability and success of this country. So, thank you. I start there. I also note that in some of the numbers that we saw in this proposal, there wasn't much information in terms of asking for more money. I am assuming that you are not asking for more money.

Specifically related to the FDA, and I wanted to focus on a few things—and I believe your approach is probably going to be, how can we be better? How can we use the resources we have to do more for the American people, deliver on their health, without spending more money.

One of those ways I believe in the FDA would be to tackle Chinese illicit vapes. I think 60 percent of their vape market that are in no way regulated, we have no idea what are in these things, chemical ridden vapes. All over the United States—being bought by all of our kids. I would ask that you dig into that and look at that.

I know the FDA has been backlogged and the excuse kept, excuses kept coming out on why they weren't following through and enforcing this thing. Meanwhile, we have more and more kids that are vaping these chemicals and we have no idea what is in them. So would you look at that with your department, using the resources that you are asking for today?

Secretary KENNEDY. Yes, absolutely. We are looking at it right now. And during the Biden administration, the FDA slow walked the approvals for U.S. vaping companies. And the U.S. vaping companies, in my view, were acting very responsibly. They were putting chips in their vapes that would make sure that young people could not use them.

They were giving good information about addiction. And they had very extensive labels. They really went out of their way not to make it attractive to children. They were slowed walked, so they are off the market. And in order to fill the vacuum, hundreds of Chinese companies came in with these colored, beautifully, attractively comic books—

Senator MOODY. Sour grape, watermelon—

Secretary KENNEDY. Watermelons—all these flavors are targeted to kids. They have video games on the vapes that lure kids into addiction. And we are going to wipe them out. We are going to get rid of all of them.

Senator MOODY. Thank you. Thank you for that commitment. As a mother of a teenager and on behalf of all moms of teenagers, I

know that vaping was going on in some of even our elementary and middle schools. We thank you. Using the resources that are given to you, if we were just more deliberate and aggressive in what we are doing within the agency, I think we can make a huge difference.

I want to direct your attention to one more important issue. One of the things that drives me crazy is when nonsense regulations are on the books and they have no benefit whatsoever, but yet they are on the book and businesses are trying to comply with them. In our citrus industry, our orange juice producers, there is a regulation that requires a certain sugar content.

It is called a Brick Standard. Doesn't affect quality or nutrition at all. In fact, our oranges now that are being produced in Florida produce slightly less sugar. But because of this arbitrary standard, producers of orange juice in Florida have now had to start importing—from foreign companies and foreign nations, oranges into our Country to mix with our products to deliver orange juice. The standard, it doesn't affect quality or nutrition.

Secretary KENNEDY. Raise the sugar content in the orange juice—

Senator MOODY. We want to lower the sugar content that is required by this regulation. I am sure you would not disagree with that. But would you look into an interim final rule that would lower that slightly to save the orange juice industry domestically?

Secretary KENNEDY. Yes. Why don't you call Heather Flick, who is behind me, or Hannah Anderson, this week and we will act on that as quickly as we can.

Senator MOODY. Again, using the resources we have, just being smarter in our approach, we can do a lot to save a once thriving industry. Thank you.

Secretary KENNEDY. Thank you.

The CHAIRMAN. Senator Kim.

Senator KIM. Thank you, Chairman. Mr. Secretary, I wanted to just relay, I had a town hall. I had a fire captain show up to this town hall—somebody who worked at Ground Zero.

He is somebody who said he was diagnosed with cancer. He said he is on borrowed time, and he was livid, absolutely livid about what he said, the Administration gutting the World Trade Center Health Program. And we have talked through some of these cuts that have happened before. Some staff cuts. Some may be brought back on.

The Administrator cut. I just need to hear from you. I promised this fire captain I would ask you about this. What in the world happened? Why was the staff cut for this program? What are we to expect going forward?

Secretary KENNEDY. I restored this after that program.

Senator KIM. Why was it cut to start with?

Secretary KENNEDY. It was part of the overall budget cuts. Our agency was asked to make very, very serious budget cuts that were going to be painful. And some of them should not have been made, and that was one that should not have, and I reversed it.

Senator KIM. Were you unaware, or were you aware, that the decision to cut NIOSH staff would cut that World Trade Center Health Program?

Secretary KENNEDY. My agency is the biggest agency in Government. It is twice the size of the Pentagon. It represents about 20 percent of the U.S. economy. We have hundreds of institutes and sub-agencies. We try to be as careful as we can about what we cut and what we didn't. We made a couple of mistakes. That was one—

Senator KIM. No, I don't think you were trying to be as careful as you can. I mean, that is the problem that we have seen by rushing these decisions. This was, I know, already in your time there.

Secretary KENNEDY. Senator, I understand that if you look at this from a distance, you would say, why don't you just do this surgically and cut one person at a time. We—this agency has grown so big, so fast, and everybody who comes in says, I am going to cut it down, and nobody has been able to do it.

There was an understanding that the longer that you wait, the more the inertia kicks in. And we had to act quickly so that we can do something for the American people that is lasting. And we understood that there would be some mistakes made, and that we would go back and reverse them when they were made.

But it was more important to do decisive action quickly that could eliminate the metastasizing of this agency which was growing, and growing, growing as our health declined.

Senator KIM. Where is this going to land now? Can you tell us right now that the staffing of the World Health—the World Trade Center Health Program will go back to where it was before you became Secretary? Is that—

Secretary KENNEDY. That program will continue. There will be continuity in that program. That is all I can tell you.

Senator KIM. Continued, yes. But at full strength to where it was before you were Secretary?

Secretary KENNEDY. The program itself will continue.

Senator KIM. Well, look, the fire captain also raised this issue about the National Firefighter Cancer Registry. Also something I promised him I would ask you about. Why was that shut down?

Secretary KENNEDY. Cancer registry—I don't know about that.

Senator KIM. You don't know about this?

Secretary KENNEDY. No.

Senator KIM. Okay. Well, look what I will just tell you is—

Secretary KENNEDY. I am happy to work with you on it though. It is—

Secretary KIM. There is a National Firefighter Cancer Registry, and this is something that is part of NIOSH. And because of the cuts, when I go to the Web site, as I am right now, it says, "the information on this page is not currently being updated and access to tool is limited.

Firefighters can no longer enroll in the National Firefighting Registry for Cancer." So I just raise this because this is incredibly important, not just for those that were at Ground Zero, but just

writ large across our Nation to try to help our firefighters. So can you promise me that we will work together and try to get this back up and running as soon as possible?

Secretary KENNEDY. I will work with you on those issues, Senator.

Secretary KIM. Look, I understand what you are saying when it comes to your prioritization, but I will tell you, it is sending an absolutely disastrous message, especially to our firefighters.

I mean, I hope that on the list of things in this Congress that we think are bipartisan, are unanimous, it should be about supporting our heroes at the World Trade Center, especially when we have more firefighters who have died since 9/11 because of medical issues that they have had working there at Ground Zero. Then, those number of firefighters that died on September 11th.

If we can't even agree on that, if that is not seen as a high enough priority to try to protect, then I am worried about everything else that is more controversial, has less unanimity.

Secretary, I will follow-up with you on the National Registry, and I do want a firm answer on you on what is the final staffing at the World Trade Center Health Program. And with that, I will yield back.

Secretary KENNEDY. Thank you, Senator.

The CHAIRMAN. Senator Murray has returned. She has asked for a request for 30 seconds to respond to what the Secretary had responded to her.

Senator SCOTT. May I ask a question?

The CHAIRMAN. Yes, sir.

Senator SCOTT. Does her 30 seconds take me down to 4 minutes and 30 seconds?

The CHAIRMAN. No, sir.

Senator SCOTT. Okay.

The CHAIRMAN. I will give you 5:30 if you want.

Senator SCOTT. Even better. Thank you.

Senator MURRAY. Mr. Chairman, thank you for accommodating and letting me speak here, because Secretary Kennedy came back and said that my constituent that I spoke about earlier was not delayed by staffing cuts. First off, she is already enrolled in that clinical trial. It is not a question of eligibility.

The issue, as I stated clearly, was the delay in care that she got. And what you stated, Secretary Kennedy, is not true. I spoke with Natalie actually last night. She asked her NIH doctor directly why, and she—when she was informed of the delay, and her doctor at NIH said very plainly twice, her care was delayed because of staffing cuts.

I would just, Mr. Chairman, I think it is important for the record to show my staff has put in inquiries with HHS leadership, and they have been unresponsive so far. And just to make it clear, this is just one case of many, but those are the facts. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Scott.

Senator SCOTT. Thank you, Mr. Chairman. Thank you, Secretary Kennedy, for being here with us today. I oftentimes hear you say that “happy to work with you.” And I will say that you said it to Senator Kennedy, and as a person who has asked you to work on a number of topics, when you say happy to work with you, you have actually been a man of your word, and I truly appreciate that.

We talked about the importance of sickle cell anemia and the research being done, and I invited you down to South Carolina and you took me up on my offer. You came last month, and I really appreciate you taking the time and investing the energy to talk about an issue that is critical to so many folks, specifically African Americans.

As a guy that is thankful that we are working to eliminate diversity, equity, and inclusion in the Federal Government, I do not want some folks to think that all things racial are somehow DEI. And frankly, sickle cell anemia is a classic example of something that has a racial nexus, but it is not diversity, equity, and inclusion. It is just a basic fact that African Americans, 99.9 percent of the time, are the folks that are suffering through sickle cell anemia.

Frankly, if you go beyond sickle cell anemic, you find other diseases that have a consistent presence in minority communities. And to that end, I think it is really important that we continue to work together on building on issues impacting minority and other communities.

I would love, Senator—Secretary Kennedy, as you move through this reorganization that you are currently going through, I would like for you to answer the question, will you commit that programs involving minority health will continue and not get tied unnecessarily and inappropriately to DEI?

Secretary KENNEDY. Yes, absolutely. We will continue. We have—I think that one of the minority health programs has been terminated and it was one that was deeply embedded with DEI ideology, but there are seven others that are going to continue.

I want to thank you for inviting me down to South Carolina. That was a wonderful trip. It was really—I got to witness a microcosm, a template for how medicine ought to be working.

Senator SCOTT. Yes.

Secretary KENNEDY. You had brought together under your leadership, hospital systems, pharmaceutical companies, and the biotech companies that developed this new technology for treating sickle cell, and they all—and patients.

They had all worked together to make it affordable so that South Carolina now has this extraordinary program where if you have sickle cell in South Carolina, you can get it 100 percent funding, with I think it is 100 percent cure, or close to it.

Senator SCOTT. Yes. Very close to. Thank you. I will just ask the two questions I was supposed to ask in the—preliminary to the questions. For all the parents with children with sickle cell, can you please just reassure them that the Administration of Health

for America will work on sickle cell and addressing minority health issues? It is a simple yes or no.

Will the full budget, and when it is released, reflect funding at AHA for both the Office of Minority Health and Sickness Health Activities that used to be housed in CDC?

Secretary KENNEDY. Absolutely. You have my commitment. In fact, I had a company in this morning meeting with FDA that has a new technology that may—that it seems as effective and may be even more economical. And I am very, very excited, and I am excited to show it to you, if it proceeds, if makes it through the TRAPs at FDA.

Senator SCOTT. Excellent.

Secretary KENNEDY. But yes, absolutely. I am going to continue to make that a priority of this agency.

Senator SCOTT. Right. Let me change topics quickly with my 1 minute and 45 seconds left, as I was extended an extra 30 seconds. Thank you, Mr. Chairman. I really appreciate the work that you are doing, frankly, as it relates to addressing how our food supply contributes to chronic diseases, including the phasing out of petroleum based as part of your make America healthy movement.

I am really encouraged by the FDA's announcement last week approving three new natural color additive petitions. During your confirmation hearing process, I shared your passion for shaking up the food industry, and you are truly doing just what you said you were going to do as it relates to food additives.

Because of your bold actions at HHS regarding petroleum-based food additives, the food industries responded by getting rid of these dyes in favor of natural alternatives. Thank you for your work in bringing healthier food options for our kids.

Can you talk about how you will use your position to continue to build on your work eliminating artificial food dyes to further improve the quality of food sold to Americans in our quest to make Americans healthier?

Secretary KENNEDY. I mean, one of the big areas of neglect has been linking specific food additives and food processes to the chronic disease epidemic. NIH has neglected that area of study.

It is now the central focus of NIH is going to be looking at—and FDA, looking at ultra-process foods, at sugars, and the 10,000 additives that are in our food that are in nobody else's food in the world.

Looking at the impact so that we can put accurate labeling on. And when they are really dangerous, we can require—we can revoke their authorizations under GRAS.

Senator SCOTT. Thank you, sir.

[Technical problems.]

Senator BLUNT ROCHESTER. Thank you, Chairman Cassidy, Ranking Member Sanders. And welcome, Mr. Secretary. I have nothing personal against you. I don't even know you.

But what I do know, as the former Deputy Secretary of Health and Social Services in Delaware, is how important your agency is to the lives of so many people in our Country. During the confirma-

tion, your confusion of Medicaid versus Medicare did not instill a lot of confidence.

But today, as you talk about these budget cuts being painful, I am reminded of Delawareans who have come up to me and cried, and said, please don't let folks take away my Medicaid—individuals with disabilities. While you talk about cutting this large, large department, there are talks about including more things in the department from the Department of Education.

I am concerned about that. And when we met in January, you committed to radical transparency and responding to all congressional inquiries within 30 days. Since then, we have sent dozens of letters. And to my knowledge, like Senator Hassan, I haven't received any responses.

Given your stated commitment to transparency, and your focus on efficiency and responsiveness in your opening comments, I think this is a great opportunity to get your commitment that you will respond to the letters from this Committee, and also an opportunity to maybe talk about a few of the things that I wrote to you about. So let's begin with this letter.

In March, I wrote you expressing my concern about the delayed meeting of the Federal Vaccine Experts, otherwise known as ACIP. The meeting of this Committee is a key step in getting vaccines to millions of people, from babies to seniors, and delays can have negative impacts on vaccine accessibility and affordability.

While I am glad that the meeting finally happened, we are quickly approaching flu season, and the CDC still hasn't adopted the April recommendations. And I can understand the delay, given that there seems to be no current CDC Director. So in the spirit of radical transparency, my question is, who is the Acting CDC Director?

Secretary KENNEDY. The Acting Director was Susan Monarez, but she is now up for permanent Director. And so, she has been replaced by Matt Buzzelli.

Senator BLUNT ROCHESTER. Does this person have a medical background?

Secretary KENNEDY. I believe—

Senator BLUNT ROCHESTER.—Or public health expertise?

Secretary KENNEDY. He is a public health expert.

Senator BLUNT ROCHESTER. Public health expert. So, the fact that the recommendations are kind of stuck is—and the fact you kind of have—

Secretary KENNEDY. Well can I clarify something? The—ACIP does not do the flu shot—

Secretary Blunt Rochester. Yes. I don't want to get into the specifics of that.

Secretary KENNEDY. Those—the flu shot was—

Senator BLUNT ROCHESTER. My question was more about do we have a CDC Director. And then I want to enter into the record information about what harms could be caused until we get one.

The CHAIRMAN. Is that a request—

Secretary KENNEDY. We want the director—

Senator BLUNT ROCHESTER. Let the——

Secretary KENNEDY. We are relying on this Committee to——

Senator BLUNT ROCHESTER. But this was my question. This is my time.

Secretary KENNEDY [continuing]. Confirm the director.

Senator BLUNT ROCHESTER. We are Senators. And so, I don't want to have the same exchange that happened before with other people. I just want to ask my questions. I want to just shift gears. Your proposed compassionate budget would cut funding for multiple maternal and child health programs.

I know as a new parent, I remember learning that my baby should sleep on their back. The NIH Safe to Sleep Campaign, you have shuttered. After launching this campaign in 1994, the rate of sudden infant deaths dropped by 50 percent. Many parents in this room maybe remember getting their children screened for hearing loss or rare diseases. That program has also been shuttered.

You cut programs that collect data on IVF, maternal health, infant mortality, all while President Trump is calling himself the fertilization President. None of these policies are based in compassion.

My only concern, even following up on Senator Kim's question, is understanding what goes into gutting a program that has increased the efficacy of parents being able to take care of their children. I will—my time has expired. But I will just say, again, a budget is a reflection of priorities.

To me, this budget, the cuts to Medicaid that are talked about right now across—in the House of Representatives, are going to have real, like you said, painful impacts on people's lives.

I hope there is some real compassion in the end, and I hope that you hear from our constituents as we are hearing from them as well. And we will continue to—we will continue to try to fight for them. So, I yield back.

Secretary KENNEDY. Let me—no time to respond, but I can assure you that I will act with compassion.

The CHAIRMAN. Senator Alsobrooks.

Senator ALSOBROOKS. Thank you so much, Mr. Chairman. Mr. Secretary—I am talking. I am over here. I have been sitting through this hearing all day today and have noted that you have been unable in most instances to answer any specific questions relating to your agency.

Secretary KENNEDY. Because I haven't been given time.

Senator ALSOBROOKS. Well, no, you have been given time, but the point of the matter is you have been unable to answer specific questions. Sir, you are the wrong person for this job.

You had in this hearing today the unmitigated gall to say at the beginning of your testimony that China is ahead of the United States in health care because China does not have DEI.

Secretary KENNEDY. I didn't say that.

Senator ALSOBROOKS. We can roll back the tape. You absolutely——

Secretary KENNEDY. You can, and you will find I didn't say that.

Senator ALSOBROOKS. That is absolutely what you said.

Secretary KENNEDY. I was talking about science. I didn't say they are ahead of us. They are ahead of us in some forms of science, certainly not in health care.

Senator ALSOBROOKS. Well, we can roll back the tape, but nonetheless, let me go on with my questions and ask you this. You just heard about the Safe to Sleep Campaign. And you have made cuts. You made it very clear here today you have no knowledge whatsoever of the absolutely amazing scientists and researchers who you have callously fired. You know nothing about the cuts—

Secretary KENNEDY. I didn't fire any working scientists, Senator.

Senator ALSOBROOKS. That, sir, is not true either. But none—

Secretary KENNEDY. That is true.

Senator ALSOBROOKS. It is not true. Let me ask another specific question.

Secretary KENNEDY. It is true.

Senator ALSOBROOKS. The Safe to Sleep Campaign. Well, can you name, sir, which office the Safe to Sleep Campaign operates out of?

Secretary KENNEDY. Which campaign?

Senator ALSOBROOKS. Well, that is the one that the Senator just asked you about 2 minutes ago that prevents babies from dying in their sleep. A 30-year program inside your agency. You would agree that it is important—

Secretary KENNEDY. I think it is part of HRSA—or ACF. It is ACF.

Senator ALSOBROOKS. No, actually it is in Health and Human Services.

Secretary KENNEDY. They are all within Health and Human Services, but the subdivision is ACF.

Senator ALSOBROOKS. No, actually the name of the Office is—

Secretary KENNEDY. Administration of Children and Families.

Senator ALSOBROOKS. No, let me tell you what it is. The National Institute of Child Health and Human Development. This is actually the one that your aunt, Eunice Kennedy Shriver, is the person who it is named after. And you noted just a moment ago, the Senator reminded you, that although this is a very important agency, prevents babies from dying, this is the same one you fired every single person in this office as of April the 1st.

Secretary KENNEDY. As I said, there were no working scientists fired during the RIF.

Senator ALSOBROOKS. We can bring you that information later, because what you just said is not true. Well, then the question also is in addition to firing the individuals who make sure babies don't die in their sleep, why did you cut funding and staff from the CDC's National Center on Birth Defects and Developmental Disabilities which supports the Special Olympics? Was that a mistake? I have heard you say you have made some mistakes today. Was that also a mistake?

Secretary KENNEDY. We have switched those programs to the Administration for Healthy America. They have not been cut.

Senator ALSOBROOKS. Well, the funding has been cut. And this is one that oversaw the Special Olympics. Are you aware of that?

Secretary KENNEDY. We have not cut the Special Olympics.

Senator ALSOBROOKS. Cut the funding. And you have also dismantled the Division of Reproductive Health and Women's Health and Fertility. You are aware of that, right?

Secretary KENNEDY. We have—right now, we have 42 divisions that do maternal health, and we are consolidating them. And the mainstream media has portrayed those as cuts, but they are not cuts.

They are consolidations. It is ridiculous to have 42 divisions that are all supposed to be doing the same thing with their own administrators.

Senator ALSOBROOKS. Well, let me ask you a question. So that it doesn't exist right now. It has been dismantled. That is a fact. That that particular division—what you plan to do in the future—

Secretary KENNEDY. There is 42 divisions on maternal health. We consolidated them.

Senator ALSOBROOKS. Sir, let me finish what I am saying here. The fact of the matter is you have dismantled it as we speak. And are you aware—what does the assistive reproductive technology mean to you? Are you familiar with that?

Secretary KENNEDY. Are you talking about IVF?

Secretary KENNEDY. Well, it is assisted reproductive technology. It is a division. Do you know what it does?

Secretary KENNEDY. Is it part of NIH?

Senator ALSOBROOKS. No, it is actually a part of your agency.

Secretary KENNEDY. NIH is part of my agency, Senator. You should know that.

Senator ALSOBROOKS. I do know that, but it is actually a part of—it is the CDC is where it is.

Secretary KENNEDY. Okay, then it is CDC.

Senator ALSOBROOKS. Right. Okay. Let me just ask you—and again, these are all other things. You seem unfamiliar with the ones—the programs that you have cut out.

Secretary KENNEDY. You are unfamiliar with my agency—that NIH and the CDC are part of HHS.

Senator ALSOBROOKS. Oh, I absolutely know. NIH is in my county. I was there this past weekend with the researchers that you have fired, so I absolutely know where NIH is, sir, and don't need any help from you in knowing that. I cede the time. Thank you.

The CHAIRMAN. Senator Blunt Rochester, did you have something you wanted in the record? You mentioned something but didn't formally ask, and I want to make sure.

Senator BLUNT ROCHESTER. Yes, Mr. Chairman. I would like to introduce this into the record. It is, the CDC has no Acting Director, source is confirmed.

The CHAIRMAN. Without objection, it is entered into the record.

[The following information can be found on page 135 in Additional Material:]

Senator BLUNT ROCHESTER. Thank you so much.

The CHAIRMAN. Senator Sanders.

Senator SANDERS. I ask unanimous consent to enter into the record 21 letters of groups raising concerns about the HHS reorganization budget and RIFs. Also ask anonymous consent on behalf of Senator Murphy to enter two articles into the record.

The CHAIRMAN. Without objection.

[The following information can be found on page 145 in Additional Material:]

The CHAIRMAN. For any Senator wishing to ask additional questions, questions for the record will be due in 10 business days on May 28th at 5.00 p.m. Thank you again, Secretary Kennedy, for being here.

The Committee stands adjourned.

ADDITIONAL MATERIAL



National Task Force to End Sexual & Domestic Violence

May 13, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary of Health and Human Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C.

Dear Secretary Kennedy,

We, the member organizations of the National Task Force to End Sexual and Domestic Violence (NTF) Steering Committee, comprising national organizations working to end domestic violence, sexual assault, dating violence, and stalking, and representing thousands of community-based programs and millions of victims and their advocates, are writing to express our grave concern about FY25 and FY26 funding for domestic violence shelters and programs, rape crisis centers, culturally specific programs, supportive resources, and prevention from the U.S. Department of Health and Human Services (HHS). We are particularly concerned about programs and resources administered by the Office on Family Violence Prevention and Services (OFVPS) and the Centers for Disease Control and Prevention (CDC) Injury Center, Division of Violence Prevention. FY25 funding delays, absence of funding opportunities, lack of communication and guidance, severe reductions in force, proposed funding cuts, and proposed program eliminations have led local, state, and national organizations to fear and plan for layoffs and program closures and will lead to severe setbacks in our nation's decades long commitment to address and end domestic violence and sexual assault. These concerns have been widely covered by the media in recent weeks.¹

Office on Family Violence Prevention and Services (OFVPS)

OFVPS has yet to release Notices of Funding Opportunities (NOFOs) that continue the Office's critical work of addressing domestic violence and sexual assault services, resources, and

¹ See for example:

<https://www.npr.org/sections/shots-health-news/2025/02/07/nx-s1-5290088/cdc-funding-delays-rape-crisis-centers>

<https://www.npr.org/2025/04/08/nx-s1-5349529/hhs-layoffs-sexual-assault-rape-prevention>

<https://www.kshb.com/news/local-news/amid-growing-need-kansas-city-domestic-violence-shelter-faces-potential-federal-funding-cuts>

partnerships as laid out in FY24 report language for the Family Violence Prevention and Services Act (FVPSA). The FVPSA program supports lifesaving services, including emergency shelters, crisis hotlines, counseling, and programs for communities throughout the United States and territories. FVPSA is the only federal funding solely dedicated to domestic violence shelters and programs and is the cornerstone of our nation's efforts to address domestic violence. There are approximately 2,000 FVPSA-funded community-based domestic violence programs and over 240 tribes and tribal organizations for victims and their children. Domestic violence programs, including culturally specific programs, use FVPSA funding to keep their lights on and doors open, which is essential for victims in every community, who must have a place to which they can flee when they are escaping life-threatening violence while also keeping the community at-large safe.

Moreover, OFVPS funding and resources for sexual assault programs including culturally specific organizations are essential to addressing the long-term public health implications of sexual assault and child sexual abuse. These funds have been crucial to ensuring all victims receive supportive services, and the commitment to this work at OFVPS must continue. The appropriated investment in domestic violence, culturally specific, and sexual assault programs at OFVPS and opportunities for community leaders to inform program development to meet the needs of their communities remains a top priority for our organizations.

CDC Injury Center Division of Violence Prevention

The Rape Prevention & Education Program (RPE) and Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) programs at the CDC Division of Violence Prevention are under grave threat. Delays, massive staff cuts, huge proposed funding cuts, and a proposed restructuring imperil RPE and DELTA. Earlier this year, RPE formula grant funds to states were delayed resulting in some programs having to lay off staff. Some states have remained uncertain about subgranting funds due to the federal funding environment leading local programs to worry about the future of their prevention work. The substantial reductions in force (RIFs) issued by HHS on April 1 have interrupted essential functions of rape and domestic violence prevention efforts and threatened decades of a successful public health response to sexual assault and domestic violence. Furthermore, the RPE coalition grants are due to be renewed for the second year of a five-year contract by June 30, but the lack of a FY25 funding plan for CDC places these grants in jeopardy.

In addition, a budget passback document from the Office on Management and Budget (OMB) to HHS dated April 10, 2025 recommended consolidating and cutting the RPE and DELTA programs and moving them to a newly created agency, the Administration for a Healthy America. RPE, a formula grant that goes to State Health Departments in all 50 states, was first authorized by Congress as part of the original Violence Against Women Act in 1994. The program has been reauthorized with increased funding several times, most recently in the Violence Against Women Act of 2022 with an authorization of \$100 million. DELTA is the only federal funding source dedicated to the primary prevention of domestic violence, supporting community and societal-level strategies in 13 states and about 45 communities. In past budgets, domestic and sexual violence efforts, RPE, and DELTA combined were funded at \$107.45 million. This proposal consolidates all of these efforts into one new program funded at \$38 million. As a reminder, RPE alone was funded at \$61.75 million and DELTA at \$7.5 million in

FY24 and FY25. These plans for FY26 leave community programs and state coalitions in grave doubt about their FY25 funding as well.

Protecting and funding RPE and DELTA is not just the right thing to do—it is a strategic move toward a healthier, more prosperous future where fewer communities and individual lives are impacted by violence. Cutting or consolidating these programs will have serious consequences: fewer resources for prevention, higher long-term costs for healthcare and criminal justice, and more communities left without the tools to stop violence before it starts.

Programs at OFVPS and the CDC save lives, but they also save money. Cutting these important programs and the national organizations who support the responsible implementation of appropriated federal funds for these programs will only lead to greater inefficiency.

We urge you to communicate concrete plans for the swift release of FY25 funds appropriated to address the needs of victims of domestic violence and sexual assault and keep our communities safe.

For more information, please contact Terri Poore, National Alliance to End Sexual Violence (NAESV), or Melina Milazzo, National Network to End Domestic Violence (NNEDV).

Respectfully,

The National Task Force to End Sexual and Domestic Violence



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U.S. Department of Health & Human Services • 200 Independence Avenue, S.W. • Washington, D.C. 20201

IN THE MATTER OF	*	BEFORE THE
DAVID A. GEIER	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number:	*	Case Numbers: 2008-0022 &
(unlicensed)	*	2009-0318
* * * * *		* * * * *

CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges David A. Geier (the "Respondent") (D.O.B. [REDACTED]), an unlicensed individual, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Rep. Vol. & 2010 Supp.).

The Respondent is charged under the following provision of the Act:

§ 14-601 Practicing without license

Except as otherwise provided in this title, a person may not practice, attempt to practice, or offer to practice medicine in this State unless licensed by the Board.^{1,2}

The term "practice medicine" is defined in the Act as follows:

§ 14-101 Definitions

(l) – *Practice medicine.* – (1) "Practice medicine" means to engage, with or without compensation, in medical:

- (i) Diagnosis;
- (ii) Healing;
- (iii) Treatment; or
- (iv) Surgery.

¹ The exceptions referred to in H.O. §§ 14-601 and 15-401 are not applicable to this case.

² H.O. § 14-606(a)(4) – Penalties – provides:

- (4) ... a person who violates § 14-601 of this subtitle is:
 - (i) Guilty of a felony and on conviction is subject to a fine not exceeding \$10,000 or imprisonment not exceeding 5 years or both; and
 - (ii) Subject to a civil fine of not more than \$50,000 to be levied by the Board.

ALLEGATIONS OF FACT³

The Board bases its charges on the following facts that the Board has cause to believe are true:

1. The Respondent is not and never has been licensed to practice medicine or any other health occupation in the State of Maryland or any other State. The Respondent has a Bachelors of Art degree in biology from a Maryland State university. The Respondent has taken several graduate courses, but has not earned a graduate degree in any specialty or discipline.
2. As detailed below, on October 8, 2008, the Board received a complaint from the mother ("Parent A") of a former patient of Dr. Mark R. Geier ("Patient A", below).⁴ Parent A complained *inter alia* that the Respondent examined and diagnosed her son at an office visit on May 19, 2008.
 - I. **The Respondent's Curriculum Vitae ("CV")**
3. According to the Respondent's CV, which the Board obtained in furtherance of its investigation, in 2008, the Respondent was a co-founder of ASD Centers, LLC,⁵ the slogan of which is: "where medical solutions for autism can be found..." The Respondent is the "Executive Director" of

³ The allegations set forth in this document are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.

⁴ Patient A in this document corresponds to Patient C in the Board's Order for Summary Suspension of Mark R. Geier, M.D.'s medical license. Names of patients and other individuals are confidential. The Respondent may obtain the names from the Administrative Prosecutor.

⁵ ASD is the abbreviation for autism spectrum disorder.

ASD Centers. The Respondent's father, Mark R. Geier, M.D.,⁶ is a co-founder of ASD Centers and its President.

4. In the Respondent's CV, he describes ASD Centers as, "a national network of genetic centers with locations in Missouri, Florida, Texas, Illinois, Indiana, New Jersey and Maryland involved in the evaluation and treatment of more than 600 patients diagnosed with autism spectrum and other neurodevelopmental disorders."
5. According to the Respondent's CV, in 1999 he founded and is currently the President of MedCon, Inc., an entity which he describes as conducting "medical-legal consulting and biochemical-epidemiological research." MedCon's address is the Respondent's home address, where he resides with Mark R. Geier, M.D.
6. From 2004 to "the present,"⁷ the Respondent was "on staff" at the Genetic Centers of America, which he describes as "[c]enters involved in the evaluating and treat (*sic*) several hundred patients with autism, neurodevelopmental disorders, and other chronic diseases. In addition, these centers help to provide prenatal genetic care and adult predictive genetic care."
7. In 2006, the Respondent founded and is currently the Vice President of the Institute of Chronic Illnesses, Inc. ("ICI"), "a non-profit 501(C)(3)

⁶ Effective April 27, 2011, the Board summarily suspended Dr. Geier's license to practice medicine in Maryland concluding that his treatment of autistic children with Lupron, a potent anti-androgen, and in some instances, chelation therapy, constituted a substantial risk of serious harm to the public health, safety or welfare. On May 12, 2011, after a hearing before the Board, the Board issued an Order to continue Summary Suspension.

⁷ The Respondent's CV contains entries through 2009.

foundation dedicated to studying chronic illnesses.” ICI’s address is the Respondent’s home address. Dr. Mark R. Geier is the President of ICI.

8. In 2007, the Respondent founded and is currently Vice-President of CoMeD, Inc. [Coalition for Mercury-Free Drugs], an entity described on one of its websites as “a not-for-profit 501(c)(3) corporation that is actively engaged in legal, educational and scientific efforts to stop all use of mercury in medicine and to ban the use of all mercury-containing medicines.” CoMeD, Inc.’s address is the Respondent’s home address. On CoMeD, Inc.’s website, the Respondent’s father is identified as the Treasurer of the corporation.

Complaint Alleging that the Respondent Practiced Medicine without a License

9. In her complaint, Patient A’s mother (“Parent A”) alleged that the Respondent examined her autistic son during a May 19, 2008 appointment at Genetic Centers of America (also referred to “Genetic Centers of Maryland” or “Genetic Consultants”). Parent A knew both the Respondent and his son, having met them both at a July 2005 consultation. The Board designated this complaint as Case Number 2009-0318.⁸
10. Patient A, was ten (10) years old when he was initially evaluated by Dr. Mark Geier in July 2005. Patient A had been diagnosed as autistic at age three (3), having regressed in his development when he was two (2) years old.

⁸ The Board had previously opened Case Number 2008-0222 as part of its investigation of Dr. Mark R. Geier.

11. Parent A had been drawn to Dr. Geier's practice because of his prior research experience at the National Institutes of Health ("NIH") and because she believed that he was an expert on the possible impact of mercury on children with autism.
12. At the initial 2005 visit, Dr. Geier observed some hair development on Patient A's legs and arms. He also noted that Patient A had received a DPT⁹ vaccination in France, after which he had a high fever.
13. Based on his interview with Parent A and his observations of Patient A, Dr. Geier diagnosed him with unspecified developmental delay, possible precocious puberty and possible childhood heavy metal exposure (mercury).
14. Dr. Geier's plan, as documented in the office note, was to prepare a laboratory work-up to assess Patient A's current health and potential causal factors for his developmental delays and then to arrange for a follow-up consultation with Patient A's mother to discuss findings and possible treatment directions.
15. Parent A did not follow-up on the 2005 initial visit. She had sought treatment for Patient A from a neurologist and did not want to interfere with his treatments.
16. In the Spring of 2008, Patient A's mother saw a YouTube video in which Dr. Geier's theory regarding the causal effect of mercury and testosterone

⁹ The abbreviation for diphtheria, pertussis (whooping cough) and tetanus.

on autism was discussed by a mother of one of his patients.¹⁰ In her complaint to the Board, Parent A wrote:

[r]elying on Dr. Geier's growing reputation as an expert witness in autism-related court cases, and his credentials as a medical geneticist, I trusted that he had the expertise to perform a competent evaluation and treatment of my son....I thought that Dr. Geier might be able to conduct tests to determine whether there was a genetic basis for my son's autism, and whether he had high testosterone. It seemed that such testing might offer some insight into his condition, and that the treatment described in the video might offer him some relief and might even eliminate his autism.

17. Parent A scheduled an appointment for Patient A to be seen by Dr. Geier on May 19, 2008 at the Genetic Centers of America's office in Rockville, Maryland.
18. On May 19, 2008, after waiting with her son for approximately one (1) hour in the waiting room, Parent A and her son were taken to an office where the Respondent was seated behind a desk.
19. Parent A and the Respondent discussed genetic testing for approximately the first half-hour of the visit.
20. Parent A reported that the Respondent, after asking very few questions regarding Patient A's medical history and symptoms, told her that he was absolutely certain that her son seemed to be a "typical high-testosterone kid" whose growth would be stunted if his testosterone production continued at its current pace.
21. Board staff interviewed Parent A during the course of the investigation. Parent A stated that she did not recall whether the Respondent had

¹⁰ This individual is President of CoMeD and is a member of ICI's Institutional Review Board ("IRB").

identified himself as a physician at the May 19, 2008 office visit; however, she had assumed that the Respondent was a physician because he was the only person with whom she had spoken about her son at that visit. She also noted that the Respondent "had this certainty about him."

22. At no time during the May 19, 2008 office visit did Parent A see, much less speak to, Dr. Geier. The Respondent was the only person who examined her son.
23. According to Parent A, the Respondent performed an ultrasound examination on Patient A, who by then was too restless to sit or lie still on the examining table. The Respondent told Parent A that he needed an ultrasound of Patient A's thyroid. The Respondent followed Patient A as Patient A walked around the room, attempting to examine his neck and abdomen by tapping him with the ultrasound wand.
24. When Parent A asked the Respondent how he could possibly obtain an accurate reading under such circumstances, the Respondent replied that everything was "okay" and that the test results were "normal."
25. The note of the May 19, 2008 visit¹¹ indicates that "comprehensive" abdominal and thyroid ultrasounds were performed. Patient A's physical appearance is described as suggesting "advancement from his chronological age."

¹¹ The note was typed on a "Patient Interview Form." Dr. Geier's name is typed at the bottom of the report, it is neither signed nor initialed.

26. Prior to seeing the Respondent on May 19, 2008, Parent A completed an Autistic Treatment Evaluation Checklist ("ATEC") form.¹² Parent A indicated on the form that hitting or injuring others was a "minor problem"¹³ for Patient A and that hitting or injuring himself was a "moderate problem." The only behaviors Parent A described as serious problems were Patient A's hyperactivity, fixation on certain objects or topics and repetitive movements. Notwithstanding Parent A's description of Patient A, the Respondent documented that Patient A appeared to be "potentially significantly physically aggressive to himself and/or others." The Respondent failed to specifically describe Patient A's aggressive conduct, except that to note that "[Patient A]...can be destructive, his (*sic*) or injuries (*sic*) self or others." The Respondent also noted that Patient A "suffers from significant sleep cycle problems," although Parent A had noted on the ATEC form that "sleep problems" were only a moderate problem for Patient A.
27. The Respondent documented in "Psychological Examination" section of the note: "It is apparent based upon examination of the DSM-IV criteria that [Patient A]'s present symptoms are compatible with a diagnosis of pervasive developmental delay – not otherwise specific (*sic*)."

¹² The ATEC is a listing of twenty-five (25) behaviors and abilities; the individual who completes the form is asked to indicate from three (3) or four (4) descriptive phrases for each behavior that best describes the patient.

¹³ The descriptors for the "Health/Physical/Behavior" portion of the ATEC are: not a problem; minor problem; moderate problem and serious problem.

28. The Respondent documented the following Impression: 1) PDD-NOS,¹⁴ 2) Sleep problems (insomnia) and 3) Unspecified Metabolic Disorder. The Respondent's plan was to prepare a laboratory work-up after which a follow-up consultation would be scheduled to discuss treatment. Twenty-six (26) laboratory studies are listed in the plan.
29. According to Parent A, the Respondent inquired if she was going to have any problems with how expensive the laboratory studies were going to be and discussed the accuracy of results of certain laboratories. Parent A responded that she was not concerned about the price because she wanted to learn whether her son had a genetic basis for his autism and wanted the most accurate results. The Respondent advised that he would have the laboratory order forms mailed to Parent A.
30. Several days after the office visit, Parent A received in the mail a laboratory order for four (4) diagnostic tests to be conducted at Laboratory A (5-Androstane-3, 17-Diol Glucuronide; Androstendione; DHEA and testicular function). The Respondent initialed that he had completed the form on May 22, 2008 and printed his father's name as the ordering physician.
31. Upon receipt of the laboratory order form, Parent A called the Respondent because the test order did not include the genetic tests she and the Respondent had discussed. The Respondent agreed to send another laboratory order.

¹⁴ The abbreviation for Pervasive Developmental Disorder – Not Otherwise Specified.

32. Parent A received the second laboratory order several days later; it was written for over twenty (20) tests from Laboratory B.
33. According to Parent A, Laboratory B personnel were “flummoxed by the amount of blood needed for the tests” and she instructed them to draw only as much blood as was necessary to assay some genetic conditions, urine metals and porphyrins, the latter because the Respondent had emphasized their importance during the visit.¹⁵
34. Parent A began to wonder why the Respondent would order so many laboratory tests that required drawing so much blood from children and then searched the internet for more information about the Geiers’ practice. It was from her research that Parent A learned that the Respondent was not a physician.
35. Parent A closely examined the laboratory orders and discovered that the Respondent had written the diagnostic code for insomnia on the first order form; on the second order form he had noted both the diagnostic codes and the diagnoses insomnia, NOS [not otherwise specified] and metabolism disorder, NOS.
36. Parent A did not return to Genetic Centers of Maryland after the May 19, 2008 office visit.
37. In late July 2008, Parent A received billing statements from Genetic Consultants of Maryland with charges listed for four (4) separate dates:

¹⁵ Laboratory B submitted an invoice to Parent A in the amount of \$3,915.96 for the laboratory studies that Parent A had requested. Parent A’s health insurance paid \$1,169.68 (\$2,453.76 had been “discounted”); Parent A was billed \$292.42.

May 19, May 22, June 17 and June 18, 2009. The charges, which totaled \$1,200.00, were as follows:

May 19, 2008 – Office Consultation (99215) - \$ 150.00
Neck Ultrasound (76536) - \$225.00
Abdominal Ultrasound (76700) - \$225.00
Psychiatric Diag[nostic] Interview Exam (90801) - \$150.00

May 22, 2008 – Prolonged 1st hour Eval[uation] and Management (99358) - \$150.00

June 17, 2008 – Prolonged 1st hour Eval and Management (99358) - \$150.00

June 18, 2008 – Prolonged 1st hour Eval and Management (99358) - \$150.00

38. After receiving the bills from Genetic Centers of Maryland, Parent A called the office and demanded a copy of all records of her son's May 19, 2008 evaluation and all of his test results.
39. Parent A received Patient A's test results from Genetic Centers of Maryland in early September 2008, but as of the date of this document has not received any of the other records she had requested.
40. A Phone Contact Sheet in Patient A's Genetic Center chart contains three (3) entries: the latter two (2) were written and initialed by the Respondent:¹⁶

5-22-08: Mailed lab specimen

6-17-08: 2 p.m. Consultation with [Patient A]'s mother re: lab testing for her son. Reviewed lab scripts and testing procedures at [Laboratory A] v. [Laboratory B]

6-18-08: 9 p.m. Registered & completed lab script for [Patient A] with [Laboratory B] using online 360 software.

¹⁶ When interviewed by Board staff in furtherance of its investigation, the Respondent acknowledged that he had written the June 17 and 18, 2008 entries.

Other Genetic Center Patients

41. In furtherance of the Board's investigation of Dr. Mark Geier, the Board obtained a peer review of the records of nine (9) of Dr. Geier's Genetic Center patients. A review of those records revealed that the Respondent documented consultations with parents; the results of ultrasound procedures and patient-specific treatment plans in which medications were started or dosages of current medications were revised. In all of the notes discussed below, the Respondent initialed his handwritten notes. Dr. Geier did not initial, co-initial or sign these notes as he did in other notes, nor did the Respondent indicate, as he did in other notes, that Dr. Geier was present during the consultations and/or that it was Dr. Geier who made the treatment recommendations.

Patient B¹⁷

42. Patient B, a female, was nine (9) years and three (3) months old when she initially presented to the Respondent on May 2, 2007.¹⁸ According to the notes in Patient E's chart, she was diagnosed with autism at the age of two (2).
43. On October 10, 2007, the Respondent documented an office visit with Patient B's mother "to evaluate the effects of ↑ Lupron SQ dosing." The Respondent documented that the "plan is to continue with present dosing. Will re-evaluate & follow-up with mother re: dosing when labs are back."

¹⁷ Patient B corresponds to Patient E in Dr. Geier's Order of Summary Suspension.

¹⁸ The vast majority of the Respondent's notes in the reviewed cases were handwritten and consisted of phrases. Several of Patient E's office notes were typed and consisted of lengthy narratives.

44. The Respondent further documented that Patient B's mother had questioned the use of an antiviral medication. The Respondent noted: "[a]t present time, [illegible] [medication] has been agreed by mutual consent to be put off."

Patient C¹⁹

45. Patient C, a female, was eight (8) years and seven (7) months old on March 14, 2008 when she was initially assessed by Dr. Geier during a telephone consultation. Patient C had been diagnosed with ASD at 23 months of age.
46. On June 23, 2008, the Respondent documented an office visit with Patient C. The Respondent documented that Patient C was seen in the office for an examination, review of laboratory results and discussion of a potential treatment plan. The Respondent documented the results of a Wood's lamp examination, a neck ultrasound and various laboratory results. The Respondent's note reads in pertinent part:

Assessment is that pt has a toxic encephalopathy & associated ↑ body-burden of heavy metals, particular (*s/c*) Hg [mercury], base upon ↑ urinary porphyrins.²⁰ Pt also has evidence of mitochondrial dysfunction. Additionally, pt has evidence of premature puberty with associated pituitary dysfunction....Plan is to: 1) start Lupron²¹ SQ & IM,²² &

¹⁹ Patient C corresponds to Patient H in Dr. Geier's Order of Summary Suspension.

²⁰ The Respondent and Dr. Geier have reported that "[m]ercury toxicity [is] associated with elevations in urinary [porphyrins]. . . Porphyrins need to be routinely measured in ASDs to establish if mercury toxicity is a causative factor and to evaluate the effectiveness of chelation therapy." Geier, D.A. and Geier, M.R. *A prospective study of mercury toxicity biomarkers in autistic spectrum disorders*. *J. Toxicol. Environ Health A.*, 20 (2007).

²¹ Lupron is a potent anti-androgen; it lowers the testosterone level the body produces. The only medically accepted use of Lupron for children is precocious (or premature) puberty.

²² IM is the abbreviation for intramuscular injection; SQ is the abbreviation for subcutaneous injection.

Aldactone 50 mg BID²³ for premature puberty; 2) start Carnitor liquid for mitochondrial dysfunction; 3) start B-12 – folonic acid for sulfur-bearing amino SNPs in MTHFR;²⁴ 4) start vitamin D 1,000 mg IU BID for low vitamin D; 5) start melatonin sublingual for sleep disturbance; & 6) will start metal DMPS²⁵ in futer (*sic*) @ present stop all chelation.

47. On January 28, 2009, the Respondent documented “authorized with pharmacist 6 additional refills of Lupron Dept 15 mg kits...”

Patient D²⁶

48. Patient D, a male, was nine and one-half (9½) years old when Dr. Geier initially assessed him during a telephone consultation on March 21, 2006.
49. On January 7, 2008, the Respondent documented a consultation with Patient D's mother regarding blood in Patient D's stools. The Respondent noted in pertinent part:

Mother reported she has been recently administering [Patient D] mega-doses of vitamin C....Plan is as follows: a) told mother to keep [Patient D] off high-dose vitamin C...Mother will follow up with us re [Patient D]'s clinical status.

50. On February 10, 2008, the Respondent documented:

Consulted with [Patient D]'s mother & reviewed record & decided to get [Patient D] script for Carnitor. Called in Carnitor script to pharmacy.

²³ The abbreviation for twice a day.

²⁴ SNP is the abbreviation for single-nucleotide polymorphism. MTHFR is an enzyme responsible for creating the circulating form of folate.

²⁵ Chelation therapy is the administration of chelating agents to remove heavy metals from the body. The Respondent and Dr. Geier have reported that high levels of mercury is the cause of autism. DMPS is a chelating agent that has not been approved by the Food and Drug Administration.

²⁶ Patient D corresponds to Patient I in Dr. Geier's Order of Summary Suspension.

Internet Communications Regarding the Respondent

51. The internet provides topic-specific forums for interested individuals to exchange ideas. In furtherance of its investigation, Board staff reviewed public communications posted in chat groups for parents of children with autism. A sampling of the messages pertaining to the Respondent follows.²⁷

52. Parent Consultations with the Respondent:

- a. Posted January 6, 2007: [the child's hormone levels are discussed] "David Geier said it's like she's in a constant state of PMS. He also said that we will see her 'move more towards neurotypical.'"
- b. Posted June 13, 2007: "...We had our consultation with David yesterday. [The child's hormone levels are discussed]. David was very nice on the phone and really explained the science."
- c. Posted June 14, 2007: "...David did tell my [x] son that the Lupron might make him 'not as strong', but that it would not do much more than that."
- d. Posted July 9, 2007: "I don't know what to do. David upped the dailies [Lupron SQ injections] from .4 to .5 last week and [the child] is still getting worse....I try to be as prepared as I can with all that is going on with her when David calls."
- e. Posted July 2, 2008: "I spoke with David today and convinced him to try the oral DSMA with [the child] again..."

²⁷ The Administrative Prosecutor will provide the specific address of the messages upon the Respondent's request.

- f. Posted October 3, 2008: "...David Geier recommend (*sic*) that since [the child] is doing so well on the Lupron that we try to get him off (*sic*) of all of his meds. I did this very slowly...and once we stopped everything it was a disaster!!!!"

53. **The Respondent and Dr. Geier as a Team**

- g. Posted March 21, 2006: [regarding the cost of Lupron injections] "Yes, they're expensive, but covered by insurance. I think it's nice that the Geiers work with insurance companies. If they didn't, we wouldn't be able to do this protocol."
- h. Posted March 21, 2006: "I love the Geiers – very competent, knowledgeable and in this for all the right reasons but please remember that the whole mercury, testosterone, Lupron, etc. is just a THEORY that they are trying to prove." [emphasis in original]
- i. Posted May 22, 2006: "We had a bout of regression when we added DSMA chelation to the protocol...after which the Geiers took her off the chelator."
- j. Posted November 7, 2006: "...the Geiers want to wait to chelate until the aggressions/testosterone is under control, because the chelation will make it worse...[discussion regarding the child's body] "which according to David and Dr. Geier, is not so typical of autistic kids."
- k. Posted June 26, 2007: "...I started emailing Dr. Geier and David directly with questions/concerns. And anything of an urgent matter,

one of the two gentlemen has always called me right away. I also use email to keep them updated on their progress. (I have [x] children on the protocol.)”

- I. Posted June 26, 2007: [regarding the start of chelation therapy for one of several children] “Dr. Geier and David just wanted him to be on the Lupron for awhile before starting the chelation.”

54. The Respondent's Qualifications

- m. Posted September 22, 2006: “Dr Geier (David) explained to me the other night [about effect of Lupron].”
- n. Response to above posting: “Dr. Geier’s name is Mark....David isn’t a doctor. But I’m confident he will get his PhD some day. He sure the heck is smart enough!”
- o. Response: “I had found out in August that David is not also a doctor, but it is already a habit for me to call him Dr. Geier...by the time I ‘untrain myself’. He will probably be one! LOL!!”
- p. Posted December 11, 2006: [Discussion by a health care provider who returned to the “Geiers” after an initial consultation to inquire about Lupron] “First of all Dr. Mark Geier was not in the room the son was giving us the lab result and the treatment protocol. As a [health care provider] I found that to be odd because the son is not an M.D. therefore I felt this was practicing without a license.”

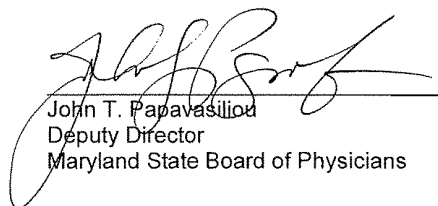
The Respondent’s conduct, in whole or in part, constitutes the practice of medicine without a license, in violation of H.O. § 14-601.

If, after a hearing, the Board finds that there are grounds for action under H.O. §§ 14-601, the Board may impose a monetary penalty.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter is scheduled for **Wednesday, July 6 2011 at 10:00 a.m.** the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference and prehearing conference is described in the attached letter to the Respondent. If this matter is not resolved on terms accepted by the Board, an evidentiary hearing will be scheduled.

5/16/2011
Date


John T. Papavasiliou
Deputy Director
Maryland State Board of Physicians

IN THE MATTER OF	*	BEFORE THE
DAVID A. GEIER	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
Unlicensed	*	Case Nos.: 2008-0022 & 2009-0318
* * * * *	*	* * * * *

FINAL DECISION AND ORDER

On May 16, 2011, the Maryland State Board of Physicians (the "Board") charged David A. Geier with practicing medicine without a license. *See* Md. Code Ann., Health Occ. § 14-601. On December 15, 2011, an evidentiary hearing was held before an administrative law judge ("ALJ") of the Office of Administrative Hearings ("OAH"). The same ALJ who presided over David Geier's case also presided over two recent Board cases against David Geier's father, Mark Geier, M.D. ("Dr. Mark Geier"). One of those proceedings concerned the summary suspension of Dr. Mark Geier's medical license ("Dr. Mark Geier's Summary Suspension Hearing"). In the other proceeding, the Board charged Dr. Mark Geier with violating the Maryland Medical Practice Act ("Dr. Mark Geier's Charges Hearing").

At David Geier's OAH hearing, Linda Grossman, M.D., an expert witness for the State, testified. David Geier, on his own behalf, also testified at the hearing. In addition, transcripts of testimony from the following witnesses at Dr. Mark Geier's Charges Hearing were admitted into evidence: Dr. Mark Geier; David Geier; Dr. Grossman; and Joshua Schafer, a Board investigator. Also, transcripts of testimony from the following witnesses from Dr. Mark Geier's Summary Suspension Hearing were admitted into evidence: Parent A (the mother of Patient A) and the mothers of Patients B, and C (as those letters were used during David Geier's hearing), and the mothers of Patients A, B, and F (as those letters were used during Dr. Mark Geier's Summary

Suspension Hearing).¹ The documents that were admitted into evidence are listed in the ALJ's File Exhibit List.

On March 7, 2012, the Administrative Law Judge issued a proposed decision recommending that the Board dismiss the charges. The administrative prosecutor filed exceptions. On May 25, 2012, the Board held a hearing on the exceptions.

FINDINGS OF FACT

The following findings of fact were proven by a preponderance of the evidence²:

David Geier has never obtained a license to practice medicine nor has he held a license to practice any health occupation. In 2002, he obtained a Bachelor of Arts degree from the University of Maryland, Baltimore County. He has not attended any medical school.

David Geier has founded and is an executive of the following organizations: MedCon, Inc., which, according to David Geier's curriculum vitae, involves "Medical-Legal Consulting & Biochemical-Epidemiological Research"; the Institute of Chronic Illnesses, Inc., which is "dedicated to studying chronic diseases"; CoMeD, Inc., which advocates for those "adversely impacted by environmental and medicinal toxins"; and ASD Centers, LLC, which is involved in "the evaluation and treatment of more than 600 patients diagnosed with autism spectrum and other neurodevelopmental disorders."

In addition to his work on the organizations he founded, David Geier was "on staff" at his father's, Dr. Mark Geier's,³ clinical practice, named the Genetic Centers of America ("Genetic Centers"). Genetic Centers operates two medical clinics in Maryland. One clinic is located at 11125 Rockville Pike, Rockville, Maryland 20852, and is called Genetic Consultants of

¹ Different letters were used to identify the patients at the various hearings.

² Additional factual findings discussed in this decision were also proven by the preponderance of the evidence.

³ During the events at issue, Dr. Mark Geier was licensed to practice medicine in Maryland.

Maryland (“Genetic Consultants”).⁴ The other clinic is located at 20 Crossroads Drive, Owings Mills, Maryland 21117, and is called Genetic Center of Baltimore. In addition to Dr. Mark Geier, one other licensed physician worked at Genetic Centers. According to David Geier’s curriculum vitae: “Centers involved (*sic*) in evaluating and treat (*sic*) several hundred patients with autism, neurodevelopmental disorders, and other chronic diseases. In addition, these centers help to provide prenatal genetic care and adult predictive genetic care.” David Geier’s curriculum vitae does not describe his responsibilities at Genetic Centers.

PATIENT A

July 1, 2005

On July 1, 2005, Patient A, a male, was 10 years old and, with his mother, Parent A, met with Dr. Geier and David Geier at Genetic Consultants for a medical appointment. Patient A has autism, and the appointment was for the treatment of his autism. An Autism Treatment Evaluation Form (“ATEC”)⁵ was completed and scored. Parent A was not made aware of David Geier’s credentials. Dr. Mark Geier and David Geier took extensive notes of their interview with Parent A and Patient A. Genetic Consultants also ordered laboratory testing at Quest Diagnostics and LabCorp for Patient A. A two-page Patient Interview Form was typed. The Impression section of the form lists Unspecified Developmental Delay, Possible Childhood Heavy Metal Exposure (Mercury), and Possible Precocious Puberty. Dr. Mark Geier’s name is

⁴ According to Dr. Mark Geier, Genetic Consultants and Genetic Center are part of Genetic Centers of America.

⁵ The ATEC is intended to measure the severity of a patient’s autism, and, if taken on multiple occasions, it is intended to measure whether the treatment the patient is receiving is effective. The ATEC is divided into four sections: (1) Speech/Language/Communication, (2) Sociability, (3) Sensory/Cognitive Awareness, and (4) Health/Physical/Behavior. Each section has multiple statements and asks how accurate each statement is. For example, under Speech/Language/Communication, “Can use sentences with 4 or more words,” one circles whether that statement is: Not true, Somewhat True, or Very true. Each section is scored and given a percentage range. The section scores are then combined for a final percentage range.

typed at the end of the second page. Dr. Mark Geier did not sign or initial the Patient Interview Form. Parent A did not take her son to get the ordered laboratory testing and did not return to Genetic Consultants until approximately three years later.

May 19, 2008

Parent A scheduled another medical appointment for May 19, 2008, in order for her son and herself to meet with Dr. Mark Geier concerning her son's autism. On May 19, 2008, as scheduled, Parent A and Patient A arrived at Genetic Consultants in Rockville, Maryland. Patient A was 13 years old.

While in the waiting room, Parent A was given an ATEC. She filled out the form, answering all the questions. Parent A gave the completed ATEC form to a receptionist.

A receptionist took Parent A and Patient A to an office in the clinic. When Parent A and Patient A entered the office, David Geier was in the office seated behind a desk. Dr. Mark Geier was not in the room; he was busy with another patient. David Geier was the only person in the office when Parent A and Patient A entered. There were two chairs for the "doctor's side" of the desk. (Testimony of Dr. Mark Geier, December 9, 2011, Tr. 941.) Dr. Mark Geier generally sat in the front chair and David Geier sat in the side chair to take notes. *Id.* In this case, David Geier sat in the front chair, not in the side chair. Parent A and Patient A sat on the other side of the desk from David Geier. Parent A, Patient A, and David Geier met for approximately a half-hour in this office and had a discussion. Nobody at Genetic Consultants explained to Parent A what David Geier's professional credentials were. Parent A assumed that David Geier was licensed to practice medicine. David Geier then had a discussion with Parent A and Patient A.

Dr. Mark Geier was not involved in the discussion between David Geier and Parent A and Patient A. And Dr. Mark Geier did not enter the office while the discussion took place.⁶ The Board finds that Dr. Mark Geier did not speak to Parent A or Patient A on May 19, 2008.⁷ The ALJ also found that Dr. Mark Geier did not speak with Parent A or Patient A on May 19, 2008. (ALJ's Proposed Decision, Finding of Fact 44, at 11; ALJ's Proposed Decision, at 23-24.)

In the discussion in the office with Parent A and Patient A on May 19, 2008, David Geier first said: "Looking at [Patient A], he doesn't look like he's thirteen, he looks like he's sixteen." Then, noting that the patient was beginning to grow a mustache, David Geier said that the patient "looks like a typical high-testosterone kid."

David Geier then had an extensive discussion with Parent A about laboratory testing for Patient A.⁸ Their discussion centered on genetic testing. David Geier spoke to Parent A about laboratory testing for microdeletion, to determine whether the patient had a rare genetic disorder. David Geier also told Parent A about testing for the porphyrin autism marker. Parent A agreed that her son would be tested for an array of genetic testing, including agreeing to microdeletion and porphyrin tests, and testing for Fragile X, Angelman, and Rett syndromes, among others. The testing required blood samples from the patient, which would be taken by the laboratories

⁶ The Board is not adopting the ALJ's finding on whether Dr. Mark Geier entered the office during the discussion between Parent A and David Geier. The ALJ found that Dr. Mark Geier "periodically popped" into the room without being seen and without talking to the parent. (ALJ's Proposed Decision, Finding of Fact 44, at 11; ALJ's Proposed Decision, at 23-24). The Board does not accept that finding. It is highly doubtful that in a case where a parent and patient had an appointment with a physician, the physician would enter the room where the discussion of the patient's treatment was taking place without saying a word (including not even greeting the parent and patient) and without even being noticed by the parent.

⁷ Parent A testified that she did not speak to Dr. Mark Geier on May 19, 2008. Parent A said that she only "might have seen [Dr. Mark Geier] with the other couple and child walking by, but that was very fleeting."

⁸ Dr. Mark Geier claimed to determine the course of medical treatment for autism based upon the results of the laboratory testing. (Testimony of Dr. Mark Geier, Interview, November 6, 2007, at 32-33.)

performing the tests. David Geier told Parent A that he would have the orders for the laboratory testing mailed to her.

After the discussion in the office, David Geier, Parent A, and Patient A went into another room for abdominal and thyroid ultrasounds of the patient. The sonographer then entered the ultrasound room. The patient was not cooperative with the ultrasound. According to Parent A, “he was running around the room, he was even behind the equipment.” Before the ALJ, David Geier testified: “Specifically, in the sonogram room, that he was engaged in kicking behavior and so I tried to help hold his feet.”⁹ The ultrasounds were attempted, although no ultrasound photographs were taken due to Patient A’s behavior. Dr. Mark Geier was not in the ultrasound room. David Geier wrote the patient’s name in the abdominal ultrasound report and, in the date section, wrote the patient’s identification number. The section titled “Patient History/Reason for Ultrasound” was left blank. The sonographer checked boxes on the report indicating that Patient A’s kidneys, spleen, and gallbladder were normal. Dr. Mark Geier wrote on the abdominal ultrasound report: “Slightly limited exam due to non-cooperation from pt. MG [Dr. Mark Geier’s initials].” The sonographer did not sign, initial, or date the report. Concerning the thyroid ultrasound, the sonographer wrote: “Please note that this ultrasound was performed with a C5-2M transducer. This can only rule out gross abnormalities.” The sonographer also wrote measurements for the right and left lobes. Dr. Mark Geier initialed the thyroid ultrasound note. The sonographer did not sign or initial the report. The report is dated May 19, 2008. The sonographer’s name is not mentioned on either report. After the ultrasound, Parent A and Patient A did not return to the office where the earlier discussion took place that day.

⁹ Dr. Mark Geier testified that David Geier “occasionally” goes into the sonogram room to help control children, by holding the children’s legs, when they kick.

On or about May 19, 2008, David Geier scored the ATEC and wrote the scores on the ATEC form. David Geier did not date, sign, or initial the ATEC.

David Geier also wrote a Patient Interview Form report concerning the May 19, 2008, visit. The Board finds that the Patient Interview Form was written by David Geier on or about May 19, 2008.¹⁰ The Patient Interview Form is typed, three pages, and single-spaced and includes the following sections: Diagnosis, History, Present Consultation, Ultrasound Examination, Medications, Sexual Development, Psychological Examination, Impression, Plan, and a list of labs that should be ordered from LabCorp and Quest Diagnostics. The section titled Psychological Examination states:

A follow-up evaluation of [Patient A] was undertaken using the Autism Treatment Evaluation Checklist (ATEC) completed by [Patient A's] mother and evaluated by me.¹¹ The results indicate that [Patient A] continues to show significant (*sic*) overall development delays (overall score at present = 60-6[9]% vs overall score previously = 70-79%). He continues to have significant problems with his sociability and sensory/cognitive awareness skills. [Patient A] has serious problems with hyperactivity and stemming behaviors. In addition, [Patient A] suffers from significant sleep cycle problems and can be destructive, his or injuries (*sic*) self and others, and is anxious/fearful. It is apparent based upon examination of the DSM-IV criteria that [Patient A's] present symptoms are compatible with a diagnosis of pervasive developmental delay (*sic*) – not otherwise specific (*sic*) (PDD-NOS).

Under the Impression section, David Geier wrote: PDD-NOS, Sleep Problems (Insomnia), and Unspecified Metabolic Disorder.

¹⁰ The only date on the form (other than the patient's date of birth) is May 19, 2008, which refers to the date of the interview. It is possible that the form was written at a later date, but the form was not written after May 22, 2008. After May 22, 2008, the information in the form would have been outdated. The form refers to LabCorp tests that *should* be ordered. Those tests *were* ordered on May 22, 2008. Dr. Mark Geier testified that he did not know when it was typed.

¹¹ David Geier testified that he scored the ATEC. (State's Ex. 20, Tr., 12/15/2011, at 130.) Dr. Mark Geier testified that he suspected that David Geier scored the ATEC. (State's Ex. 19, Tr., 12/9/2011, at 943.)

The Patient Interview Form also lists four tests (with code numbers) that should be ordered from LabCorp: Androstane Diol Glucuronide, Androstenedione, Dehydroepiandrosterone (DHEA), and Testicular Function Profile II. The form also lists 22 tests that should be ordered from Quest:

1. Gene Alter, Postnatal, CGH
2. Fragile X DNA w/Chromosome, BLD
3. Rett Syndrome Mutation
4. Prader-Willi/Angelman Syndrome
5. Heavy Metals Group II, Blood
6. Heavy Metals, Complete, Urine
7. Zinc, RBC;
8. Copper, RBC
9. RBC Folate, B12 Folate
10. Porphyrins, Fractionated, Plasma
11. Porphyrins, Fract, Random Urine
12. Carnitine & AcylCarnitine
13. Ammonia, Plasma
14. Lactic Acid, Plasma
15. Vitamin B6
16. Vitamin A (Retinol)
17. Vitamin D, 1,25-Di & 25-Hydroxy
18. Myelin IGG AB, IFA+
19. 22Chem W-eGFR, AMY, LIP, UA
20. Organic Acids, QT, UR, full
21. Amino Acid Analysis, LC-MS (P)
22. Estrogens, Fract, Serum.

Each test had a code number next to it. The Patient Interview Form also has Dr. Mark Geier's name – "Mark R. Geier, M.D., Ph.D., FABMG, FACE" – typed at the end of the report on page three. Dr. Mark Geier testified that he usually initials or signs the Patient Interview Form if someone shows it to him. Dr. Mark Geier did not sign, date, initial, or otherwise mark the May 19, 2008, Patient Interview Form.¹² David Geier is not mentioned by name on the

¹² In contrast, there are Patient Interview Forms signed by Dr. Mark Geier, such as Patient B's. (State's Ex. 8, at MG11077.)

form. David Geier, however, wrote and typed the Patient Interview Form without Dr. Geier's input or review.

Genetic Consultants billed the insurance company covering Patient A \$150 for a "psychiatric diag interview exam" for May 19, 2008. In addition, for May 19, 2008, Genetic Consultants billed the insurance company \$150 for an office consultation, \$225 for a neck ultrasound, and \$225 for an abdominal ultrasound. David Geier determined the billing for Genetic Consultants.

May 22, 2008

On May 22, 2008, David Geier completed an order form for laboratory testing for Patient A at LabCorp. (State's Ex. 7, at MG10865.) David Geier wrote at the top of the form: "Completed 5/22/2008 Dg [David Geier's initials]." The order was written on a LabCorp form. The number 53958831788 is printed several times on the order form. David Geier entered the code for insomnia under the diagnosis section. In the Physician's Signature space on this LabCorp form is a signature that reads "Dr Mark Geier."¹³ The Board agrees with the ALJ that the "D" in the "Dr" immediately preceding "Mark Geier" "is remarkably like the formation of the first letter in Respondent's [David Geier's] first name." (ALJ's Proposed Decision, at 17.) In other words, the handwriting of the "D" in "Dr" preceding "Mark Geier" has an uncanny resemblance to the distinctive "D" in David Geier's initials when David Geier initials a document. David Geier signed "Dr. Mark Geier" in the Physician's Signature section of the May 22, 2008, LabCorp order form.

¹³ It is possible to view the signature as "D Mark Geier," but upon very close inspection there appears to be a slight squiggle at the end of the D which the Board finds was intended to be an "r." Thus, the Board finds that the signature says "Dr Mark Geier" instead of "D Mark Geier."

The LabCorp order form requests four tests, which are the same four lab tests listed on the May 19, 2008, Patient Interview Form as tests that should be ordered from LabCorp. On May 22, 2008, Genetic Centers mailed the LabCorp order to Parent A. Genetic Centers' contact sheet states: "5-22-08 Mailed Lab Specimen 53958831788." No signature or initials are next to this entry. This entry indicates that Genetic Centers mailed the LabCorp order form to Parent A on May 22, 2008. Genetic Consultants billed the insurance company \$150 for a prolonged 1st hour evaluation and management for May 22, 2008. David Geier determined the billing. Shortly thereafter, Parent A received the LabCorp testing order in the mail.

David Geier, however, forgot to order the 22 lab tests from Quest.

June 17, 2008

On June 17, 2008, Parent A had a telephone conversation with David Geier. Parent A called Genetic Consultants because she only received the LabCorp order, which did not include the genetic testing that Parent A had discussed with David Geier during the visit on May 19, 2008 (the testing that David Geier forgot to order, i.e., the Quest testing). David Geier agreed to send the order for the missing testing. Parent A did not speak with Dr. Mark Geier. An entry on Genetic Centers' contact sheet, written and initialed by David Geier, states: "Dg [David Geier's initials] 2PM 6-17-08 Consultation with [Patient A's] mother re: lab testing for her son. Reviewed Lab scripts & testing procedures @ LabCorp vs Quest."

Genetic Consultants billed Patient A's insurance company \$150 for a prolonged 1st hour evaluation and management. David Geier determined the billing.

June 18, 2008

On June 18, 2008, as he had agreed to do the day before on the telephone with Parent A, David Geier typed in the order for the 22 tests for Quest which he had forgotten to order after the

May 19, 2008, visit. David Geier also registered the patient with Quest. Genetic Centers' contact sheet states: "Dg 9PM Registered & completed lab script for [Patient A] with Quest using Online 360 software." The Quest order form is dated "6/18/2008" and lists the same 22 tests and test codes listed on the May 19, 2008, Patient Interview Form for testing that should have been ordered from Quest. There is no signature line on the order form. The diagnoses David Geier listed on the order form are Insomnia, NOS and Metabolism Disorder NOS. The Quest testing order was mailed to Parent A. Parent A received the Quest order form shortly thereafter. Parent A and Genetic Centers had no further contact. Genetic Consultants maintained a copy of the Quest order form. Genetic Consultants billed Patient A's insurance company \$150 for a prolonged 1st hour evaluation and management. David Geier determined the billing.

July 11, 2008

On July 11, 2008, Parent A took Patient A to Quest for the 22 blood tests. Quest asked Parent A if she realized how many tubes of blood would be needed for all the blood. According to Parent A, she understood, after a discussion with Quest, that the 22 tests would involve an "insane amount of blood," and that one couldn't draw that much blood in one sitting. Parent A opted only for the testing that she considered appropriate. By July 23, 2008, Quest had completed the reports for the testing and sent the results to Genetic Consultants. Genetic Consultants maintained the Quest reports in its file for Patient A. Genetic Consultants did not attempt to schedule another appointment and did not take any further action in regard to Patient A. Parent A did not take her son to LabCorp for testing.

October 2, 2008

After taking her son to Quest for the laboratory testing, Parent A began to research David Geier and Dr. Mark Geier through the internet and learned that David Geier was not a physician. Parent A was also upset after receiving billing statements from Genetic Consultants, which contained billing inconsistent with the services provided. Parent A was also disappointed that there was no follow through by Genetic Consultants after the Quest laboratory testing results had been sent to Genetic Consultants. On October 2, 2008, Parent A filed a complaint with the Board concerning her interactions with David Geier and Genetic Consultants in 2008.

CREDIBILITY DETERMINATIONS

The ALJ determined that David Geier was more credible than Parent A. The Board rejects this credibility determination. After carefully reviewing the transcripts and the documents admitted into evidence, it is clear that David Geier's testimony was not reliable and that he was not a credible witness. Dr. Mark Geier's testimony from his Charges Hearing was also admitted into evidence. Dr. Mark Geier's testimony also was not reliable or credible. In addition to being misleading, evasive and implausible, the testimony of David Geier and Dr. Mark Geier contradicted each other and the documentary evidence. Often times, their testimony was self-contradictory. While at times noting obvious discrepancies in their testimony, the ALJ failed to adequately address those discrepancies. The ALJ also failed to adequately address the contradictions between David Geier's and Dr. Mark Geier's testimony, the contradictions between their testimony and the medical records, and their self-contradictory statements. Parent A's testimony, on the other hand, was much more consistent and aligned with the records in evidence.

In addition, the ALJ's negative credibility determination regarding Parent A in this case was based upon grounds that were different from the basis of her credibility determination that she previously made regarding Parent A concerning the same testimony, which was transcribed from Dr. Mark Geier's Summary Suspension Hearing. The same ALJ presided over the evidentiary hearing regarding Dr. Geier's Summary Suspension. In the ALJ's view, Parent A lacked credibility in that case because Parent A did not even notice a fourth person (the sonographer) in the ultrasound room. This observation by the ALJ was incorrect. Parent A had consistently maintained that there was a fourth person in the room. The administrative prosecutor pointed out that the basis of the ALJ's negative credibility determination was incorrect. After the administrative prosecutor demonstrated to the ALJ that the basis of the ALJ's previous credibility determination was incorrect, the ALJ then, in the instant case, found Parent A not credible again but for different reasons. However, the ALJ's new credibility finding is again belied by the record in this case. In sum, there are extremely strong reasons for rejecting the ALJ's credibility determinations.

David Geier

The reliability of David Geier's testimony before the ALJ was diminished immediately. He began his testimony discussing his curriculum vitae. On direct examination, he was asked whether his curriculum vitae was up-to-date. David Geier responded: "Pretty much, yes." He then explained that after looking at it, that there were "probably some additional publications, peer review publications." On cross examination, however, he was asked about the following statement on his curriculum vitae: "2009-Present Appointed by Maryland Governor Martin O'Malley to serve on the Maryland Commission on Autism (3 year-term)." The question was whether he was presently on the Maryland Commission on Autism. He responded: "No, I am

not.” David Geier said that he was “asked to stop serving.” On redirect he was asked whether he agreed to stop serving, but he evaded the question: “Well, that was the end of my services.”

On direct examination, David Geier was asked whether he assisted his father at his father’s clinical practice. David Geier said that he did and then described what that entailed:

It can take a variety of different ways of assistance; it can be things like calling in prescriptions for hi[m]; it can be acting as a note-taker for him for patients.

It can also be administrative in nature, meaning billing, helping to put charts together, that kind of thing.

He did not mention that he assisted his father by meeting with the patients and parents alone and discussing the course of treatment with the parents when Dr. Mark Geier was busy. He also failed to mention that he scored ATECs, resolved blood testing order problems, and typed medical documents. He clearly minimized his role at the clinic.

On January 19, 2010, David Geier was interviewed under oath by Joshua Schafer, a Board investigator. It is evident from the interview that David Geier was not a credible witness:

Q. [Mr. Schafer] As part of your duties and responsibilities at the Genetic Centers of America, do you meet with patients there?

A. [David Geier] No.

Q. You don’t meet with patients at the Rockville Pike location?

A. What do you mean by “meet with patients?” I’m not trying to be evasive, but what do you mean by “meet with patients?”

Q. Have face-to-face interaction with patients.

A. Can I answer in my own words, or you want a “yes” or “no” answer to that question?

Q. Well, I will ask it in a yes or no way. Do you have face-to-face interaction with minor patients and their parents at the Rockville Pike location?

A. I would like to answer in my own words, if I could.

Q. That’s the only words that I’m interested in.

A. I am sometimes an administrative assistant in Rockville. So in the sense of patients coming through the door, there are patients that come through the door. I wouldn’t -- you know, that’s how I see them in the sense of they come through and they’re seen in the office. That doesn’t mean that I conducted a face-to-face meeting. I wouldn’t describe it in the words that you are saying. [State’s Exhibit 6, Tr. 7-8.]

This is certainly contradicted by his own testimony that he “tried to help hold [Patient A’s] feet” and Dr. Mark Geier’s testimony that David Geier occasionally controls the legs of patients during ultrasounds. And it is, of course, contradicted by his own testimony and Dr. Mark Geier’s testimony that he met with Parent A and Patient A.

During the hearing before the ALJ, David Geier was asked about Parent A’s and Patient A’s visit to the clinic on May 19, 2008, and he testified:

Yes. I remember that [Parent A] came to our office. This was a day that I went with my father to the practice. They came in. They were in the office. They were eventually seen in an office room there. And in the office room I was *present*, as well as my father, who came in and out.

The patient also had a series of procedures performed while in the office, referring to the sonograms.

It is clear that David Geier reduced his role in the visit. Remarkably, at no point in his testimony does David Geier acknowledge speaking to Parent A on May 19, 2008. He only goes so far as to say he was “present.” The Patient Interview Form, however, does address the discussion that David Geier had with Parent A on May 19, 2008, regarding laboratory testing:

Reviewed with mother laboratory testing presently being employed by our office to help evaluate children diagnosed with autism spectrum disorders. It was decided following an informed consent decision that new laboratory testing would be ordered for [Patient A] through LabCorp for hormone testing (androgens) and the other tests to be ordered would be conducted through Quest Diagnostics.

The review of the laboratory testing, the informed consent, and the testing that would be conducted by LabCorp and Quest had to have taken place in a conversation between David Geier and Parent A, because Parent A did not talk with Dr. Mark Geier that day. As the ALJ found, Dr. Mark Geier did not speak to Parent A: “. . . [Dr. Mark Geier] did not address [David Geier], Parent A, or Patient A . . .” (ALJ’s Proposed Decision, Finding of Fact 44, at 11.) The Patient Interview Form, which describes a significant discussion, is consistent with the testimony of Parent A. David Geier purposely obscured his role during the appointment. There is no doubt

that David Geier had a discussion with Parent A on May 19, 2008. David Geier's failure to acknowledge that he spoke with Parent A was meant to mislead.

David Geier's testimony before the ALJ became even more unreliable. He did not deny, but claimed no memory of significant factual issues related to whether he was practicing medicine or not. On direct examination, David Geier was asked by his attorney whether he "prepared" the three-page, single-spaced Patient Interview Form (State's Ex. 7, at MG10891-93) pertaining to Patient A's visit to the clinic on May 19, 2008. Although he was the one who interviewed Parent A, David Geier testified that he could not recall. The Board finds this implausible. When David Geier was asked whether he recalled making the comment that "[Patient A] looked like a typical high-testosterone kid," David Geier testified that he did not know.¹⁴

The ALJ wrote that she doubted David Geier's testimony that Dr. Geier spent a significant amount of time with Parent A and Patient A on May 19, 2008. The ALJ appears to have nevertheless made a positive credibility finding concerning David Geier based almost entirely on his demeanor. The ALJ, thus, failed to consider whether his testimony was consistent with the rest of the evidence. A witness's demeanor while testifying is significant, and the Board grants the ALJ's demeanor-based credibility determinations substantial deference, but the Board cannot rely upon the ALJ's positive demeanor-based credibility determination when the medical records and the transcripts show decisively that the testimony was not credible.

On June 17, 2008, Parent A called Genetic Centers because David Geier had failed to send her the order for the testing at Quest. The next day, June 18, 2008, David Geier wrote the

¹⁴ The ALJ was "impressed" with David Geier's "candid admission" that he did not know whether he said that Parent A's son "looked like a high-testosterone kid." It is certainly possible that David Geier did not remember making that statement to Parent A. But, if that were the case, this would have been a rare example of David Geier's candor.

order for the Quest testing. The testing that was ordered on June 18, 2008, was the exact same testing that he had determined, on May 19, 2008, was going to be ordered. Those tests are listed, with their codes, on the May 19, 2008, Patient Interview Form. On June 18, 2008, David Geier simply copied the tests and codes listed on the Patient Interview Form onto the Quest order form. The tests are even listed in the same order. But Genetic Consultants billed \$150 for one hour of a prolonged 1st Hour Evaluation and Management on both June 17, 2008, and June 18, 2008. David Geier testified that a physician must perform the prolonged first-hour evaluation and management in order to bill for that service.

On cross examination, David Geier was asked to testify as to what occurred on June 17 and 18, 2008, and to explain the billing for those days. David Geier's testimony is directly contradicted by the following medical records: the May 19, 2008, Patient Interview Form; the May 22, 2008, LabCorp order; and the June 18, 2008, Quest order.

David Geier testified on what the billing for July 17, 2008, was for:

A. The billing is indicative of the fact that Dr. Geier spent a significant amount of time reviewing the laboratory tests that were ordered for this patient and discussing with me and others about what this patient should have in evaluating LabCorp versus Quest.

* * *

A. This was a discussion with Dr. Geier and myself. The billing would reflect that we were consulting about the issue of laboratory testing for this patient. I guess it's Patient A.

David Geier was then asked whether the discussion concerned at which facilities (LabCorp or Quest) the tests should be conducted. David Geier said "Yes." But it is clear from the medical records that the decisions as to where the testing would take place and what tests were to be performed were made a month earlier and documented as such in the Patient Interview Form. Again, the order for the testing at LabCorp had already been written, sent, and

received weeks earlier. Dr. Mark Geier's involvement on June 17, 2008, would thus have been entirely unnecessary. David Geier was then asked about the contradiction – that the May 19, 2008, Patient Interview Form already contained the testing information that he testified was extensively labored over on June 17, 2008. He could not reconcile the contradiction nor did he even attempt to do so. (David Geier's Testimony, 12/15/2011, Tr. 126-27.)

David Geier then testified about the bill submitted for Dr. Geier's time on June 18, 2008. David Geier testified that Dr. Mark Geier's time was billed for his (David Geier's) typing the Quest registration and orders on the computer. According to David Geier, Dr. Mark Geier "would have been overseeing and ensuring what I was doing was accurate and appropriate." This testimony, however, was contradicted by Dr. Mark Geier, who said: "I don't have anything to do with the registration." And Dr. Mark Geier did not testify that he oversaw David Geier typing the Quest laboratory order. This testimony by David Geier concerning what occurred on June 17 and 18, 2008, was false.

Dr. Mark Geier's testimony concerning the events of June 17 and 18, 2008, was equally false. Dr. Mark Geier testified that on June 17, 2008, he (Dr. Mark Geier) did a lot of work figuring out the Quest *lab codes*. But this is inconsistent with David Geier's testimony and does not make any sense, because the Quest lab codes were already figured out and written on the May 19, 2008, Patient Interview Form. Dr. Mark Geier then tried to explain the \$150 bill Genetic Consultants submitted for June 18, 2008. Dr. Mark Geier testified that Parent A called back on June 18, 2008, and he had to handle an unspecified further request from her. There is nothing to corroborate this testimony. Parent A did not call back on July 18, 2008. Dr. Mark Geier also testified that he "helped with both of those [the Quest and LabCorp orders] to get them straight." But the LabCorp order was already completed and sent on May 22, 2008.

What did occur was that, on May 22, 2008, David Geier ordered the LabCorp testing but forgot to write the Quest testing order. The LabCorp order was then sent to Parent A. Parent A called Genetic Centers on June 17, 2008, and asked David Geier to send her the order for the missing tests (the Quest order). David Geier then billed for this telephone conversation and perhaps for reviewing the medical file to verify that the Quest tests had not been ordered. On June 18, 2008, David Geier ordered the Quest testing by copying the tests and codes listed on the May 19, 2008, Patient Interview Form. David Geier also registered the patient with Quest. The actual work for which the bill was submitted to the insurance company for June 18, 2008, was simply the typing of the Quest order and registering the patient. Dr. Mark Geier was not involved. Parent A's testimony and the medical records that Genetic Consultants maintained and which were admitted into evidence support a finding that these events occurred. David Geier's and Dr. Mark Geier's versions of events conflict with each other and with the documents in evidence. The reasons for rejecting the ALJ's demeanor-based credibility determination concerning David Geier are both strong and manifold.

Parent A

The ALJ found that Parent A was not credible in the Dr. Mark Geier Summary Suspension Hearing. Parent A did not present live testimony in David Geier's case. The transcript of Parent A's testimony from Dr. Mark Geier's Summary Suspension Hearing was admitted into evidence instead.

In her proposed decision in David Geier's case, the ALJ quoted her credibility finding regarding Parent A from Dr. Mark Geier's Summary Suspension Hearing, which, in relevant part, reads:

The single parent witness I did not find to be credible was Parent A The reliability of Parent A's recollections disintegrated on cross-examination when

she admitted that there might have been someone else in the treating room, and when the “diagnosis” was revealed to be little more than an observation.

At the David Geier case, however, the administrative prosecutor pointed out to the ALJ that the ALJ’s finding concerning Parent A’s “admission” that “someone else” (a fourth person, the sonographer) had been in the “treating room” (ultrasound room) was incorrect. Parent A, in fact, did not “admit” on cross examination that there might have been someone else in the room, because Parent A had said all along that there were four people in the room. Parent A’s testimony had been consistent in her Complaint, in the Board interview, and in her testimony before the ALJ. The basis for the ALJ’s credibility finding in the ALJ’s Proposed Decision in Dr. Mark Geier’s Summary Suspension Hearing was, therefore, unfounded.

But, in David Geier’s case, the ALJ again found that Parent A’s recollection disintegrated on cross examination. But the ALJ changed the point at which she remembered Parent A’s recollection disintegrating. This time the ALJ found that Parent A’s recollection did not disintegrate when Parent A “admitted” that there might have been “someone else” in the treating room. Instead, Parent A’s recollection disintegrated this time, according to the ALJ, when Parent A realized that the LabCorp order stated “Dr Mark Geier” under Physician’s Signature. Parent A had previously thought that the handwriting in the Physician’s Signature section on the LabCorp order said “David Geier.” However, Parent A’s recollection could not have disintegrated at this point either because the question did not call for a recollection, it called for her opinion of what the handwriting said, and the very next area that Parent A testified about was the number of people in the ultrasound room, which the ALJ now acknowledges was accurate and consistent with the parent’s previous statements. The Board finds that Parent A’s testimony was credible. The Board rejects the ALJ’s finding that parent A’s recollection disintegrated on cross examination. The signature on the LabCorp form is significant, though.

The Board finds that the “Dr Mark Geier” written as the physician’s signature on the May 22, 2008, LabCorp order was written by David Geier, not by Dr. Mark Geier. The ALJ found that the handwritten “D” in the “Dr Mark Geier” is “remarkably like” the “D” that David Geier writes when he initials a document.¹⁵ The Board agrees. The “D” in “Dr Mark Geier” is extraordinarily similar to David Geier’s distinctive “D” when he initials a document. The “D” is also very different from the “D” in “Dr.” that Dr. Mark Geier uses when Dr. Mark Geier signs documents. In addition, it does not appear from Dr. Mark Geier’s testimony that he was aware of *when* the LabCorp order was issued, nor does it appear that he was even aware that the May 22, 2008, LabCorp order existed.

Dr. Mark Geier’s testimony on the laboratory testing orders was so vague, confusing, and inaccurate that there is no indication that he had any knowledge of or involvement in ordering the laboratory tests. For example, when he was asked about the billing for May 22, 2008, exemplified by the contact note for May 22, 2008, (State’s Ex. 7, at MG10859) and the billing entry for May 22, 2008 (State’s Ex. 7, at MG10858), Dr. Geier had no idea what this contact note was for, nor what the billing entry was for. (State’s Ex. 19, Tr., 12/9/2011, at 950-51). Both documents referred to the May 22, 2008, LabCorp order. (State’s Ex. 7, MG10865).¹⁶ The billing document, the contact note, and the LabCorp order are the only medical records for Patient A with respect to May 22, 2008. These documents indicate that the only things that occurred on May 22, 2008, were the completion, the signing, and the sending of the LabCorp order. Dr. Mark Geier, however, did not know what occurred on May 22, 2008, other than what was written on the contact note. Dr. Mark Geier’s lack of knowledge of the May 22, 2008,

¹⁵ The ALJ, however, does not appear to have considered the obvious issue of whether David Geier wrote the “Dr Mark Geier.”

¹⁶ The May 22, 2008, LabCorp order and the May 22, 2008, contact note both have the same transaction number: 53958831788.

LabCorp order is another indicator that he did not sign the document. And in Dr. Mark Geier's testimony, he (Dr. Mark Geier) did not claim that he (Dr. Mark Geier) signed or authorized or even knew about the LabCorp order. Dr. Mark Geier was not involved in the LabCorp order. Instead, David Geier chose the LabCorp tests, David Geier obtained informed consent from Parent A for those tests, David Geier completed the LabCorp order form, David Geier signed Dr. Mark Geier's name to the LabCorp order, and then David Geier determined what should be billed for May 22, 2008. There is no reliable evidence to indicate otherwise.

The State argued in its Exceptions that the Board should not adopt the ALJ's credibility determinations. David Geier responded to the State's Exceptions. David Geier argued that the ALJ made demeanor-based credibility determinations and that the Board must adopt the ALJ's demeanor-based credibility findings or the "Board's decision would be reversed." (David Geier's Response to State Exceptions, at 5.) For three reasons, the Board does not accept David Geier's analysis. First, David Geier does not accurately describe the relevant case law. The relevant case law does not require that agencies accept administrative law judges' demeanor-based credibility determinations. The relevant case law instead allows an agency to reject an ALJ's demeanor-based credibility determination if the agency "gives strong reasons for doing so." *Anderson v. Department of Public Safety and Correctional Services*, 330 Md. 187, 217 (1993), quoting 1 Charles H. Koch, Jr., *Administrative Law and Practice* (1995), § 6.73, p. 520; *Maryland Board of Physicians v. Elliott*, 170 Md. App. 369, 385 (2006); *Gabaltoni v. Board of Physician Quality Assurance*, 141 Md. App. 259, 261, 263 (2001); *Shrieves v. Department of Health and Mental Hygiene*, 100 Md. App. 283, 302 (1994). Second, David Geier asserts that the ALJ made several crucial demeanor-based credibility determinations in regard to Parent A. It is, however, not clear that the ALJ's credibility determinations regarding Parent A were

“demeanor-based credibility determinations” as those determinations are construed under the relevant case law. Third, if the ALJ did make demeanor-based credibility determinations regarding Parent A, those should be rejected because only the written transcript of Parent A’s testimony was admitted into evidence. Parent A did not testify in person or on video during David Geier’s hearing, and the ALJ did not admit into evidence a copy of the video recording of Parent A’s testimony. The demeanor of Parent A while testifying should not have been considered at all, since it was not part of this proceeding.¹⁷

It is not clear that the ALJ made any “demeanor-based credibility determinations” regarding Parent A as those determinations are recognized under the relevant case law. David Geier listed nine examples of what he asserts are demeanor-based credibility determinations made by the ALJ concerning Parent A. The examples he listed are that Parent A: (1) was “outraged,” (2) was “angry,” (3) disintegrated on cross examination, (4) had an “unconscious leaning” against David Geier, (5) added testimony in a “self-designed fabrication,” (6) was “clearly distracted,” (7) was frustrated and embarrassed by her son’s behavior, (8) had an “unusual crusader-like tone,” and (9) testified in a voice that demonstrated puzzled frustration that her insurance company failed to take these claims seriously. These examples, however, are not “demeanor-based credibility determinations.”

“Demeanor-based credibility determinations” pertain to the demeanor of the witness *while* the witness testifies. *Elliott*, 170 Md. App. at 388. Most of the examples offered by David Geier pertain instead to Parent A’s demeanor at times other than while she was testifying. For example, according to the ALJ, Parent A was “clearly distracted.” But, according to the ALJ,

¹⁷ The State offered to present the recording of the videoconference testimony of Parent A from Dr. Mark Geier’s Summary Suspension Hearing, but the ALJ rejected the recording. The ALJ instead only admitted the written transcript of Parent A’s testimony. (Tr., 12/7/2011, at 6.)

Parent A was “clearly distracted” “*during this visit*.” “This visit” was the visit on May 19, 2008, to Genetic Consultants, thus, Parent A was not “clearly distracted” while testifying. Likewise, the ALJ found that Parent A’s emotions of “frustration and embarrassment” diminished Parent A’s ability to be a keen observer. But, again, Parent A’s emotions of “frustration and embarrassment” occurred at Genetic Consultants, not while testifying. The ALJ found that Parent A was “outraged” and “angry.” Parent A was no doubt outraged and angry upon seeing a copy of the bill Genetic Centers submitted to the insurance company. But the ALJ did not find that Parent A was “outraged” and “angry” while testifying. In fact, the ALJ found that “Parent A’s Complaint to the Board was initiated, in large part, because of her outrage over the bills sent to her insurance company.” The outrage, thus, was present, according to the ALJ, when the Complaint was *initiated*. If the ALJ meant that Parent A was “outraged” and “angry” while testifying, the ALJ could have at least set forth her observations on how Parent A manifested her outrage and anger, such as whether Parent A raised her voice, had a red face, or was shaking with anger. But it does not appear that this is what the ALJ meant. Similarly, the ALJ found an “unusual ‘crusader-like’ tone” to Parent A’s written complaint. Parent A’s written complaint is dated October 2, 2008. The ALJ did not find that Parent A had an “unusual crusader-like tone” while she testified on June 17, 2011. The ALJ’s findings, described above, are not entitled to the deference *Anderson, Elliott, Gabaldoni, and Shrieves* reserve for “demeanor-based credibility determinations.”

The ALJ’s “unconscious leaning” finding is not a valid “demeanor-based credibility finding” in any respect. The ALJ found that Parent A’s “unconscious leaning” against David Geier caused her to “translate” the signature of “Dr Mark Geier” written under Physician’s Signature on the May 22, 2008, LabCorp form to “David Geier.” But when Parent A was asked

to examine the signature during the evidentiary hearing before the ALJ, Parent A said that it said Mark Geier. Thus, Parent A's "unconscious leaning" did not diminish the accuracy of her testimony before the ALJ, because the handwriting at issue does say Mark Geier.

Next, the ALJ's finding that Parent A included in her testimony a "self-designed fabrication" does not even involve demeanor. But, more significantly, the testimony that the ALJ inferred was a "self-designed fabrication" should not have been interpreted as such. The ALJ found that Parent A testified falsely that she (Parent A) had asked David Geier whether he was issuing a "diagnosis" during their discussion in the office on May 19, 2008. But Parent A did *not* testify that she asked David Geier whether he was issuing a "diagnosis." After Parent A testified that David Geier said that her son looked "like a high-testosterone kid," she was then asked by the administrative prosecutor whether David Geier mentioned any diagnosis. Parent A responded that she thought that he had stated a diagnosis, namely "high- testosterone." The transcript reads:

- A. Okay. We went into the office, and one of the first things I recall was David Geier saying that my son was like a high testosterone kid right off the bat. Just looking at him, he felt that my son looked a lot older than he was. And I – thought it was curious that he thought that, that he looked like he was about age 16.
- Q At that time did he mention any diagnosis?
- A I'm sorry, what?
- Q. Did Mr. David Geier mention any medical condition or diagnosis related to your son?
- A. Well, he though[t] he was a typical high-testosterone kid –
- Q. Um-hum.
- A. – so I did say, "A – diagnosis, high-testosterone levels?" Other than that, not really.

Parent A's testimony was not meant to convey that she *asked* David Geier whether *he* was "issuing" a "diagnosis." For that to be unambiguously the case, the word "say" would have been "asked." Parent A did not even say that she said this *to David Geier*. Thus, the ALJ

wrongly interpreted Parent A's testimony. Parent A's testimony was "so I did say a diagnosis" (punctuation of transcript omitted); it was not "[I] asked [David Geier] if he was issuing a 'diagnosis.'" (See ALJ's Proposed Decision, at 18). And if Parent A were fabricating her testimony, it seems more likely that she would have testified that David Geier, and not herself, used the word "diagnosis." Parent A was simply confused by the administrative prosecutor's question and tried to convey that she considered "high testosterone levels" to be a diagnosis and thus had already answered the administrative prosecutor's question. The Board does not agree with and does not adopt the ALJ's inference that this testimony was a "designed fabrication."

The final two examples are closer to "demeanor-based credibility determinations," because they at least seem to be related to demeanor-type findings of Parent A while she was testifying. The first of these, the purported disintegration of Parent A's recollection, was discussed above, where the Board has found that the ALJ's second version of Parent A's "disintegration" was, as was the ALJ's first version, not supported by the transcript. But, more to the point at hand, if this did constitute a "demeanor-based credibility determination," it was improper because Parent A's demeanor while testifying should not have been considered: only the written transcript of Parent A's testimony from Dr. Mark Geier's summary suspension hearing was entered into evidence. Since the videoconference recording was not admitted into evidence in David Geier's hearing, and only the transcript of Parent A's testimony was, no demeanor-based credibility determination of Parent A should have been made by the ALJ in David Geier's case.

David Geier lastly points to the ALJ's comment that "Parent A's voice in the Summary Suspension Hearing demonstrated puzzled frustration that her insurance company failed to take these claims seriously." The ALJ's reference to the parent's voice does seem to pertain to Parent

A's demeanor while she testified at the hearing. Parent A was probably frustrated and puzzled by the insurance company's lack of interest in her complaint. But this does not suggest that her testimony concerning the insurance company's lack of interest or any other part of the parent's testimony was false. There was no evidence to suggest that the insurance company was interested in her complaint.

The Board accepts the State's exception concerning Parent A's credibility, thus, the Board rejects the ALJ's credibility determination that Parent A was less credible than David Geier. The Board finds that Parent A was a credible witness.

PRACTICING MEDICINE WITHOUT A LICENSE

Relevant Legal Authority

Section 14-601 of the Health Occupations Article states:

Except as otherwise provided in this title, a person may not practice, attempt to practice, or offer to practice medicine in this State unless licensed by the Board.

Section 14-101(*l*) of the Health Occupations Article (2007 Supp.)¹⁸ reads, in relevant part:

(1) "Practice medicine" means to engage, with or without compensation, in medical:

- (i) Diagnosis;
- (ii) Healing;
- (iii) Treatment; or
- (iv) Surgery.

(2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:

- (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual:
 - 1. By physical, mental, emotional, or other process that his exercised or invoked by the practitioner, the patient, or both; or
 - 2. By appliance, test, drug, operation, or treatment;

¹⁸ Effective October 1, 2010, the definition of "Practice medicine" was moved without a change to the substance of the definition from § 14-101(*l*) to § 14-101(*n*) of the Health Occupations Article.

COMAR 10.32.12.04 provides, in relevant part:

A. A physician may not delegate to an assistant technical acts which are exclusively limited to any individual required to be licensed, certified, registered, or otherwise recognized pursuant to any provision of the Health Occupations Article and the Education Article, Annotated Code of Maryland.

B. A physician may delegate technical acts consistent with national standards in the medical community and the approved policies and procedures of the sites for the delivery of health services in the following categories:

* * *

(2) Nonsurgical technical acts while the assistant is under the physician's direct supervision or on-site supervision if the assistant performs the act in accordance with procedures of the site.

* * *

D. At sites not included in Health-General Article, §§19-114 and 19-3B-01(b), Annotated Code of Maryland, when providing the following specified levels of supervision, a physician may delegate to an assistant technical acts which include but are not limited to:

(1) Without on-site supervision:

- (a) Patient preparation for physician examination;
- (b) Patient history interview;
- (c) Collecting and processing specimens, such as performing phlebotomy and inoculating culture media;
- (d) Preparation of specimens for selected tests including:
 - (i) Pregnancy tests,
 - (ii) Dipstick and microscopic urinalysis, and
 - (iii) Microbiology (rapid streptococcal testing and throat cultures);
- (e) Laboratory tests that the physician is satisfied the assistant is qualified to perform under State and CLIA regulations;
- (f) Clinical tests such as:
 - (i) Application of tuberculin skin tests,
 - (ii) Electrocardiography,
 - (iii) Administering basic pulmonary function tests; and
 - (iv) Visual field tests;
- (g) Transmitting prescriptions to a pharmacy;
- (h) Providing sample packets of medication, selected by a physician who is physically present at the time of selection, to patients as directed by the delegating physician and in conformance with Health Occupations Article, §12-102(a), (d), and (f), Annotated Code of Maryland; and
- (i) Preparing and administering oral drugs;

(2) With on-site supervision:

- (a) Preparing and administering injections limited to intradermal, subcutaneous, and intramuscular (deltoid, gluteal, vastus lateralis) to include small amounts of local anesthetics;
- (b) Establishing a peripheral intravenous line: and

(c) Injecting fluorescein-like dyes for retinal angiography; and
 (3) With direct supervision, injecting intravenous drugs or contrast material.

E. A physician may not delegate to an assistant acts which include but are not limited to:

- (1) Conducting physical examinations;
- (2) Administering any form of anesthetic agent or agent of conscious sedation other than topical anesthetics or small amounts of local anesthetics;
- (3) Initiating independently any form of treatment, exclusive of cardiopulmonary resuscitation;
- (4) Dispensing medications;
- (5) Giving medical advice without the consult of a physician; and
- (6) Providing physical therapy.

Diagnosis

The May 19, 2008, Patient Interview Form contains the following impression of Patient A: “pervasive development delay (*sic*), not otherwise specific (*sic*)”; “Sleep Problems (Insomnia)”; and “Unspecific Metabolic Disorder.” The impressions were different from the those from July 1, 2005, which listed Unspecified Developmental Delay, Possible Childhood Heavy Metal Exposure (Mercury), and Possible Precocious Puberty.

The diagnosis of “pervasive developmental delay, not otherwise specific” or “PDD-NOS” is written in the Psychological Examination and Impression sections of the May 19, 2008, Patient Interview Form. The Board finds that David Geier made this diagnosis, not Dr. Mark Geier.

In 2008, Patient A was almost exclusively handled by David Geier. It is undisputed that David Geier was present for the entire discussion with Parent A and Patient A in the clinic’s office; scored the ATEC; was present during the attempted ultrasounds; wrote the patient’s name and identification number on the abdominal ultrasound report; completed the LabCorp order form on May 22, 2008; spoke to Parent A on the telephone on June 17, 2008; ordered the Quest testing; and registered Patient A at Quest. In contrast, the only undisputed acts that Dr. Mark

Geier performed in 2008 with regard to Patient A were to write on the abdominal ultrasound report that the results were slightly limited, initial this note, and initial the thyroid ultrasound report.

David Geier also did not deny that he prepared the Patient Interview Form. The Board finds that David Geier wrote the Patient Interview Form. Dr. Mark Geier's name is typed at the end of the form, but Dr. Mark Geier did not sign or initial the form. And Dr. Mark Geier testified that he usually initials or signs the Patient Interview Form if someone shows it to him. Thus, Dr. Mark Geier neither prepared nor reviewed the Patient Interview Form.

The Psychological Examination section in the Patient Interview Form states that the ATEC was completed by Patient A's mother and "evaluated by me." David Geier testified that he (David Geier), not Dr. Mark Geier, scored the ATEC. The Board is aware that scoring may be different from evaluating, but even if the writer of this form meant scoring and evaluating to be different, the scoring was certainly part of an evaluation of the ATEC. Thus, the fact that David Geier, who scored the ATEC, is not referenced at all, indicates that, even if one accepted the Geier's version of events, the Psychological Examination section is misleading. And the fact that Dr. Mark Geier testified that he did not even know who scored the ATEC suggests that he (Dr. Mark Geier) was not involved in the evaluation.

The Psychological Examination section ultimately states: "It is apparent based upon examination of the DSM-IV criteria that [Patient A's] present symptoms are compatible with a diagnosis of pervasive developmental delay (sic) – not otherwise specific (sic) (PDD-NOS)." This diagnosis was made by David Geier and was not reviewed by Dr. Mark Geier. The DSM-IV criteria for Pervasive Developmental Disorders were filed in Patient A's medical record at

Genetic Consultants. The DSM-IV criteria for 299.80 Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS) states:

This category should be used when there is a *severe and pervasive impairment* in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, *but the criteria are not met for a specific pervasive developmental disorder*, schizophrenia, schizotypal personality disorder, or avoidant personality disorder. For example, this category includes “atypical autism” – presentations that do not meet the criteria for autistic disorder because of late age of onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

(State’s Exhibit 7, at MG10898) (emphasis added).

At his summary suspension hearing, Dr. Mark Geier was asked about the diagnoses listed on the 2008 Patient Interview Form. He then read the diagnoses listed on the form, which are “PDD-NOS, sleep problems, and unspecified metabolic disorder.” Dr. Geier was then asked why the diagnoses were different from 2005. Dr. Geier testified:

-- the child was older, and second of all, *it became obvious that the child had autism*. And PDD-NOS is, as a tentative diagnosis, just means sort of *medium*. It’s a -- it means that the child is -- it has language and is not banging his head against the wall, not full-blown autism, but not mild. It’s a --

* * *

-- working diagnosis. And sleep problem, I think she told us about at the time.

Dr. Mark Geier’s testimony gives the Board no confidence that he diagnosed Patient A in 2008. His testimony amounts to medical imprudence in the Board’s opinion. His testimony contradicts itself and the DSM-IV criteria, which the diagnosis PPD-NOS was purportedly based upon.

Dr. Mark Geier testified at first that it was “obvious that the child had autism.” If a patient has autism, however, it is inappropriate under the DSM-IV criteria to diagnose PPD-NOS. *See* States’ Exhibit 7, at MG10898. The diagnosis PPD-NOS is reserved for those conditions which do not meet the criteria for a specific pervasive developmental disorder. *Id.* Autism is a specific pervasive developmental disorder. *See* Autistic Disorder - 299.00, State’s

Exhibit 7, at MG10897. A patient who meets the criteria for autism is thus not properly diagnosed with PPD-NOS. And, in contrast to Dr. Mark Geier's testimony, the DSM criteria does not consider PPD-NOS "sort of medium"; the DSM-IV criteria instead states that PPD-NOS is a "severe and pervasive impairment." Dr. Mr. Geier's explanations for why this patient with autism was diagnosed with PPD-NOS were inconsistent and medically unintelligible to the Board.

Additionally, the correct name of the disorder is not "pervasive developmental delay – not otherwise specific." It is pervasive developmental *disorder*, not otherwise *specified*. It is highly unlikely that a licensed physician specializing in the field of pervasive developmental disorders would not know the correct name for the disorder.

And Dr. Mark Geier's attempts at explaining the sleep problems (insomnia) and unspecified metabolic disorder were just as unconvincing. The diagnoses on the 2008 Patient Interview Form were made by David Geier. By diagnosing Patient A, David Geier practiced medicine without a license. See Health Occ. § 14-404(I)(1)(i) (2007. Supp.); Health Occ. § 14-601.

On May 22, 2008, David Geier entered the diagnostic code for insomnia in the diagnosis section of the LabCorp testing order. On June 18, 2008, David Geier completed the Quest testing order and provided as the diagnosis codes his diagnoses of Insomnia, NOS and Metabolism Disorder NOS. He was practicing medicine without a license in ordering the lab testing, as well.

Ordering Laboratory Testing

On May 19, 2008, David Geier discussed with Parent A the laboratory testing that would be ordered for Patient A. Parent A agreed that the laboratory testing, as discussed, should be

ordered. David Geier then determined specifically which tests should be ordered. He listed the tests to be ordered on the May 19, 2008, Patient Interview Form. Each test to be ordered, along with the test's code, is listed under the laboratory that should be used to conduct those tests. On May 22, 2008, David Geier completed the order form for LabCorp, as he had determined the testing should be and as he documented on the Patient Interview Form, and then he signed on the LabCorp order "Dr Mark Geier" for the physician's signature. Dr. Mark Geier had no involvement in ordering these tests. David Geier's actions in determining the tests to be ordered and in ordering those tests, without any involvement or real oversight from a physician, constitutes practicing medicine without a license. Health Occ. § 14-101(*l*) (2007 Supp.); Health Occ. § 14-601.

Because the physician's signature on the May 22, 2008, LabCorp order states "Dr Mark Geier," the ALJ found that David Geier did not order the LabCorp testing. The Board, however, finds that David Geier signed "Dr Mark Geier" and, thus, rejects the ALJ's finding that Dr. Mark Geier ordered the LabCorp testing.

On June 18, 2008, David Geier ordered laboratory testing for Patient A at Quest. The testing that he ordered was as he determined on May 19, 2008, and as he documented on the Patient Interview Form. Dr. Mark Geier was not involved in this Quest order. David Geier's actions in ordering the 22 Quest tests also constitutes practicing medicine without a license.

The ALJ also found that David Geier was authorized to order the laboratory testing because the laboratory testing was "the delegation of a routine technical task by Dr. Geier to [David Geier]." (ALJ's Proposed Decision, at 30 n. 17.) Based upon Dr. Grossman's testimony, the ALJ also found that an unlicensed individual "may properly order laboratory tests if the physician has written specific guidelines about what tests need to be done." (ALJ's Proposed

Decision, Finding of Fact 51, at 12.) The Board's regulations state: "A physician may delegate technical acts consistent with national standards in the medical community and the approved policies and procedures of the sites for the delivery of health services. . . ." COMAR 10.32.12.04B. And an unlicensed individual may perform nonsurgical technical acts while "the assistant is under the physician's direct supervision or on-site supervision if the assistant performs the act in accordance with the procedures of the site." A technical act is defined as "a routine medical or surgical act which does not require medical judgment. . . ." COMAR 10.32.12.02B(8). The ALJ erred.

The laboratory testing orders were not routine. Dr. Mark Geier testified that "[t]here is individuality, but there is a central group." Further, Genetic Consultants had no approved policies and procedures (and certainly none that were written) for the ordering of laboratory testing by unlicensed individuals. No such policies and procedures are in the record. And the lack of policies and procedures at Genetic Consultants was further established by David Geier's testimony in the instant case in his response to a question about the seemingly random nature of the initialing and signing of documents at the clinic:

It's a reflection of the way that it just happened. I mean, the answer is that thousands of patients, thousands of charts we're talking about, there are just times when things happen.

I mean, we don't have a formal protocol in place in the office that says you will do it this way or that way. It's simply what happened in the course of patient care.

The ALJ simply disregarded the requirements that technical acts must: (1) not involve medical judgment, (2) be consistent with national standards, and (3) be performed consistent with written policies and procedures. The laboratory testing that David Geier ordered required medical judgment, was not routine, and was not in compliance with the written policies and procedures of the site (since the site did not have any policies and procedures on the ordering of laboratory

testing by unlicensed individuals). And there was no evidence that the laboratory testing was consistent with national standards.

RECUSAL

David Geier filed a motion with the Board on exceptions requesting that all members of the Board recuse themselves from the case. At the exceptions hearing, on May 23, 2012, the Board notified the parties that David Geier's motion to recuse was denied.

Under COMAR 10.32.02.07:

A. A Board member may not participate in an investigation or a proceeding in which the impartiality of the Board member might reasonably be questioned, including but not limited to proceedings and investigations in which the Board member has or appears to have:

- (1) A personal bias or prejudice concerning a party; or
- (2) Personal knowledge of disputed evidentiary facts concerning a proceeding.

B. A Board member shall determine whether the Board member falls within §A of this regulation and shall state the recusal on the record.

C. In a hearing before the Board, the parties may waive the recusal.

D. Participation by a Board member in an investigation, CRC, WRP, or other administrative proceeding involving a respondent does not constitute a basis for recusal in a contested case proceeding unless the Board member has:

- (1) Personal bias or prejudice against the respondent; or
- (2) Knowledge of disputed evidentiary facts outside of the administrative process.

David Geier argued that the Board's Cease and Desist Order concerning Dr. Mark Geier's alleged violation of the order summarily suspending his medical license shows an appearance of personal bias by Board members. According to David Geier, the Cease and Desist Order contained detailed personal medical information concerning Dr. Mark Geier and his family members and the inclusion of this detailed personal medical information was "clearly intentional and designed to inflict humiliation rather than fulfill a legitimate and legal goal of this Board." David Geier also states that the Board issued the order publically and argues that the public issuance was illegal.

Assuming David Geier's description of the Cease and Desist Order is true, this would not lead to the conclusion that the Board included detailed medical information for the purpose of inflicting humiliation. Detailed facts and medical information are generally included in charging documents in order to provide adequate notice to the Respondent. The detailed medical information pertains to the factual grounds for the order. David Geier does not argue that the information was irrelevant. He argues instead that the information could have been described in more general terms. Other than the assertion that medical information in the Cease and Desist Order was detailed, no evidence was presented to support a finding that the Board intended to humiliate anyone or has a personal bias against David Geier or anyone else. David Geier's speculation as to why certain information was included is not a valid basis to disqualify each and every Board member. And David Geier's assertion that the Board acted illegally by issuing the order publicly is contravened by section 14-411(g) of the Health Occupations Article and section 10-617(h)(2)(vi) of the State Government Article, which make Board orders and charges public documents.

David Geier then argued that all Board members should have recused themselves because Dr. Geier, his wife, and son filed a Maryland Tort Claim with the State Treasurer concerning the information contained in the Cease and Desist Order. According to David Geier, with the prospect of litigation, the Board members will not be able to impartially decide David Geier's case. The Board disagrees. If recusal were required when a lawsuit is filed or threatened, the Board, like every regulatory body, would be paralyzed and there would be a perverse incentive to sue government agencies. There is no law or reasonable policy supporting David Geier's argument that a tort claim filed with the State Treasurer or a threatened lawsuit against individual Board members necessitates recusal. *See Regan v. State Board of Chiropractic Examiners*, 355

Md. 397, 414 (1999), quoting *United States v. Studley*, 783 F.2d 934, 940 (9th Cir. 1986) (a “judge is not disqualified by a litigant’s suit or threatened suit against him”).

David Geier also argued that all Board members should have recused themselves because Paul T. Elder, M.D., Board Chairman during the events at issue,¹⁹ while speaking before the Maryland Senate’s Education, Health and Environmental Affairs Committee, referenced Dr. Mark Geier. David Geier did not provide a transcript of Dr. Elder’s comments. David Geier instead relies upon an article from the Baltimore Sun. The article, however, does not quote Dr. Elder’s comment referencing Dr. Mark Geier. And David Geier does not quote the article’s reference to Dr. Mark Geier. The reference in the article to Dr. Mark Geier is in a paragraph that states that Dr. Elder disputed certain criticism of the Board and “noted several actions it had taken in recent years.” The suspension of Dr. Mark Geier’s license was one of the several actions the article states that Dr. Elder noted as being taken by the Board. Thus, if the Baltimore Sun article is accurate, Dr. Elder noted that Dr. Mark Geier was suspended. Dr. Mark Geier was summarily suspended. This is undisputed. It is also possible from the article to infer that Dr. Elder did not think the Board’s decision to summarily suspend Dr. Mark Geier was wrong. It is self evident from the fact that the Board summarily suspended Dr. Mark Geier that the Board did not think that that decision was wrong. That does not mean that when cases involving the Geiers return to or show up anew before the Board that Dr. Elder or the Board cannot impartially decide those cases. See *Doering v. Fader*, 316 Md. 351 (1989). And there is no indication that Dr. Elder’s alleged comment was based upon anything other than information he properly received through the administrative adjudicatory process. *Id.* David Geier’s motion for recusal was properly denied.

¹⁹ Dr. Elder’s last day as a Board member was June 27, 2012, after his completion of two complete terms.

CHAT ROOM DOCUMENTS

During the evidentiary hearing before the ALJ, the State attempted to admit into evidence chat room documents. (Offered State's Exhibit 11 – not admitted.) The ALJ rejected the admission of these documents. The State filed exceptions. The Board agrees with the ALJ that the chat room documents should not have been admitted into evidence in this case, and, thus, the Board has not considered the chat room documents in reaching its decision in this case. The State's exception on this issue is, thus, denied.

CONCLUSIONS OF LAW

As explained above, the Board concludes that David Geier practiced medicine in Maryland without being licensed by the Board to practice medicine in violation of section 14-601 of the Health Occupations Article.

SANCTION

The Board has carefully considered the extent to which David Geier derived financial benefit from the improper conduct, the willfulness of the improper conduct, and the extent of potential harm caused by his misrepresentations. After weighing these factors, the Board imposes a \$10,000 civil fine upon David Geier for his violation of section 14-601 of the Health Occupations Article. *See* Health Occ. § 14-606(a)(4)(ii).

ORDER

Based upon David Geier's violation of § 14-601 of the Health Occupations Article and an affirmative vote of a majority of a quorum of the Board, it is hereby

ORDERED that David Geier is fined \$10,000; and it is further

ORDERED that David Geier, within three months of the date of this Final Decision and Order, shall pay the \$10,000 civil fine by money order or bank guaranteed check made payable

The **MAKE AMERICA
SICK AGENDA**

Stories from Trump &
RFK Jr.'s first 5 months

Senator Edward J. Markey (D-MA)



Dear Reader,

On January 20, 2025, Donald Trump was sworn into office. Less than one month later, on February 20, 2025, the Senate confirmed Robert F. Kennedy, Jr. as Secretary of Health and Human Services. Since Trump and Kennedy took office, the U.S. Department of Health and Human Services has cut billions of dollars in life-saving research into diseases such as Alzheimer's and cancer. The Trump administration has thrown community health centers and hospitals into chaos by revoking grants, dismantling programs that support seniors, slashing funding for addiction care, and seeking to cut money to train first responders on how to use naloxone. It has fired workers committed to controlling infectious disease outbreaks, keeping workers safe, and helping families pay their utility bills. And the Administration has attacked reproductive care and made immigrants and LGBTQ+ people afraid to get the health care they need. All the while, as a measles outbreak spreads unabated, the Administration has propagated misinformation about vaccines. For the second time in 30 years, the United States has surpassed 1,000 annual measles cases and it is only May.

Trump and Kennedy are now turning their sights on Congress, where they are working with Republicans to hollow out the American health care system to pay for tax breaks for billionaires. The Trump administration and Republicans in Congress are weighing how many billions to cut from Medicaid as Americans ration their medications, skip doctor's appointments, and watch hospitals close due to corporate greed.

The stories included here are from the voices of people across the country who the Trump administration has betrayed. They are terrified of losing lifesaving care. They are angry that their government would treat them this way. And they are frustrated that protecting billionaires is more important to the Administration than ensuring their ability to get the care they need, when they need it, without going into debt. These are the stories of the Trump administration's Make America Sick Agenda. The American people deserve better.

We can turn the tide and work together to build a health care system that works. We can build a system where people can pick up their medications, get their scans, or use an ambulance — without being pushed into bankruptcy. We can build a system that doesn't force hospitals and community health centers to close because of corporate greed. We can build a system that doesn't burn out our health care providers and staff by forcing them to treat too many patients with too few resources. We can build a system where every person walking into their health provider's office knows that that they will get care meant for them, care that is not dictated by politicians or meant to pad the pockets of corporate executives. We can treat every person with dignity and respect, and we can guarantee health care as a human right.

The fight ahead is challenging. The forces maintaining the health care system status quo are entrenched, and it is much easier to tear something down than build it up. But a better health care system that works for everyone is our goal. Thank you to those who have trusted me with your stories. Keep raising your voices. Keep organizing. Keep sharing: www.markey.senate.gov/TrumpStories

Sincerely,

Edward J. Markey
United States Senator from Massachusetts

“

I am a stage 4 cancer patient at Dana-Farber Cancer Institute and am currently enrolled in a clinical trial there. I have a rare cancer that has no cure and few drugs to treat it. In the past 20 years, clinical trials and research about my cancer have been instrumental in helping people live longer. Cuts to the NIH and cancer research are devastating to cancer patients. Cuts to vaccine research also indirectly affect cancer patients as we are typically immunocompromised and need vaccines and for the population around us to be vaccinated. Anti-vaccine sentiments from HHS and the CDC could be detrimental to cancer patients like myself.”

- Jennifer, Shrewsbury, MA

“I am a cancer patient on chemotherapy and Medicare. I need Medicare coverage to continue treatment. Without treatment, my survival odds are very poor. Please help.”

- David, Lexington, MA

“

I rely on Medicaid to keep me alive. I've been on consistent oxygen for almost three years. I have several co-morbidities and have survived COVID twice. I'm worried that if Medicaid is destroyed, I will die. I've fought very hard to do everything I can to change my life after I fell at the end of August, 2022 when I was diagnosed with AFib, every month after that until December I had something major happen with my health.”

- Melissa, Saint Charles, MO



I am a 62 year old educator living with spina bifida and metastatic breast cancer. Last year, when I was forced to leave my full time position in higher education administration due to health issues, I relocated from New York to Massachusetts.

Since I am only 62, I have not yet reached full retirement age, and am not eligible for Medicare. The fact that I have access to MassHealth in the interim is for me a life sustaining benefit. I have been living (and thriving) with spina bifida my whole life and with breast cancer for 12 years, largely due to access to excellent health care, first through my employer, and now through the state. After working tirelessly for 32 years to give students with disabilities the educational opportunities that I had, I am now at risk, as are millions of others, of losing this critical health care safety net.”

- Julie, MA



I've spent 50 of my 68 years pursuing research and teaching in the Life Sciences. Although I'm reaching the end of my career, I am training, and have trained, roughly 100 students who have since pursued their own careers in the life sciences. These proposed cuts to the NIH will destroy those careers and send progress in curing human disease down the drain. This means that the proposed cuts to the NIH budget will hurt the American people. Personally, I must say that the proposed attacks on NIH-funded programs (such as the one I lead) will hurt our students, who are already under-resourced and unable to adequately access health care. How is any of this even remotely justifiable? ”

- Jill, Boston, MA

“My story is all too familiar. My son, Zach, died of an overdose. He is a statistic, but more important he was a loving and loved family member, a productive hard working, self supporting member of our society. He had the illness of addiction.

The shortsightedness and vindictiveness of the Trump administration will allow this to continue to happen in increasing numbers. Addicts have an illness, illness deserves treatment. Closing borders, even if it served the asserted purpose of lowering the amounts of drugs in the country, doesn't solve the problem. Helping people find avenues to a life without drugs works. This means we need scientists to help us find material solutions, drug treatment programs available without stigma, and employing and celebrating persons of compassion who work with this population.

Addiction is not a disease of immigrants, nor of the poor. It is not found only in marginalized populations. It happens to people who serve their country in the military, in the judiciary, in public service sector. The self righteous of the GOP, who believe that taking from those in need in order to enrich the already wealthy, are showing a lamentable lack of character. I hope they will not one day be mourning their beloved child.”

Lou, MA



My parents were the first generation in their families to go to college and I was a Pell Grant recipient. I am not from an 'elite' upbringing. I am a mother, a pediatrician and public health professor. I have dedicated my career to trying to address the health disadvantages accrued by people in lower income and otherwise socially disadvantaged and stigmatized populations with a specific focus on women and children. One of my NIH grants that sought to understand and improve the experiences in behavioral/mental health care of LGBTQIA+ youth ages 14-17 was terminated. The message sent is that these vulnerable youth do not matter, further making them feel unwelcome in this society. It also has had a chilling effect on my students and staff who are funded through this research, discouraging them from continuing to be part of the workforce trying to understand and make better the care and opportunities for those whom our societal decisions have disadvantaged for reasons that are beyond their control.

- Anonymous, Amherst, MA



HIV is a preventable disease and if not prevented, outrageously expensive to the individual and the health care system. Significant stigma prevents many at risk individuals from being tested. In addition, if an individual has no access to affordable HIV care, why get tested? This just results in ongoing transmission and extremely poor health outcomes at great societal costs. Do we really want to go back to the 1990s when HIV was a death sentence?

- Pamela, Retired Physician, Evergreen CO



It is a sad commentary, that in a high-income country such as the US, we lagged behind other similar high-income countries in all healthcare indicators and now we are jeopardizing the even further the health of all Americans and our scientific reputation in the world.

There is always room for improved organization and being efficient with our taxpayer monies but the restructuring that is taking place is without any reasonable justification based on evidence and thus, lacks in transparency to the American people. The future of all Americans is at risk here and the damage being done to the health of our people and the education system as well as our scientific innovation is devastating. We must push back.”

- Anonymous, East Longmeadow, MA

I have kidney cancer. As an active patient receiving extremely expensive immunotherapy treatment, if I lose my job, I'll also lose health insurance. That is literally a death sentence.

- Joe, Bridgewater, MA



“We are adding uncertainty to an already uncertain sector 90% of startups fail. Massachusetts was the hub of biotech for so long because we offered certainty, and that is being taken away.”

- Anonymous, MA



My lab employs 4 people. If I have to close my lab, it will be 5 people to lose their employment.

I also have two pending major grants submitted to NIH. One submitted as part of a call for project from researchers with a Diverse background. It should have been reviewed in February. never did. Now is no longer assigned to a study section for review. No explanation from NIH.

The other one submitted in February, has not yet been assigned to a study section for review. This is usually done in the first 2 weeks after submission. No communication from NIH to know if it will ever be reviewed or considered.”

- Stephanie, Worcester, MA



I am a cardiac patient in need of a valve replacement in the near future, so preventable disease transmission is important to me and millions of others.”

- Anonymous, White City, OR



My fear is if Mr, Kennedy dissuades people from vaccinating their children we will have a polio outbreak and people like me will be at risk of getting it... He is putting people at extreme risk. And none of this is good for the country.”

- Bonnie, FL

“I am an NIH-funded epidemiologist and have been working in the field of HIV prevention research for 20 years. On Thursday and Friday, I received termination letters for 3 of my NIH grants because they “no longer effectuate agency priorities.” The staff at NIH who oversee my grants were not aware of these terminations until I notified them.

I'm one of hundreds of researchers whose labs are disintegrating overnight. I had been doing research on preexposure prophylaxis, a medication that's nearly 100% effective in preventing HIV, and now I'm just trying to get my mentees their last paychecks while bracing for my next termination letter.

To be clear, it's not just HIV research that's being destroyed. NIH funding has practically flatlined across the board, including research that would advance treatments for conditions like cancer and Alzheimer's that affect millions of Americans. NIH-funded research contributes to almost every single medicine approved in this country, and that research has now slowed if not stopped entirely.

These drastic cuts aren't just going to devastate local jobs and people's livelihoods and a generation of scientists. They're rapidly destroying the infrastructure for scientific research in this country, and that's going to have very real effects on the public's health. The treatment and prevention advances we need for ourselves and our loved ones just won't be there.

I cannot overstate how critical it is that we act NOW. The scientific research infrastructure is far easier to break than it will be to rebuild.”

Julia, Newton, MA



My best friend suffered a significant medical event on January 6th, 2023 that has left her permanently disabled. Prior to that, she had been working in the biomedical field, focused on Parkinson's and Alzheimer's research. She now utilizes a wheelchair for mobility and requires assistance with most areas of independent living including chores, feeding herself, and self-care.

In the two years, 3 months, and two days since I first brought her to the emergency room, my best friend has been denied social security disability benefits three times and we are now waiting on a hearing date with a judge—something I have only recently found out could take another 450 days. In total, that will be 1,272 days of waiting for her to receive support she desperately needs—time that will only lengthen with possible cuts to Medicaid funding and support services for people with disabilities. We need to protect Medicaid to ensure that she and others have access to the needed support services they require to live fulfilled lives. It is not about surviving but about thriving, and my friend should be given every opportunity to thrive. I appreciate what you have done thus far in supporting disabled individuals and I urge you to continue to fight the good fight for people like my friend.”

- Anonymous, West Boylston, MA

I have a senior post doc ready to start her own lab. Last two meetings I have had with her she has told me she is looking at other career opportunities – she is thinking “why would I start a lab in these conditions?” And she is one of the greatest scientists I have ever trained.

- Anonymous, MA

Massachusetts Coalition for Occupational Safety and Health Official Statement in Opposition to the Trump-Musk Legislative and Fiscal Aggressions

To Senator Markey,

On behalf of the Massachusetts Coalition for Occupational Safety and Health (MassCOSH), we vehemently condemn the regressive and reckless legislative and financial maneuvers advanced by the Trump administration, in tandem with tech billionaires like Elon Musk. These measures, including the dismantling of critical health infrastructure, the attempted obliteration of the U.S. Department of Education, and the decimation of NIH and Medicaid funding, are not simply attacks on institutions, they are deliberate acts of violence against workers, families, and the underserved communities we serve every single day.

Let us be unequivocal: these policies will kill jobs, kill opportunity, and kill people

As an organization committed to ensuring that all workers earn a living wage and return home alive and well, we recognize these cuts not only as a threat to health and safety but as an acceleration of the economic abandonment of working-class people — particularly Black, Brown, Immigrant, and low-income communities who have borne the brunt of inequity for generations.

Under the Trump-Musk blueprint, over 10,000 public health workers are slated for termination. Essential research into cancer, Alzheimer's, and addiction — all major causes of occupational distress and family hardship — is being eliminated. The cancellation of \$12 billion in federal grants is a direct strike on the services our members rely on for addiction recovery, mental health stabilization, and infectious disease protection.

This is not fiscal restraint. It is fiscal sabotage.

The economic stagnation that will result from these policies is not theoretical. It is intergenerational. Workers without health coverage miss more work. Young people denied quality education are locked out of future careers. Families without safety nets become chronically vulnerable to exploitation and poverty. These are not isolated impacts — they are systemic, cumulative, and devastating.

We are proud to align with Senator Ed Markey in calling for a full investigation into the administration's abuses. We will continue to gather testimony, track harm, and work with our legal and policy partners to ensure this moment is documented and fought against at every level — local, state, and national.

But this is not a moment for quiet resistance. It is a moment for clarity and confrontation.

We are calling on every community-based organization, every educator, every labor union, and every health and safety practitioner to raise their voice and join us in refusing to accept this dystopian vision for America. Our safety is not expendable. Our youth are not disposable. Our future is not for SALE!



I worked for a mine that was deep, hot, seismically active and had rockbursts frequently they shook the surface facilities. We had a collapse in the mine and I was part of the team that had the task of figuring out what happened and how to prevent it from happening again. A group of Researchers from the NIOSH spokane mining research Division showed up and offered to help. They took large blocks from the roof collapse, cored them, tested them and provided us with information that we needed to be able to figure out the failure Mechanism, as well as help us develop the remedy. Over the years the team from the spokane mining Research Division conducted many experiments, investigations, and provided Technical assistance to our mine and the mines nearby. It seems ridiculous that the current administration is getting rid of the only mining research body in the government when they want to increase domestic mining. ”

- Tyler, ID

“Without advancements in medical research, the cost of managing incurable diseases will rise. Patients may require more intensive and prolonged care, increasing the financial burden on healthcare systems and families. We want to move incurable disease to curable, or manageable.”

- Anonymous, MA

““

As a contractor for NIH, I am horrified by the psychological warfare currently enacted on our agency resulting in the illegal firings of several of my colleagues. These include individuals undergoing treatment for stage 3 cancer, on maternity leave, and under other protected classes. I am terrified my contract will be unceremoniously cancelled any day despite the period of performance lasting several years. It is a constant fear of mine and other colleagues.”

-Anonymous, Acton, MA

““

I work as an administrative assistant in Cancer Research and I will likely be laid off at the end of the fiscal year due to the cuts in NIH funding. My entire department at Brown that has been working for decades to build a cancer research hub in Rhode Island has been decimated by the NIH cuts. I am disabled and have high medical bills and little to no savings to fall back on, living paycheck to paycheck because of my health. I fear for the impacts to the job market and economy that these layoffs will cause as we all search for new jobs that don't exist.”

- Henri, RI

““

I am now faced with the elimination of resources and ability to train future safety professionals in industrial hygiene, occupational medicine, occupational ergonomics, occupational health nursing, and occupational safety engineering. Our graduates are in such demand that I have a 100% placement rate before they graduate, and I have had three companies contact me about graduates in the last week. We also research home healthcare (fastest growing industry), firefighters (15 years of research), and manufacturing. Elimination will make workers in these sectors less safe and less productive.”

- Kermit, Cincinnati, OH



Transgender youth are 3-6x more likely to attempt suicide than non-transgender kids. And the people who care for transgender kids, like parents and mental health therapists, are desperate to have the skills and knowledge needed to support them. My NIH funded research focuses on helping prevent or reduce major mental health problems, like suicide and depression, for transgender youth by giving the adults who care for them the tools and information they need to help these youth feel better. For example, we teach these adults how to talk about gender and refer kids to the mental health resources they so desperately need. Research shows that when adults have these tools, ALL kids benefit (not just transgender kids). Without these supports - none of which involve medical intervention - transgender youth suicide will become an even bigger problem than it already is. Defunding NIH research on transgender youth will hurt all of our kids and increase youth suicide.”

- Anonymous, MA

I'm an autistic adult working as a support group facilitator at an autism advocacy organization. The broad impact of recent HHS rhetoric on autism is evident not only in the clients I work with but in myself as well. It's been deeply unsettling to witness people shift from feeling safe enough to unmask and express themselves to retreating back into hiding.

- Anonymous, Worcester, MA

“I work for a research group at a large hospital. In March a grant was terminated which we were subcontractors on. We do not know why it was terminated and were given no explanation. This resulted in my group having to lay off 4 staff members. Then last Friday the NIH froze grants with foreign components. We have some very tiny foreign components in our grants, and due to the blanket nature of the policy we will now be losing nearly half a million dollars by October. My group will probably have to lay off more people or the whole group may shut down.

Before I got this job 5 years ago, I was underemployed and struggling financially. I was getting benefits like SNAP and I worked very hard to learn new skills so I could get a job that would make me financially independent. Then I got this job - an entry level staff position - and was finally able to achieve that goal. I was so proud of my achievement and being able to get off the benefits, and now I'm devastated to think that due to an arbitrary and vague policy, I might end up without a job again and having to apply for things like unemployment benefits - potentially going back on other benefits or risking my housing if I am not able to find another job soon.

I may not have a blue collar job, but I do not consider myself to be a member of the elite. I am just an ordinary person who pulled herself out of poverty and based on what the current government states are its values and priorities, I would have thought they would want to keep me employed and not on benefits.

Freezing funding in this broad and seemingly arbitrary way risks actually increasing costs without getting any benefits from it, while also harming ordinary Americans like me, and that is not something anybody wants.”

Anonymous, Cambridge, MA



Like many other researchers, my colleagues and I have been forced to decide between self-censoring to avoid "bad buzz words" and risking our grant applications not even being read by reviewers. It is demoralizing, a waste of time (and \$), and divides us from researchers whose work is centered around the topics deemed amoral by the Trump administration who cannot simply change a few words to avoid being noticed. As a postdoctoral researcher working on health disparities projects and planning to dedicate my career to alleviating health inequity, I am concerned about who will be able to continue doing this work. What is the point of biomedical or public health research if the ultimate goal of improving lives does not include everyone? Why care about human health if you don't care about the health of all humans?"

- **Therese, MA**

I ask RFK to sit down and listen to the voices of Autistic people and their loved ones who are speaking out and saying "nothing about us without us.

- **Maggie, Lowell, MA**



"My lab researches what happens to the brain after a stroke, and we have discovered a new strategy to treat strokes that we are trying to bring to the clinic. With the recent turmoil at the NIH, we have already lost funding, and new funding is delayed. The existence of my lab, and even my job, is now acutely endangered."

- **Anonymous, Boston, MA**

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Scoop: CDC has no Acting Director, sources confirm.

The power vacuum means upcoming vaccine recommendation decisions will legally fall to RFK Jr.



JEREMY FAUST, MD
APR 09, 2025



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Image: Chat-GPT 4o.

The United States Centers for Disease Control and Prevention does not have an Acting Director, *Inside Medicine* has learned—a seemingly unprecedented and legally significant lapse in leadership. Multiple sources in the agency provided details about the development, and three legal scholars independently confirmed the accuracy of the assessment that Dr. Susan Monarez—who served as Acting Director from January 23 through March 24—could no longer lawfully serve (and, in fact, is *not* currently serving) in that position. And yet, both the CDC’s website and two separate memos sent to staff last week incorrectly stated that Monarez remains in control of the agency.


Here’s why Dr. Monarez cannot legally continue to serve as Acting Director, and first, why the lack of an agency lead, even temporarily, is a potential hazard to everyday Americans.

Why CDC leadership matters.

While the absence of legally authorized leadership is a technicality, it could theoretically have significant consequences for millions of Americans. For example, if an emergency department tomorrow, a flu pandemic could become immediately necessary. In that situation, the CDC or Acting Director would be expected to be coordinating key aspects of any all-of-a-kind deadly epidemic.

“When the emergency operations center is activated, the Director,” said Dr. Tom Frieden, who served as the CDC’s acting director during the Obama administration. In an interview with *Inside Medicine*, he said that the CDC is not prepared for time-sensitive decisions during emergencies.

Even absent a major crisis, however, the CDC’s leadership must be made by Acting or permanent staff. The CDC’s website rejects recommendations of the Advisory Committee on Immunization Practices



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[ACIP],” he noted. After the committee’s winter meeting was suddenly canceled, ACIP is currently scheduled to meet on April 15-16, Frieden pointed out. “It’s unclear who would be in the position to accept or reject those recommendations at this time.”

Legal scholars I spoke with later, however, had more clarity on the issue. The answer, unsettling though it may be, is that absent a CDC Director, the Secretary of the Department of Health and Human Services *alone* possesses the [legal authority](#) to make these calls. This means that ACIP recommendations on RSV and other vaccines under consideration on next week’s agenda will either have to be approved or vetoed by Robert F. Kennedy Jr. himself—a man confirmed by the US Senate despite his long and troubling history of spreading misinformation about vaccines.

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What happened?

On January 23, President Trump [named](#) Dr. Susan Monarez as Acting Director of the CDC. That was fine until March 24, when Monarez was named as the [nominee](#) for the permanent position. (Dave Weldon, the previous nominee, [withdrew](#) from consideration after members of Congress expressed concerns over his record of repeating falsehoods about vaccines. Apparently RFK Jr.’s early performance in his job was disturbing enough to Senators who believe in the science and safety of vaccines that they didn’t want to repeat the mistake of installing another person with a history of spreading vaccine misinformation into a powerful position atop our public health system. Better late than never.)

Immediately after being named Trump’s nominee for permanent CDC Director on March 24, Monarez stopped showing up to leadership meetings at the agency. According to a CDC source, “easily a dozen” routine and ad hoc briefings that had

been scheduled with and for Monarez have been canceled during the last two weeks. The topics of the canceled meetings ranged from preparing for the arrival of the permanent Director (which had become moot) and the future of the agency given the unfolding and often opaque HHS reorganization plans (which remain anything but moot).

All of this is what is *supposed* to happen. That's according to Professor Anne Joseph O'Connell (Stanford Law), Professor Dorit Reiss (UC Law San Francisco), and Professor Steve Vladeck (Georgetown Law). All three experts independently concluded that it is simply not legally permissible under [federal law](#) for the nominee for the permanent CDC Director position to simultaneously function as the Acting Director.

The reasoning behind this policy is sensible. Absent such a rule, the President could just name someone as Acting Director and then subsequently nominate them to the permanent position shortly thereafter. That would mean that the nominee is serving prior to confirmation, a reversal of how the appointments process is supposed to occur.

Who's the boss?

Many CDC employees seem to have no idea who is running the agency at the moment. In fact, in at least one recent meeting, a rank-and-file employee asked that very question to a manager, a source said. No definitive answer was given.

However, recurring meetings of top leadership are continuing to happen, only now without anyone at the helm. Trump appointee Matt Buzzelli, the CDC's newly installed Chief of Staff, is said to attend some, but not all, of the meetings. As a Trump appointee and loyalist, he is seen as representing the political leadership of the agency. But he's also a lawyer with no scientific training or public health experience; he lacks even the faintest technical knowledge needed to understand the content of those meetings. So, despite being the only political appointee at the CDC other than Monarez, nobody seriously believes Buzzelli has now somehow slid into the Acting

Director position—nor that he could credibly function in the role, given his limited experience.

Still, some CDC staffers continue to believe Dr. Monarez remains the Acting Director in part due to a memo* sent out by Matt Buzzelli last week, and because of a CDC leadership [website](#), which continues to list Monarez as Acting Director.



Awkward timing.

This transition to a leaderless agency could not have happened at a more awkward time. By the time thousands of CDC employees were terminated, and dozens of projects had been gutted on April 1, Monarez had been quietly *not* leading the agency for about a week. So, with restructuring, downsizing, and reorganization on everyone's mind at the CDC, wheels are spinning, but nothing is happening.

Meanwhile, somewhere, somehow, a small number of DOGE operatives are opaquely working out plans to reinvent the agency. Experts are not being brought into discussions (or at least not very many, and not very often) about the future of the agency, several sources have told me. "It's more than not knowing," a CDC source said of DOGE. "There's no interest." And even if anyone wanted to listen, there's nobody officially at the helm within CDC to listen anyway. As the source told me, "Anyone who thinks they have power, doesn't."

An unprecedented legal situation.

Such a power vacuum at the CDC appears to be unprecedented. Never before has the agency been without either an Acting or permanent Director. The reason for this is that, until now, the Director position has not been a Senate-confirmed one. Now that it is, the Federal Vacancies Reform Act applies, Professor O’Connell said.

The upcoming ACIP vaccine decision is an important test of whether the law is being followed, O’Connell believes, a decision that *would* have been perfectly fine landing on Susan Monarez’s desk until President Trump nominated her for the permanent position. Now, despite what the CDC’s website and Mr. Buzzelli’s memos say, she can’t make that decision, because she had to drop the formal Acting Director title when she received the permanent nomination, O’Connell pointed out. Of course, she could still try, but it’s unlikely that she will. After all, according to sources, Monarez stopped attending leadership meetings once she was announced as the nominee for the permanent position. This suggests that she is aware of (or has been briefed on) the law and is taking it seriously.

RFK Jr.’s options.

The Trump administration has a couple of options here *vis-a-vis* the ACIP recommendations. First, it could simply name a new Acting Director—and it could be anyone *other* than Susan Monarez. Second, Robert F. Kennedy Jr. could take the decision (normally made by CDC Directors) upon himself. But that might not sit well, especially if he overrides any ACIP recommendations—a rarity, albeit one that has happened in recent memory. (Sidebar: when CDC Director Dr. Rochelle Walensky overrode ACIP on some aspects of Covid-19 booster recommendations, many observers, [myself included](#), [questioned](#) the wisdom of that decision, in part because we anticipated that future CDC or HHS leaders might abuse that privilege in far worse ways....)

If Mr. Kennedy wishes to sidestep a potential scandal around this, one seemingly tempting option might be to turf the decision back down to someone else at CDC, like the Chief Medical Officer. That too, would not be lawful, O’Connell said. “If Secretary Kennedy delegates the CDC’s Director’s role in ACIP to someone else (other than

himself), that could produce litigation,” she said. A particular section of the Federal Vacancies Reform Act governs this, she noted (Section 3348, for anyone keeping score at home). The upshot is that a task—like rubber-stamping or vetoing ACIP vaccine recommendations—can’t just be relegated if that activity was already assigned to a specific role (like the Director) in the 180-day period leading up to the vacancy. So, if RFK Jr. tried to reassign the task of accepting or rejecting ACIP vaccine recommendations to a different person, it “would be voided by the court—if someone had standing to sue,” O’Connell said.

Finally, even if a new Acting Director were to be installed (or the permanent Director quickly confirmed) the HHS Secretary still has the authority to overturn his or her vaccine policy decisions. And that’s the real problem, isn’t it? Regardless of who eventually takes control of the CDC, the long-term tension will not have been resolved, and we may enter uncharted territory. Indeed, while we’ve seen cases of CDC Directors overriding ACIP recommendations, will we soon see the first example of an HHS Secretary overriding an ACIP vote? If so, that would certainly be legal—but likely exceedingly controversial among Senators, even those who voted for RFK Jr.’s confirmation. Unfortunately, their recourse would be minimal. Once confirmed, the Secretary of HHS serves at the pleasure of the President.

If you have information about any of the unfolding stories we are following, please email me or find me on Signal at [InsideMedicine.88](#).

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***Below is an abridged version of one of two memos sent to CDC staff last week. The memo states who occupies various leadership positions as of April 2, 2025. However**

as above, it is legally not possible for Susan Monarez to be Acting CDC Director.

Dear CDC Colleagues,

I would like to express my appreciation to each of the individuals who have been willing to step in to acting director roles on such short notice.

While we are waiting to gain better clarity on the future of each of the centers, we do not want to leave any gaps in CDC's day-to day functions. These acting positions are for an undetermined amount of time and each center will have its own specific challenges.

Leadership appreciates your flexibility and patience as the consolidation of services evolves.

Once again, thank you to directors who have lent us their staff, and to the new acting directors who have stepped up to the plate. Deb Houry will be connecting with each of the centers this week.

IOD [Immediate Office of the Director]

Acting CDC Director – Susan Monarez

CMO – Deb Houry

COS – Matt Buzzelli

Deputy Director for Public Affairs/Acting OC – Nina Witkofski

Acting OCOO – Sara Patterson (Deb Lubar retiring 4/19)

Senior Advisor – Stuart Burns

....

Sincerely,

Matt Buzzelli

CDC Chief of Staff

Thanks to Professor Anne Joseph O'Connell, Professor Dorit Reiss, and Professor Steve Vladeck, as well as Dr. Tom Frieden, and the active and RIF'd CDC employees who bravely shared key information that made this post possible.

Thanks to YOU for reading, sharing, speaking out, and supporting Inside Medicine. Please as your questions in the comments.

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Comments Restacks

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 **Lyn Horan** Apr 9
 Liked by [Jeremy Faust, MD](#)
Outrageous and totally expected. Thanks for update.
 LIKE (6)  REPLY  SI

2 replies by [Jeremy Faust, MD](#) and others

 **Mary Beth Miotto MD MPH FAAP** Apr 9
 Liked by [Jeremy Faust, MD](#)
Is it possible that there was full knowledge of this legal discrepancy when she was nominated AND t
ACIP meeting rescheduled? After all, having the Secretary make a call that is dubious or having to
reschedule ACIP again is an "oops" that works in favor of the chaos playbook.
 LIKE (4)  REPLY  SI

2 replies by [Jeremy Faust, MD](#) and others

10 more comments...

May 12, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
Room 120F, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC

Dear Secretary Kennedy:

The below-signed disability rights, civil rights, and public health organizations and professionals write to raise our significant concerns about the National Institute of Health (NIH) proposal to create a national autism “registry.” The proposal, released as part of an April 21 presentation by NIH Director Jay Bhattacharya, detailed the development of a “real-world data platform” that would serve as the basis for “developing national disease registries, including a new one for autism.”¹ Although the Department of Health and Human Services (HHS) has since stated it is not creating an “autism registry,” the larger platform’s unclear purpose and potential for abuse necessitates that HHS and NIH engage with disability and civil rights advocates and implement fundamental safeguards.

Data collection and sharing can pose serious risks. Some data collection enables researchers and policymakers to better understand and meet the needs of people with disabilities, while other types of data collection can and have led to increased surveillance, stigmatization, and marginalization. Disabled people in the United States have a long and troubled history with governmental efforts to find and track disability for the purpose of eliminating it.² The lack of clarity about what NIH specifically intends to do has led to immense concern among autistic people, family members, privacy advocates, and researchers.

HHS and NIH’s failure to engage with autistic people and autistic advocates has exacerbated this lack of clarity. Under previous administrations led by both Democrats and Republicans, autistic people, advocates, and other organizations had direct lines of communication with autism policy experts within HHS. That communication enabled autistic people and advocates to give feedback, raise concerns, and ask questions. If autistic people, advocates, and researchers had the opportunity to provide input into Dr. Bhattacharya’s proposal, we would have urged the administration to clarify important details, such as whether they planned to collect personally identifiable information, how

¹ Dr. Jay Bhattacharya, Director, National Institutes of Health, *NIH Director’s Update* (Apr. 21, 2025), <https://dpcpsi.nih.gov/sites/default/files/2025-04/Council-of-Councils-04.21.25-Director-Update.pdf>; Alexander Tin, *Health Agencies “Not Creating an Autism Registry,” Official Says, Contradicting NIH Director*, CBS News (Apr. 25, 2025), <https://www.cbsnews.com/news/health-agencies-not-creating-autism-registry-hhs-nih>.

² *On A ‘Eugenics Registry,’ A Record Of California’s Thousands Of Sterilizations*, NPR (Dec. 18, 2016), <https://www.npr.org/2016/12/18/505000554/on-a-eugenics-registry-a-record-of-californias-thousands-of-sterilizations>.

they would go about collecting data they proposed to gather from sources like wearables, and how this data would be used and secured.³

Unfortunately, disengagement with autistic people and advocates has been emblematic of HHS's approach to autism policy under this administration: it has kept autistic people and leading autism organizations from the discussion. Autism advocates have been pointedly denied the opportunity to weigh in on our community's research priorities. NIH's failure to engage the larger autism community before launching its "real-world data platform" is deeply troubling and a missed opportunity for autism support.

We continue to have many unanswered questions about the data platform and the study (if not a "registry") of autism that it will support. HHS must answer essential questions as soon as possible such as what data it will collect, what sources it will rely on, and how it will deidentify and secure the data. Many key research projects rely on data from multiple sources,⁴ and where the data's collection, use, and retention are accompanied by sufficient safeguards, the research can provide meaningful benefits while reducing its risks, as has been well established in medical research for decades.⁵ Research to better support autistic people is extremely valuable and should be continued; that work, however, is only possible through the use of health data with meaningful privacy protections. Failure to provide those protections may chill individuals' willingness to participate in research, seek services, or even openly identify as autistic.

To establish trust in the "real-world data platform" and the projects it supports, NIH and HHS must take three key steps:

- **Engage with disability rights, privacy, and civil rights advocates.** Meaningful communication with autistic people and advocates is essential to ensuring that data-driven projects are rooted in trust. People with autism and their families can help shape HHS projects in meaningful ways based on their lived experience, and advocates with expertise in disability rights, privacy, and civil rights can advise on establishing proper policy and technical safeguards to protect privacy and civil rights. Engagement will also facilitate transparency around the collection and ultimate use of data and help ensure that the autism community is invested in the work.
- **Establish fundamental privacy safeguards.** Building trust in data collection and use requires establishing safeguards that help prevent misuse and abuse of the

³ NIH is actively establishing the infrastructure for its data platform and autism study, including by implementing data sharing with the Centers for Medicare and Medicaid Services (CMS). Although NIH and CMS have stated the data sharing will be "privacy and security compliant," it has not provided details of that arrangement to the autism community. See *NIH, CMS Partner to Advance Understanding of Autism Through Secure Access to Select Medicare and Medicaid Data*, Nat'l Inst. Health (May 7, 2025), <https://www.nih.gov/news-events/news-releases/nih-cms-partner-advance-understanding-autism-through-secure-access-select-medicare-medicaid-data>.

⁴ *E.g.*, Administration for Community Living, *Developmental Disabilities Projects of National Significance* (2024), https://acl.gov/sites/default/files/programs/2025-01/projects-natl-significance_factsheet-acl.pdf.

⁵ *E.g.*, 42 C.F.R. §§ 164.306–164.316; *id.* §§ 164.502–164.514.

data. Federal data collection and use is rooted in key principles established in policies such as the Fair Information Practice Principles⁶ and the Office of Management and Budget's Circular A-130.⁷ Data must be collected for a specific purpose and its use limited to that purpose. Agencies should ensure the quality and integrity of the data, foster public transparency, and obtain individual consent to share personally identifiable information or to use it for any purpose beyond those necessary to deliver services. Any NIH research or data platform must comply with these essential requirements.

- **Ensure that the data platform helps, not hurts, autistic people and people with disabilities.** The ultimate goals of the NIH's data platform should be to advance the well-being of autistic people, people with disabilities, and the public health — while minimizing potential harms. This can be achieved by ensuring that studies and research rely on the sound scientific practices that are at the heart of any “gold-standard research.” Similarly, engaging with affected communities and establishing privacy safeguards, such as conducting privacy impact assessments under the e-Government Act,⁸ can help identify potential harms early on. Ultimately, however, it is up to NIH and HHS to assess its proposal, before deploying it, to ensure that its benefits outweigh its risks.

Trust and collaboration in NIH's data platform is essential. We urge NIH and HHS to revisit its approach to its “real-world data platform” to ensure that impacted communities are consulted, that the platform is accompanied by privacy safeguards, and that the platform furthers the wellbeing of autistic people, people with disabilities, and the public health.

Please feel free to reach out to Larkin Taylor-Parker (ltaylorparker@autisticadvocacy.org) and Greg Robinson (grobinson@asan.org) at the Autistic Self Advocacy Network and Cody Venzke (cvenzke@aclu.org) and Vania Leveille (vleveille@aclu.org) at the American Civil Liberties Union with any questions.

Sincerely,

Access Living
 Advocacy for Principled Action in Government
 Alliance For TransYouth Rights
 American Civil Liberties Union
 American Music Therapy Association
 American Therapeutic Recreation Association
 Autism Society of America
 Autistic People of Color Fund
 Autistic Women & Nonbinary Network
 Bronx Developmental Parents Association, a Chapter of The Arc New York

⁶ *Fair Information Practice Principles (FIPPs)*, Federal Privacy Council (2022), <https://www.fpc.gov/resources/fipps>.

⁷ Office of Management and Budget, Circular No. A-130 (2016), <https://www.cio.gov/policies-and-priorities/circular-a-130>.

⁸ 44 U.S.C. § 3501 note.

Brooklyn Center for Independence of the Disabled
 Caring Across Generations
 Center for Democracy & Technology
 Center for Law and Social Policy (CLASP)
 Center for Public Representation
 CenterLink: The Community of LGBTQ Centers
 Changing Perspectives
 CIDA
 Coalition for Asian American Children and Families
 Coalition on Human Needs
 CommunicationFIRST
 Consumer Federation of America
 CUNY School of Law, Disability Rights and Social Justice Clinic
 Defending Rights & Dissent
 Demand Progress Education Fund
 Robert D. Dinerstein, Professor of Law Emeritus, American University Washington College
 of Law*
 Disability Belongs
 Disability Law Center of Utah
 Disability Rights Arizona
 Disability Rights Arizona
 Disability Rights California
 Disability Rights Center - NH
 Disability Rights Florida
 Disability Rights Iowa
 Disability Rights North Carolina
 Disability Rights South Carolina
 Disability Rights Tennessee
 Easterseals
 Electronic Frontier Foundation
 Electronic Privacy Information Center
 Empowering Pacific Islander Communities (EPIC)
 Fight for the Future
 Hertog Education Law PC
 IEC (Institute for Exceptional Care)
 Integrated Community Collaborative
 Inter Agency Council of Developmental Disabilities Agencies, Inc.
 Iowa Developmental Disabilities Council
 Japanese American Citizens League
 Law Office of Kimberly Spire-Oh
 Long Island Center for Independent Living, Inc. (LICIL)
 National Advocacy Center of the Sisters of the Good Shepherd
 National Association for Rights Protection and Advocacy
 National Association of Councils on Developmental Disabilities
 National Disability Rights Network (NDRN)
 National Disabled Legal Professionals Association
 National Down Syndrome Congress
 National Health Law Program
 National LGBTQI+ Cancer Network

National PLAN Alliance
Native American Disability Law Center
Nevada Disability Advocacy & Law Center
New America's Open Technology Institute
New York Alliance for Developmental Disabilities
North Dakota Protection & Advocacy Project
NYC FAIR Family Advocacy and Information Resource
Open MIC
PASILC
Primary Care Development Corporation
S.T.O.P. - The Surveillance Technology Oversight Project
South Asian Public Health Association (SAPHA)
Southern Tier ADAPT
Southern Tier Independence Center
Suffolk Progressives
The Advocacy Institute
The Autism Connection of PA
The Institute for Health Research & Policy at Whitman-Walker
The Leadership Conference on Civil and Human Rights
TransFamily Support Services
Treatment Action Group
United Church of Christ
United Church of Christ Media Justice Ministry
Utah Disability Advocacy Network (UDAN)

*For identification purposes only

Cc: Dr. Jay Bhattacharya, Director, National Institutes of Health
Dr. Mehmet Oz, Director, Centers for Medicare and Medicaid Services
Heather Melanson, Chief of Staff, Department of Health & Human Service
Sean Keveney, Acting General Counsel, Department of Health & Human Services
Stefanie Spear, Principal Deputy Chief of Staff & Senior Counselor, Department of
Health & Human Service



AMERICAN ACADEMY
OF OPHTHALMOLOGY

Michael X. Repka, MD, MBA
President
American Academy of Ophthalmology
Statement for the Record
Senate Health, Education, Labor and Pensions Committee
May 14, 2025

20 F Street NW
Suite 400
Washington, DC

P.O. Box 7424
San Francisco, CA

aao.org

Chairman Cassidy and Ranking Member Sanders,

The American Academy of Ophthalmology appreciates the opportunity to share our concerns on specific National Institutes of Health (NIH) reform proposals included in the President's Fiscal Year (FY) 2026 Proposed Budget ahead of the Committee's hearing on the Department of Health and Human Services FY2026 Budget. The Academy is the largest association of eye physicians and surgeons in the United States. A nationwide community of over 20,000 medical doctors, we protect sight and empower lives by setting the standards for ophthalmic education, supporting research, and advocating for our patients and the public. We innovate to advance our profession and to ensure the delivery of the highest-quality eye care.

In 1968, Congress created the National Eye Institute (NEI), providing an independent institution for eye and vision research. At that time, millions of Americans were going blind from common eye diseases which resulted in their isolation and a diminished quality of life. Previously, the National Institute of Neurological Diseases and Blindness (NINDB), now the National Institute of Neurological Diseases and Stroke (NINDS), was home to federal vision research programs. With growing concern about the lack of interest in vision research at NINDB, Congress aligned with stakeholders who felt that the rising incidence of eye disease and vision impairment necessitated an independent vision research institution. Since its creation, NEI's mission has been to protect and prolong vision, and over the past 57 years, NEI has grown into the global leader in eye and vision research, spearheading initiatives that have led to transformational breakthroughs in the prevention, recognition, and treatment of eye disease and vision impairment. Successes in gene therapy and regenerative medicine may translate into a brighter future for both rare and common eye diseases. NEI's status as the global leader in eye and vision research could not have happened without strong bipartisan support from Congress and every presidential administration since its inception.

The history of the NEI, including the rationale for its creation, provides important context for why we write today. We are extremely concerned with a provision of the President's FY2026 Budget Proposal that seeks to merge the National Eye Institute into a broader institute with the National Institute of Neurological Diseases and Stroke, and the National Institute of Dental and Craniofacial Research (NIDCR). We believe that the proposed consolidation of NEI into a broader Institute on Neuroscience and Brain Research will upend the progress that NEI has made over the past 57 years improving ocular health and vision of our citizens and diminish its immense success in advancing eye and vision research for the benefit of future Americans. The proposed change is of threat to the growing patient community in the US

that relies on the Institute's prioritization of vision science research to address sight-threatening eye diseases and vision disorders. The Academy is adamantly opposed to the loss of NEI as an independent institute. We strongly believe that our opposition is shared by the American people, including the millions of Americans living with eye disease and vision impairment.

Maintaining the NEI's status as an independent institute within the NIH is essential to ensuring that vision research continues to be prioritized to address the growing disease burden in the United States. By 2050, without effective interventions, Center for Disease Control and Prevention (CDC) estimates there will be a 72% increase in diabetic retinopathy, an 87% increase in cataracts, a 100% increase in glaucoma, a 100% increase in age-related macular degeneration, and an 150% increase in vision impairment and blindness. Dedicated research is needed to improve diagnosis, treatment, and care for people who are impacted by these diseases that fundamentally change the way they experience the world. This is especially important as we live in an increasing digital age where our work and daily lives increasingly depend on visual technology, making healthy vision essential. Without it, individuals face significant barriers to fully engaging with and excelling in this technology-driven society. This is a tremendously important issue for ensuring our children can achieve in school, that the American workforce can thrive, and that seniors can enjoy a high quality of life in their retirement. To address these challenges, our nation needs both a thriving, innovative private sector and a strong NEI that is centrally focused on advancing vision science and research.

Recent criticism of the NIH has been centered a lack of transparency, meandering research focuses, and silos that limit engagement with stakeholders, including the private sector. These criticisms are not applicable to today's NEI, which has thrived despite being one of the lowest funded independent institutes at NIH. The restrained budget has prompted the NEI to have a tailored research focus and active collaboration with the private sector to achieve meaningful results for the American public. NEI has demonstrated success bolstering accomplishments in the private sector, as NEI-funded investigator-initiated research grants and Small Business Innovation Research (SBIR) grants have resulted in several commercialized products, including:

- **Drug Therapies for Age-related Macular Degeneration (AMD) and Diabetic Eye Disease**
NEI supported development of the first generation of Food and Drug Administration (FDA)-approved anti-angiogenic ophthalmic drugs to inhibit abnormal blood vessel growth in "wet" AMD, which stabilize vision loss and, in some cases, improve lost vision. These drugs were fast-tracked by FDA for approval to treat diabetic eye disease and now represent the standard of care. These sight saving innovations were transformational for patients with AMD and diabetic eye disease. AMD is an eye disease that can blur a patient's central vision and is a leading cause of vision loss for older adults. Diabetic eye disease is a group of eye problems that can affect people with diabetes. These conditions include diabetic retinopathy, diabetic macular edema, cataracts, and glaucoma.
- **Artificial Intelligence**
The NEI has established itself as a leader in the development of artificial intelligence technologies in medicine and research. The investment has been critical for advancing patient care. NEI-funded research led to the first autonomous AI system in any field of medicine, IDx-DR, which was approved by the FDA in 2018 to detect diabetic retinopathy in people with diabetes. The Centers for Disease Control and Prevention (CDC) says that about 90% of vision loss from diabetes can be prevented. Early detection is key.
- **Gene Therapy**

The NEI supported the development of Luxturna, the first FDA-approved gene therapy for an inherited disease. This groundbreaking treatment for the previously untreatable Leber congenital amaurosis has paved the way for other gene therapies targeting vision and non-vision-related genetic disorders.

- **Optical Coherence Tomography (OCT)**

OCT allows eye care providers to view the back of the eye without dilation in three dimensions, making patient visits faster and more comfortable, with more accurate diagnoses than possible with previous techniques. In a 2017 *American Journal of Ophthalmology* study, this technology supports a private commercial market of more than \$1 billion per year, at least 16,000 high-paying jobs, and saved more than \$11 billion by reducing unnecessary injections of prescription drug therapies

In 1971, when NEI launched a series of clinical trials to identify treatment options for diabetic retinopathy, it was estimated that 300,000 Americans had the disease. Today, CDC estimates nearly 10 million Americans have diabetic retinopathy. This tremendous rise in the incidence of but one eye disease underscores that the challenges our country faces to address eye disease and vision impairment are growing. A standalone institute focused on addressing these challenges must continue to be prioritized to improve the quality of care and push innovation in that care.

Closing the NEI and merging it into a broader Institute on Neuroscience and Brain Research would stunt NEI's partnerships with the private sector, shred NEI clinical trial networks, damage targeted research programs, and be detrimental for patients with eye disease and vision impairment. For stakeholders, including the Academy, it would be a startling reversion and promote the same fights of nearly 60 years ago when stakeholders fought for the prioritization of vision research within a bigger institute including much of neuroscience.

The preservation of the NEI as an independent institute under the NIH umbrella is of paramount importance to the Academy. We urge you and your colleagues in Congress to protect the NEI and continue the nearly six decades of bipartisan support for an independent institute focused on eye and vision research. We are committed to engaging with you about alternative concepts of NIH reform that can be beneficial to its mission and drive benefit for our patients.

Sincerely,



Michael X. Repka, MD, MBA
President
Medical Director for Governmental Affairs
American Academy of Ophthalmology



CLASP Statement for the Record
United States Senate Committee on Health, Education, Labor and Pensions
“Hearing on Fiscal Year 2026 Department of Health and Human Services Budget”
May 14, 2025

Chairman Cassidy, Ranking Member Sanders, and Members of the Senate Committee on Health, Education, Labor and Pensions, we thank you for the opportunity to submit a statement for the “Hearing on Fiscal Year 2026 Department of Health and Human Services Budget.” The Center for Law and Social Policy (CLASP) is a national, nonpartisan, anti-poverty organization advancing solutions to improve the lives of people with low incomes. For over 50 years, our organization has used research and analysis to advance policy solutions that disrupt structural and systemic racism and remove barriers blocking people from economic security and opportunity. CLASP has a long history of advocating for child care and early childhood programs, promoting maternal health, ensuring people of color and those with disabilities have access to health services, and ensuring resources for mental health services.

We are gravely concerned about whether the integrity of the programs that the Department of Health and Human Services (HHS) is responsible for can withstand the cuts and restructuring that the Trump Administration has proposed in recent weeks. HHS plays a fundamental role in addressing the well-being of the nation’s 340 million people, and everyone benefits from HHS’s work to promote public health and provide essential human services. This testimony seeks to underscore the importance of these programs, particularly those that help families and children with low incomes access vital supports. We urge the committee to ensure that these programs are robustly funded and that Congressional intent is carried out in the execution of the programs by HHS.

Child Care and Early Education Programs

Child care programs are incredibly valuable for children, families, and the economy. Without child care, parents and caregivers cannot participate in the workforce, go to school or training programs, or take care of other responsibilities. Unfortunately, for many families, child care costs remain unaffordable and inaccessible. According to our research, only 14 percent—or 1 in 7 eligible families—are able to access federal child care subsidies through the Child Care and Development Fund (CCDF) based on state income eligibility requirements. This is because child care funding is not adequately resourced. Currently, federal funding flows to states through CCDF, which consists of the Child Care Entitlement to States (CCES) and the Child Care and Development Block Grant CCDBG. States can also decide to utilize Temporary Assistance for Needy Families (TANF) block grant and the Social Services Block Grant (SSBG) to support child care. Head Start and Early Head Start are also vital and complementary programs that provides affordable early education and supportive services for nearly a million families with low incomes each year. This includes parenting support, supporting prenatal health, connecting families to local and federal assistance, and employment assistance. However, funding for these programs comes nowhere close to meeting the need and proposals to cut or reduce investments in these vital programs threaten the already limited access.

Unfortunately, the Trump Administration has already started threatening access to the programs that help fund child care through states and at the local level by freezing funding, firing federal workers at HHS who oversee these programs, and signaled further cuts in proposed budget plans. All of this is causing chaos and confusion for program administrators and uncertainty for families relying on federal funds for child care, particularly those with low incomes and families of color. In late January, the administration froze federal funding, and that locked administrators out of the websites they use to access grants. Dozens of Head Start programs had to close temporarily. Then, the administration announced layoffs in February and April for the Office of Head Start and the Office of Child Care, resulting in a reduction of 40-50 percent of federal staff and the closure of five regional offices, which oversaw grantees in 23 states and 5 territories. These offices provided training, technical assistance, and administrative support to ensure that grants reached the intended beneficiaries and also served as a liaison between program administrators and the federal government. In addition, the HHS leaked budget document proposes eliminating Head Start altogether. This would have a profound effect on the nearly 800,000 children served by Head Start and the 250,000 child care providers employed through the program with additional domino effects impact who communities, especially in rural communities where Head Start is a cornerstone.

The Trump Administration's proposals and actions will move families further away from the goal of achieving economic stability and quality child care and early education support for their children. It will make it harder for our economy to prosper when child care jobs disappear and parents and caregivers are forced to leave the workforce because they cannot access child care and other supportive programs. This committee should push for robust and sustained funding of child care and early education programs and should ensure funds are being used in the way Congress intends to support families and communities across the country.

Dismantling our nation's public health infrastructure

Along with the numerous agency, department, and regional office cuts and reductions in critical funding that supports state and local health departments, the reorganization and cuts stated in the HHS skinny and leaked budgets will be detrimental to the nation's health. Public health departments are integral to ensuring populations have critical programming to maintain and improve their physical and mental health, and to be safe where they live, work, and play. Recent and proposed budget cuts and job losses are eroding our public health safety net. We've noted a few examples below.

Disability Programs

The HHS leaked document proposes [dismantling the Administration for Community Living \(ACL\)](#), eliminating its budget of \$2.6 billion, and splitting the department into three parts. ACL supports older adults, disabled people, caregivers, and families, and includes programs such as Meals on Wheels, disability research, independent living, and nutritional programs. This represents just one of the many attacks by the administration on the disability community, including cuts to the Department of Education and the Social Security Administration.

Prevention and Public Health Fund

The HHS leaked budget [eliminates funding to the Prevention and Public Health Fund](#), critical funding to help bolster the public health infrastructure. It supports programs to increase physical activity; improve

nutrition; expand mental health and injury prevention programs, including for suicide prevention; and financially supports states to decide how to improve prevention efforts for their populations.

Mental Health and Substance Use

The HHS leaked budget document also calls for dismantling the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA). This will have substantial ripple effects on people's behavioral health. For example, SAMHSA facilitates the treatment of over 1.5 million people in substance use facilities annually and supports programs that families and communities depend on for mental health support, suicide prevention, and more. Earlier this year, the administration cut 10 percent of the almost 900 employees at SAMHSA, impacting the provision of critical suicide hotline (988) grants to states, among other key services. SAMHSA also provides significant block grants in community mental health and substance use nationwide. Cutting staff and reorganizing HRSA funding and technical assistance will exacerbate critical gaps in the behavioral health workforce.

The President's skinny budget also calls for 40 percent cuts to the National Institutes of Health and would include the Institute on Minority Health and Health Disparities, which has conducted critical research, including in mental health. Likewise, the Centers for Disease Control and Prevention's Office of Minority Health, the Centers for Medicare and Medicaid Services' Office of Minority Health, and the HHS Office of Minority Health have been severely gutted and kept mostly in name only, because of legislative statute by the ACA. The elimination of these departments and their budgets will seriously impact community-based organizations that receive grant funding.

The budget also calls for the elimination of the Healthy Transitions grant, which focuses on mental health prevention for youth, and is the only grant of its kind within HHS. The Healthy Transitions grantees we've worked with over the years have told us how critical the funding has been to support the young people that they serve.

National Institutes of Health Higher Education Funding

The budget request codifies an already utilized strategy of using federal research grants as bargaining chips to force universities to comply with the administration's larger anti-diversity agenda. On April 21, the National Institutes of Health (NIH) announced that it was terminating grants and taking back research funding for institutions that offer diversity, equity, and inclusion programs. These institutions had already been targeted by the administration, which had made earlier NIH cuts depriving medical schools of over \$1 billion in funding from terminated grants. Of the 220 organizations that experienced NIH funding cuts throughout March, 94 were public universities. The administration is facing multiple lawsuits for this practice, which serves only to punish institutions seeking to center equity in public health.

We appreciate the opportunity to submit a statement about this important topic, and we thank the committee members for considering the importance of funding HHS programs at appropriate levels so people who rely on these programs can access them. If you have any questions, please contact Richa deCant at rdecant@clasp.org.



May 12, 2025

The Honorable Bill Cassidy, Chair
The Honorable Bernie Sanders, Ranking Member
Senate Committee on Health, Education, Labor, and Pensions
428 Dirksen Senate Office Building
Washington, DC

*Re: Hearing of the Senate Health, Education, Labor, and Pensions (HELP)
Committee – Secretary Robert F. Kennedy Jr.*

Dear Chairman Cassidy, Ranking Member Sanders, and Members of the HELP Committee,

On behalf of Disability Belongs™, I am pleased to submit this statement for the record for the May 14, 2025, Senate HELP Committee hearing with Secretary Robert F. Kennedy Jr. regarding the proposed reorganization of the Administration for Community Living (ACL).

Disability Belongs™ is a disability-led, nonpartisan nonprofit committed to advancing community living, independence, and opportunities for people with disabilities. We welcome this opportunity to address the critical importance of preserving ACL's structure and mission to protect the rights, well-being, and self-determination of people with disabilities and older adults.

Concerns Regarding the Proposed ACL Reorganization

Since its establishment in 2012, ACL has served as the sole federal agency focused exclusively on promoting the rights, health, and independence of people with disabilities and older adults. The agency's unified structure has effectively coordinated essential federal programs, including independent living services,

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Mail: 43 Town & Country Drive, Suite 119-181, Fredericksburg, VA



assistive technology, traumatic brain injury initiatives, and civil rights enforcement.

The proposed reorganization threatens to dismantle ACL's cohesive structure, dispersing its programs across multiple HHS offices and eliminating its dedicated leadership. Such fragmentation risks undermining statutory obligations under the Older Americans Act (OAA), the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), and the Workforce Innovation and Opportunity Act (WIOA), jeopardizing the progress made in advancing community living and civil rights for people with disabilities.

Impact on Community Living, Independence, and Civil Rights

If ACL's standalone structure is fragmented, critical programs and protections could be compromised, including:

- **Community-Based Services:** Reorganizing ACL would disrupt access to home and community-based services, assistive technology, and independent living programs, increasing the risk of unnecessary institutionalization.
- **Civil Rights and Abuse Prevention:** Fragmenting ACL's authority could weaken protections against abuse, neglect, and exploitation, particularly in institutional settings where people with disabilities and older adults remain vulnerable.
- **Nutrition and Family Support Programs:** Critical programs like Meals on Wheels and caregiver support could face service disruptions, exacerbating food insecurity and workforce disparities for family caregivers.
- **Research and Data Collection:** Integrating ACL's research initiatives into broader HHS offices may dilute their focus on disability and aging populations, hindering effective policy development and oversight.

Policy Recommendations and Requests

Disability Belongs™ respectfully urges the Committee to:

1. Halt the proposed reorganization of ACL and maintain its status as a standalone agency with dedicated leadership.

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Fredericksburg, VA



2. Ensure ACL retains the staffing, resources, and authority necessary to meet its statutory mandates under the OAA, DD Act, WIOA, and its other enabling statutes.
3. Maintain full funding for ACL programs that empower older adults and disabled people to live independently in the community.
4. Urge HHS to actively engage the disability and aging communities in public consultation to inform any future restructuring of ACL, ensuring that decisions are grounded in the lived experiences of those most affected.

Closing and Willingness to Assist

At a time when millions of Americans rely on ACL-supported programs to live independently and with dignity, the agency's stability and authority are more critical than ever. Disability Belongs™ urges the Committee to protect ACL's vital role in promoting community living, preventing unnecessary institutionalization, and safeguarding civil rights.

We are ready to work with the Committee, Secretary Kennedy, and other stakeholders to ensure that ACL's mission remains intact and that its programs continue to serve people with disabilities and older adults effectively and equitably.

Thank you for the opportunity to provide this statement.
Sincerely,

A handwritten signature in black ink, appearing to read "A. Simms", with a long horizontal flourish extending to the right.

Ariel A. Simms, Esq. (they/them or she/hers)
President and Chief Executive Officer
Disability Belongs™

Action@DisabilityBelongs.org

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Fredericksburg, VA



Diabetes Prevention Program Outcomes
Study
www.dppos.org

May 9, 2025

Dear Senator Sanders,

I am writing to you as an investigator in the Diabetes Prevention Program Outcomes Study (DPPOS) and as one of our State's constituents to ask you to help restore funding for this important study.

As widely reported in the press (NYT, March 18: *'Colossally Wasteful': Trump's Cuts Imperil Medical Research at Columbia*; NYT, April 7, *As Kennedy Champions Chronic Disease Prevention, Key Research Is Cut*; WSJ, April 9, *Collateral Research Damage at NIH*; among many others) and in a March 25th letter from the Diabetes Caucus to Secretary Kennedy and Director Bhattacharya, funding for the DPPOS, a 30-year study of diabetes prevention, was terminated abruptly on March 10th, 2025. The issue of funding of health-related research, including diabetes, was also discussed at the Senate Appropriations Committee hearing on "Biomedical Research: Keeping America's Edge in Innovation" on April 30, 2025. Importantly, the termination of DPPOS funding was part of the halt in federal funding of Columbia University in which DPPOS was an innocent bystander.

The DPPOS is the long-term follow-up of the Diabetes Prevention Program which demonstrated in 2001 how to reduce the development of type 2 diabetes in our country. DPPOS is following more than 1700 DPP participants to study the long-term consequences of diabetes prevention and, most recently, the occurrence, causes and possible treatment of Alzheimer's disease and other dementias in people with diabetes and pre-diabetes. The DPPOS study population is representative of more than one-half of all adults in the United States. Without funding, the DPPOS will need to close in the very near future, losing the opportunity to continue studying chronic diseases such as diabetes and dementia.

Since 2022, the NIH required the funds for this multicentered study to flow through a single center, Columbia University, which in turn distributed them to the individual centers. Thus, although the funds are sent to Columbia, more than 90% of the funds are distributed to 30 centers, such as ours, in 21 states. *Importantly, the DPPOS had nothing to do with the alleged Title VI infractions which led to the termination of funding at Columbia.* Although we have contacted the Department of Health and Human Services (HHS) and the NIH repeatedly to restore our funding, to date there has been no response. Further, it is our understanding that despite the request of the co-chairs of the Diabetes Caucus (Representatives Diana DeGette and Gus M. Bilirakis) in their March 28, 2025 letter to Secretary Kennedy and Director Bhattacharya that they "respond in detail no later than April 8, 2025", no reply to their letter has been proffered.

Without the restoration of funding, our centers will be forced to close soon and the 30-year-old DPPOS will be over. Questions that are critical to public health related to diabetes, diabetes prevention and their long-term consequences, including Alzheimer's disease and dementia, will remain unanswered. The termination has occurred despite the stated interest of the current Secretary of HHS to address chronic diseases, such as diabetes and dementia, as a high priority for the Administration.

DPPOS is a national biomedical treasure. Please help us to restore its funding.



Grandparents for Vaccines

Statement for Congressional Record

Senate HELP Committee Hearing

FY 2026 Department of Health and Human Services Budget

May 14, 2025

Witness: HHS Secretary Robert F. Kennedy Jr.

[Grandparents for Vaccines](#) (GPV) calls on the Senate HELP Committee to demand the immediate removal of Robert F. Kennedy Jr. as Secretary of Health and Human Services (HHS) either by firing or resignation for cause. Specifically, Secretary Kennedy uses his power to increase the chance that our grandchildren will die from diseases we have the ability to fully prevent. He also has degraded America's ability to develop cures and treatments they will need in the future.

GPV was founded by grandparents in response to direct efforts to deny our grandchildren protection from deadly and disabling diseases that are entirely preventable by immunization. We represent the voices of a majority of the 67 million Americans who have grandchildren.

Of particular concern is that Robert F. Kennedy Jr. lied to the U.S. Senate and nation when describing what his highest priorities as the head of Health and Human Services (HHS) would be. On January 30, 2025, Secretary Kennedy raised his hand and took an oath, swearing to faithfully discharge the duties of the office for which he was about to enter. In overseeing HHS he was tasked with enhancing the health and well-being of all Americans by ensuring effective health and human services, fostering advances in the sciences underlying medicine, public health and social services, and protecting against public health emergencies. Secretary Kennedy has betrayed every one of these core responsibilities.

During his short tenure as Secretary of HHS, two children and an adult have died from measles; at least [four people in the U.S. have died from pertussis](#), including two infants from Louisiana; and [12 children have died of influenza](#) surpassing the previous high for a flu season

outside of a pandemic year, as reported in the Centers for Disease Control and Prevention (CDC) [weekly update](#) on May 2, 2025.

Secretary Kennedy received a letter signed by [several Senators on March 11th](#) requesting he immediately commence a national vaccination campaign to prevent these childhood fatalities. Instead of averting childhood deaths, his actions have only increased the chance more of our grandchildren will lose their life including:

- Advising parents and guardians of children sickened with measles to use Vitamin A and cod liver oil, [resulting in their hospitalization due to liver toxicity](#), and encouraging them to shun the MMR vaccine, the only option available to end the threat of measles. [Stated](#), “We are developing now a worksheet for doctors to address the epidemic, to address people who have it, not just with vaccination, but actually with budesonide, with clarithromycin, with vitamin A and many, many other treatments that have been shown very effective.” Again, by telling America their best hope is with remedies that *do not save lives from measles*, the HHS Secretary is pushing more and more Americans to shun the MMR.
- Eliminating [\\$11.4 billion in funding by the Centers for Disease Control and Prevention and the Department of Health and Human Services](#) intended for clinics planned in areas in Texas, the center of the current measles epidemic, and where vaccination rates for measles, mumps, and rubella are low. These are not simply budget cuts. Closing these clinics directly threatens the ability of our grandchildren to receive the vaccinations they need to survive this surge of measles and pertussis.
- Pushing the discredited slander that vaccines cause autism. The question of vaccines and autism has been studied exhaustively and every study shows no connection. In populations that do not get vaccinated, autism rates are no different. By abusing his power, Secretary Kennedy again pushes this false premise. To that end [he has hired an individual who masqueraded as a doctor](#) until he was caught practicing without a license and commanded him to create such a paper with its foregone conclusion in a few months. Let the record show that science does not work that way. We do studies and wait to see what they show. We never start a study committing it to a preordained result. Pushing the lie that vaccines cause autism directly pushes more of our grandchildren away from vaccinations which they need to stay alive, especially now.

- [Demanding that any new variation on even known vaccines](#) be once again studied with placebo controlled trials. These trials are expensive and pose considerable risk to those receiving placebos, especially when there is already a safe and effective vaccine to prevent the disease in the first place. The direct intent to harm our grandchildren is demonstrated when one considers the case of the flu shot. We must determine which new strains will hit the world every winter. That means a new flu shot mix must be created every summer. The flu shot was tested in placebo-controlled trials when it was first developed. It has been administered billions of times since then and we already know its benefits and risks. It takes time to create the new batches every year and forcing them to undergo placebo-controlled trials will delay their delivery long after the new strains hit in the winter. In short, Secretary Kennedy's scheme will cripple the ability to get flu shots into our grandchildren's arms when they face flu's greatest threats.
- [Claims the MMR vaccine contains tissue from aborted fetuses](#). This is an absurd, 100% false statement. Once again, as long as Secretary Kennedy is allowed to wield the power the American people place into the hands of an HHS Secretary, he is devoted to using his bully pulpit to intimidate people, wrongly convincing them to avoid life-saving vaccines.

These and other actions by Secretary Kennedy is increasing vaccine hesitancy, helping to place our grandchildren in the line of fire of deadly infections that rage when America drops its guard by reducing its vaccination coverage rates. [A recent survey by the Kaiser Family Foundation](#) found that the number of Americans who have heard these attempts to terrify parents away from vaccinating has soared to over 50%, and many are now afraid to protect our grandchildren.

HHS fuels the great energies of American medical science, and instead of expanding its greatness, Secretary Kennedy is focused on destroying it. For anyone who goes to a drugstore for a prescription, there is a 99% chance the medication they purchase only exists because of NIH funded research that developed it. By eliminating funding for medical science, Secretary Kennedy is denying our grandchildren and all Americans new cures and therapies yet to be discovered. His actions will freeze Americans into a world where Alzheimer's, cancer, heart disease, and infections that threaten us will continue today's suffering with no relief or more importantly, hope, in sight.

[Immunizations have saved 154 million lives from 1974 to 2024.](#) We now know that even as recently as 2024, any child under age 10 is 40% more likely to live to see their next birthday if they are immunized. Not only is the chance of living another year improved with immunization, but life expectancy increases as well.

Secretary Kennedy is doing all in his power to sink our grandchildren into a dystopian future where these stunning increases in the ability to live are denied, where measles becomes endemic, where pertussis deaths soar and where polio returns.

Secretary Robert F. Kennedy Jr. is a danger to the public's health and especially our grandchildren. He must resign or be fired.

Arthur Lavin MD, Pediatrician

Founder and Leader [Grandparents for Vaccines](#)

Shaker Heights, Ohio



May 5, 2025

The Honorable Bill Cassidy, M.D., Chairman, Senate Committee on Health, Education, Labor, and Pensions
 The Honorable Bernard Sanders Ranking Member, Senate Committee on Health, Education, Labor, and Pensions
 The Honorable Members of the Senate Health, Education, Labor, and Pensions (HELP) Committee
 United States Senate, Washington, D.C.

Subject: Urgent Concerns Regarding the Dismantling of NIOSH

Dear Members of the Senate HELP Committee,

We are writing to express our profound concern regarding the recent decision to almost completely dismantle the National Institute for Occupational Safety and Health (NIOSH) as part of a restructuring plan under the Department of Health and Human Services (HHS). This decision, which includes laying off two-thirds of NIOSH's workforce and merging it into a new Administration for a Healthy America (AHA), poses significant risks to worker safety and public health across the United States.

For over five decades, NIOSH has been a cornerstone of workplace safety research and innovation with a mandate to assure "every man and woman in the Nation safe and healthful working conditions and to preserve our human resources." It is the only federal agency mandated to conduct research and recommend practices to prevent work-related injuries, illnesses, and deaths. It has provided critical services such as certifying respiratory protection equipment like N95 masks, investigating workplace hazards, and recommending new or updated exposure limits for hazardous substances. The agency's work has saved countless lives and prevented injuries in industries ranging from healthcare to mining.

NIOSH does this without issuing citations. Instead, the intra- and extra-mural workforce—about 1,400 researchers and professionals—partner with industry and labor make recommendations to workplaces on both long-standing health and safety issues, like asbestos, coal mine dust, and a variety of other toxic chemicals. Critically, they respond to emerging threats like the H5N1 bird flu.

This investment has paid vast dividends over time. As one example, the estimates of the annual economic value from risk reductions in fatal and nonfatal illness for silica alone are \$692 million per year. The savings from this one program are larger than NIOSH's entire annual budget.

The consequences of this move are far-reaching and deeply troubling.

- **Loss of competitiveness:** This decision comes at a time when occupational safety is more critical than ever, as the nation seeks to bring manufacturing industries and jobs

back to the US, revitalize many sectors of the economy, and expand critical mineral extraction capabilities.

- **Loss of Critical Research and Data:** NIOSH’s research initiatives, such as the National Occupational Research Agenda (NORA), and Surveillance programs will be halted, leaving gaps in our understanding of workplace hazards.
- **Weakened Oversight:** The closure of the National Personal Protective Technology Laboratory undermines our ability to certify protective equipment essential for healthcare workers, miners, and first responders. This also reduces competitiveness of key American businesses that produce these products, like 3M, if such products cannot be certified.
- **Increased Workplace Hazards:** Without NIOSH’s independent investigations into workplace outbreaks and injuries, employers may face less accountability, potentially leading to higher rates of workplace fatalities and illnesses. Worker deaths in America are down—on average, from about 38 worker deaths a day in 1970 to 15 a day in 2023.
- **Impacts on Industry:** Strong, evidence-based occupational health and well-being initiatives reduce turnover, enhance productivity and improve product quality (including patient outcomes for healthcare). Worker health and mental health outcomes are estimated to cost American businesses hundreds of billion dollars annually—costs expected to increase without NIOSH leadership.

This decision not only jeopardizes worker safety but also undermines the broader public health infrastructure that supports emergency preparedness and response efforts. It is imperative that Congress intervenes to preserve NIOSH’s mission and resources.

Key Questions for Secretary Robert F. Kennedy Jr.:

1. How does the elimination of NIOSH align with HHS’s stated mission to improve public health outcomes and the Secretary’s own commitment to address chronic diseases?
2. How does HHS plan to address the potential increase in workplace injuries and fatalities resulting from these cuts as well as the economic impact of such losses?
3. What alternative mechanisms will be established to ensure continued research on workplace hazards and certification of protective equipment?
4. Why was there no consultation with key stakeholders—such as labor unions, industry leaders, and public health experts—before making this decision?
5. What assurances can you provide that worker safety will remain a priority under the new Administration for a Healthy America?

We urge you to hold Secretary Kennedy accountable for these decisions and advocate for the restoration of NIOSH’s funding and staffing levels. Worker safety is not a partisan issue; it is a fundamental right that underpins our nation’s economy and well-being. We call on the Senate HELP Committee to take immediate action to reverse these cuts before irreparable harm is done.

Thank you for your attention to this urgent matter. We are confident that you will prioritize the health and safety of American workers in your deliberations.

Sincerely,



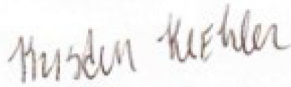
Gurumurthy Ramachandran, Ph.D., CIH

Director, Johns Hopkins Education and Research Center for Occupational Safety and Health (JHU ERC);



Meghan Davis, DVM MPH PhD

Director, Johns Hopkins Psychosocial, Organizational, and Environmental *Total Worker Health*® Center in Mental Health (POE Center); _____



Kirsten Koehler, Ph.D.

Deputy Director, The Johns Hopkins Education and Research Center for Occupational Safety and Health,

**The Leadership Conference
on Civil and Human Rights**

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Women & Families
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People for the American Way
Religious Action Center of
Reform Judaism
Service Employees International Union
Sikh Coalition
UnidosUS

President and CEO

Maya Wiley

May 12, 2025

The Honorable Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC

Dear Secretary Kennedy:

The Leadership Conference on Civil and Human Rights is the nation's oldest, largest, and most diverse civil and human rights coalition, charged by its membership of more than 240 national organizations to promote and protect the civil and human rights of all people in the United States. Our coalition provides a powerful and unified voice for the many constituencies we represent, including communities of color, people with disabilities, women, LGBTQI+ people, immigrants, Limited English Proficient (LEP) individuals, older adults and children, people with low incomes, rural communities, and other systemically underserved groups. The undersigned organizations are united by the universal ideals of dignity, equity, justice, and inclusion. We believe that working together to protect, defend, and expand the rights of every person in the United States will in turn lead to a more open and just society — an America as good as its ideals.

The Leadership Conference's work is conducted primarily through our 11 task forces, which bring our members together around issues including health care, education, immigration, employment, and housing. Our Health Care Task Force is co-chaired by the National Health Law Program (NHeLP) and the National Partnership for Women & Families and is comprised of organizations who work to promote and protect the civil rights and health of all people in the United States. As members of the Health Care Task Force, we offer the following recommendations for the Department of Health and Human Services, which has a duty to fulfill the civil rights promise and intent of improving health care quality, access, affordability, and equity. The Leadership Conference and its Health Care Task Force intend to ensure that the department and all those tasked with the immense responsibility of enforcing our nation's civil rights laws and health care policies are held accountable to do exactly that.

Health care is a civil and human right. Our foundational civil rights laws, made meaningful through enforcement and oversight, stand guard to protect that right. Every human being in this country should be able to obtain timely, affordable, comprehensive, high-quality, and accessible health care. This includes access to the full scope of best-practice medical care for transgender people, as well as sexual and reproductive health services, including abortion.



May 12, 2025

Access to quality health care coverage and services should not be based on income, pre-existing conditions, health status, substance use or mental health history, immigration status, criminal record history, or geographic location, and barriers based on these issues must be removed. Race, ethnicity, national origin (including language), age (from birth through death), sex (including sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions, including termination of pregnancy; sexual orientation; and gender identity), disability, religion, or employment status must not impede access to care. Further, for people to be able to truly access health care, they must have access to other supports, including paid leave, paid sick days, transportation, housing, and affordable child care.

We recognize that systemic issues prevent true health equity. Health inequities must be addressed as a matter of social justice, and also as an economic imperative; failure to address these inequities adds hundreds of billions of dollars to our country's health care spending each year.¹ Health care policies must dismantle barriers that exist due to entrenched and systemic sexism, racism, xenophobia, ableism, and discrimination against LGBTQI+ people and those with intersectional identities in the health care system. Health reforms must aim not only to reduce disparities, but also to ultimately eliminate disparities entirely. The department must also ensure that discrimination does not impede individuals from accessing health care and services. This requires robust implementation and enforcement of not just health care laws but also, importantly, civil rights laws across all entities throughout the health care system. Further, reforms should not allow the religious and/or personal beliefs of a hospital, clinic, insurance company, or provider to impede anyone's ability to make decisions about their health and receive the health care they need. Robust implementation also requires the collection, analysis, and use of health data to understand where disparities exist and whether and how policies are successfully addressing them. However, any data collected or shared about individuals or communities across the health care system must be kept confidential, in compliance with appropriate security protocols and confidentiality laws, used only for the express purpose for which it was collected, and not be used to discriminate against them. When data are used outside of the intended purpose for which they were collected or are not accurately deidentified, it can chill people from accessing services and contribute to declining response rates in necessary federal data collections, which in turn worsens outcomes and costs the system more money.

Health care coverage must be affordable for all people. This includes those who are underserved or have lower incomes or higher than average health care costs. Any burdens imposed on populations with lower incomes by premiums or cost-sharing requirements must be mitigated. Additionally, benefit design must not be discriminatory. Reforms must continue prohibitions on discriminatory health care benefit designs that could exclude or have a disparate impact on specific populations with higher health care costs or who are part of a protected class. This includes cost-sharing structures that disproportionately and discriminatorily affect individuals who have higher health care needs or require uncommon services or treatments.

¹ "Health inequities add \$320 billion annually to health care spending in the United States, a figure that could surpass \$1 trillion by 2040 if left unaddressed." See "Health equity remains a business imperative in the life sciences and health care industries," Deloitte Center for Health Solutions (Jan. 28, 2025), <https://www2.deloitte.com/us/en/insights/industry/health-care/health-equity-business-imperative-in-2025.html>.



May 12, 2025

Health care and long-term services and supports must be high quality, including being person-centered, responsive to cultural, social, behavioral, and linguistic needs, and allow individuals to receive the right care, at the right time, and in the setting best suited for their needs. This includes expanding access to appropriate supports and services, including home and community-based services (HCBS), that enable people to continue to live and thrive in their communities. High quality care and support requires engagement and collaboration with the people receiving care, their families and their caregivers, community-based organizations, and consumer advocacy organizations. High quality health care means that there should be no room for waiving any aspect of health care insurance or delivery in a manner that could adversely impact consumers and undermine minimum federal protections.

The department must address social drivers of health in all policy efforts and recognize that much of a person's health care outcomes result from factors outside of the health care setting and outside of their individual control. The delivery of health care must account for health impacts resulting from discriminatory laws, policies, and norms that have led to disparate outcomes due to differences in where people are born, live, learn, work, play, worship, and age. Reform efforts should incentivize providers and institutions to incorporate strategies that address social determinants of health in their care models. Such efforts should have health equity as an explicit goal, rely on multi-sector partnerships, and be person-centered. The department must acknowledge and address structural racism and other forms of discrimination that create and reinforce inequities; support and promote community partnerships; require robust and privacy-preserving data collection, analysis, and reporting; and leverage and build upon existing care delivery models and resources that offer promising opportunities to advance health equity.

The aforementioned principles are essential to the work our organizations do to advance civil rights and health equity. These values must guide every action the department takes to address access to health care for all and to improve the health care system. We expect the department to adhere to democratic tenets of transparency and accountability and to faithfully uphold the rule of law, including utilizing proper notice and comment in the rulemaking process. We are deeply concerned about recent actions taken by the administration to restructure and enact drastic cuts to the department, which will seriously jeopardize its ability to fulfill its promise to ensure the health and well-being of all people in this country. These actions not only undermine the effectiveness and efficiency of the department, but they have also put the private health information of individuals at risk and disrupted critical research, amounting to a wholesale assault on public health.

The elimination of the Administration for Community Living (ACL) and drastic cuts and changes made to the Substance Abuse and Mental Health Services Administration (SAMHSA) and Office for Civil Rights (OCR) raise serious concerns about the ability of the department to deliver on its obligation to ensure that everyone in this country can receive crucial health care, support, and services and can seek redress when they experience harm. Likewise, the elimination of all of the department's offices of minority health, tasked with the coordination of efforts to eliminate health disparities and improve the health of racial and ethnic minority populations, puts the health of these communities at even greater risk. Additionally, cutting tens of thousands of jobs across the Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Health Resources and Services Administration (HRSA), and Food and Drug Administration (FDA) has



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implications for the ability of the department to adequately address public health needs, engage in oversight and investigations, and ensure access to health services. Most recently, the closure of CMS' Office of Equal Opportunity and Civil Rights calls into question its ability to comply with civil rights law and properly address claims of workplace harassment and discrimination.

As organizations dedicated to protecting and advancing civil rights in health care, we are particularly concerned about the impact of the reorganization on OCR. As you know, OCR is HHS's primary enforcement and regulatory agency of civil rights and health information privacy and security. OCR has a unique responsibility to engage in outreach, education, training, implementation, and enforcement around the core civil rights and privacy laws and their application in health care settings. At its core, OCR works to ensure that all people receiving services from HHS-conducted or HHS-funded programs are not subject to discrimination and that they can trust the privacy, security, and availability of their health information, consistent with the laws of this nation. The reorganization, including the closing of half of HHS's regional offices, could severely impact the ability of people to seek recourse from discrimination and undermine OCR's ability to fulfill its civil rights obligations. OCR's budget has remained flat for many years, resulting in increasingly strained resources and staff and leading to a growing backlog of unaddressed complaints — a situation that will only be exacerbated by the recent cuts. Additionally, the reorganization could weaken OCR's ability to maintain and enforce privacy standards under HIPAA and 42 CFR Part 2, endangering the ability of people who require confidentiality in medical conditions to receive treatment without fear of retribution.

The undersigned organizations expect the department to be transparent about its actions and abide by requirements that allow for public participation in the federal rulemaking process. These requirements ensure the public has an opportunity to provide meaningful input as regulations that profoundly impact our health care are proposed or changed. We urge HHS to ensure that all of its proposed regulations are open for public comment and to appropriately consider all public input during the regulatory process. Our call for transparency and public input is particularly pressing as Medicaid faces unprecedented attacks, threatening health care access for people across the country. The 80 million people who receive their health care through this program deserve to have their voices heard about proposed changes that will impact their health and well-being. Our communities must not be relegated to bystanders as others determine how our health care is delivered.

We will not tolerate any attacks on access to our health care, including attacks against people of color, people with disabilities, women, LGBTQI+ people, immigrants, Limited English Proficient (LEP) individuals, older adults and children, people with low incomes, rural communities, and other underserved communities. We call for the department to uphold the core American tenets of equal opportunity, nondiscrimination, and diversity, as well as transparency and a respect for the rule of law. We hope that you will be guided by these values as you make decisions that will impact the health and civil rights of all people in the United States. The Leadership Conference and its Health Care Task Force stand ready to ensure that those who are tasked with faithfully enforcing our nation's civil rights laws and health care policies fulfill their mandate to do so.



May 12, 2025

If you have any questions, please contact The Leadership Conference Health Care Task Force through Peggy Ramin, senior policy counsel at The Leadership Conference on Civil and Human Rights at Mara Youdelman, managing director of federal advocacy at the National Health Law Program at ; or Sarah Coombs, interim vice president and director for health system transformation at the National Partnership for Women & Families at

Sincerely,

The Leadership Conference on Civil and Human Rights
 National Health Law Program, Health Care Task Force Co-Chair
 National Partnership for Women & Families, Health Care Task Force Co-Chair
 American Civil Liberties Union
 American Federation of State, County and Municipal Employees (AFSCME)
 Americans United for Separation of Church and State
 APAPA National (Asian Pacific American Public Affairs Association)
 Asian & Pacific Islander American Health Forum (APIAHF)
 Asian American Psychological Association (AAPA)
 Autistic Self Advocacy Network
 Bazelon Center for Mental Health Law
 Center for Law and Social Policy (CLASP)
 Center for Reproductive Rights
 Community Catalyst
 Disability Rights Education and Defense Fund (DREDF)
 Empowering Pacific Islander Communities (EPIC)
 Equality California
 Families USA
 Human Rights Campaign
 The Institute for Health Research & Policy at Whitman-Walker
 Japanese American Citizens League
 Justice in Aging
 Lawyers' Committee for Civil Rights Under Law
 Legal Action Center
 NAACP
 National Abortion Federation
 National Asian American Pacific Islander Mental Health Association
 National Council of Asian Pacific Americans (NCAPA)
 National Council of Jewish Women
 National Education Association
 National Immigration Law Center
 National Latina Institute for Reproductive Justice
 National Network for Arab American Communities (NNAAC)
 Planned Parenthood Federation of America



May 12, 2025

Service Employees International Union (SEIU)
Southern Poverty Law Center
SPAN Parent Advocacy Network (SPAN)
UnidosUS



Reactions to Medicaid Cuts in the Reconciliation Bill

American Academy of Family Physicians:

"Family physicians are at the forefront of health care delivery, caring for individuals and families across the lifespan, and we witness firsthand the positive impact that Medicaid has on our patients' lives. Medicaid is a lifeline for more than 72 million low income individuals and families, children, pregnant women, elderly adults, and individuals with disabilities."

American Academy of Pediatrics:

"...we shouldn't ask children to bear the burden of paying for other policy priorities, such as tax cuts. The policies and cuts under consideration will harm children's health. When we protect these programs, we invest in children's health, make America healthier and support our country's future. Pediatricians urge lawmakers to reject cuts to these programs and put children first."

American College of Obstetricians and Gynecologists:

"Pregnant patients who keep their coverage under Medicaid will still face challenges accessing care as labor and delivery unit closures escalate as a result of Medicaid cuts, leaving patients to travel longer distances to give birth...the cuts will threaten the 12 months of postpartum coverage...which will leave so many without access to medical care during the year after delivery when two-thirds of maternal deaths occur."

American Dental Association:

"...losing dental coverage has ripple effects on overall health. Untreated oral infections and dental pain can exacerbate chronic conditions like diabetes and heart disease, and they pose risks for pregnant women that can affect birth outcomes...dental benefit cuts can even reduce the detection of serious illnesses, for instance, states that dropped adult dental coverage saw a decline in oral cancer diagnoses..."

American Health Care Association:

"Any federal proposals that aim to lower the provider tax "Safe Harbor" limit from the current 6% would restrict states' ability to finance their Medicaid programs. This would exacerbate Medicaid funding shortfalls, ...force more nursing homes and long-term care facilities to close, and worsen workforce shortages by reducing resources available for staff recruitment and retention."



American Network of Community Options & Resources (ANCOR):

"...community providers who support people with I/DD are already struggling ... due to insufficient Medicaid funding. If Congress cuts Medicaid even more—whether or not those cuts are specifically targeted to disability services—the programs that enable people with I/DD to meaningfully participate in our society will be first on the chopping block when state budgets are unable to absorb the financial shock."

American Nurses Association:

"Medicaid policy changes could also have an adverse impact on our nation's nursing workforce, which is already in crisis. Often, it is the nurses who are left to shoulder the full patient care burden and face increased workloads and less time to devote to each patient due to higher patient volume. This only serves to further exacerbate existing nursing workforce challenges that lead to lower job satisfaction, nurse burnout and attrition, and worse patient outcomes."

America's Essential Hospitals:

"This unprecedented level of Medicaid cuts would devastate the program, undermining the ability of essential hospitals to provide critical services, including trauma care, behavioral health, maternal health, and public health emergency response. These hospitals, which already operate on thin margins, cannot absorb such losses without reducing services or closing their doors altogether."

Association of Community Affiliated Plans:

"...the practical effect of additional eligibility checks and verifications for Medicaid and Marketplace coverage is to generate additional paperwork for enrollees, providers and states – leaving people one paperwork glitch away from losing their health coverage."

Catholic Health Association of the United States:

"...the cascading effects of lost coverage, including higher costs and greater strain on the system, will impact nearly all Americans – not just those who rely on Medicaid...As we have continued to state: Medicaid is not just a health program – it is a lifeline. It provides access to care for those who need it most – poor and vulnerable children, pregnant women, elderly, adults, and disabled individuals in our nation while ensuring their dignity. Congress should not take America down a dangerous path of drastically reducing access to health care in the United States."


THE PARTNERSHIP FOR MEDICAID

Children's Hospital Association:

"Children's hospitals rely heavily on Medicaid reimbursement to provide high-quality care, and without a strong Medicaid program, children's hospitals will be forced to make tough decisions. Families often can't just go to their closest general hospital – children aren't little adults, and their health care needs aren't the same as their parents'."

Easterseals:

"Medicaid supports local economies across the country, where thousands of caregivers and direct support professionals are employed to help provide these critical services, and thousands more can go to work each day knowing that their loved ones are cared for while they're away."

LeadingAge:

"We have been told that the intent of all these policies is not to harm older adults, but they will...the provider tax moratorium limits states' flexibility to adjust their taxes based on state needs or to redirect these funds where they are needed most, which could threaten the viability of our members and limit access for those they serve."

Medicaid Health Plans of America:

"...these proposals create downstream consequences that could result in significant problems across the health care ecosystem. Let us be clear: it is not possible to protect the most vulnerable in our society from Medicaid cuts of this size and scope."

National Association of Community Health Centers:

"Even a small shift in patients from Medicaid to uninsured status could force clinics to reduce services or close locations, jeopardizing access to cost-effective primary care and medical services in communities. Rural communities would lose critical access points for primary care, dental services, and behavioral health."

National Association of Counties:

"Counties employ more than 3.6 million Americans who support 1,900 local public health departments, 900 hospitals, 700 long-term care facilities, 750 behavioral health centers and 91 percent of local jails...When federal funding is reduced or eliminated, counties are forced to either raise additional revenue or reduce essential services. However, counties are often limited in our ability to raise local revenue. Forty-two states limit county property tax authority, and restrictions have expanded extensively in recent decades."



National Association of Pediatric Nurse Practitioners:

"...the deepest cuts to the Medicaid program ever considered, threatening coverage and care for children by capping federal funding and imposing restrictions that will cause tens of thousands of children and other enrollees to lose health care coverage and force states to reduce eligibility, eliminate benefits, and cut payments to health care providers."

National Association of Rural Health Clinics:

"Significant increases in the uninsured population could have negative financial viability impacts for Rural Health Clinics, as we do not receive funding support to treat this patient population."

National Council for Mental Wellbeing:

"Specifically, we are concerned that many of the individuals we serve, especially those with severe mental illness and chronic substance use disorder, would face more barriers in getting the care they need. Likewise, we are concerned that our uncompensated care patient caseload will escalate substantially."

National Health Care for the Homeless Council:

"Like everyone, unhoused people deserve comprehensive, high-quality health care—and access to health insurance to pay for it. The Medicaid program—and specifically the expansion of Medicaid to single adults—is a vital lifeline for people experiencing homelessness and financially strengthens health care systems."

National Rural Health Association:

"Medicaid is more than just health care coverage in rural communities – it plays a significant role in sustaining the viability of rural healthcare systems, including hospitals, clinics, long-term care, and community health centers."



May 13, 2025

The Honorable Bill Cassidy
 Chair
 Senate Committee on Health, Education
 Labor & Pensions
 Washington, D.C.

The Honorable Bernie Sanders
 Ranking Member
 Senate Committee on Health, Education
 Labor & Pensions
 Washington, D.C.

Dear Chair Cassidy and Ranking Member Sanders:

Thank you for allowing the National Safety Council (NSC) to submit this statement for the record on today's hearing titled: "Hearing on Fiscal Year 2026 Department of Health and Human Services Budget." This hearing could not come at a more needed time given the current workforce and programmatic challenges facing the Department of Health and Human Services (HHS). NSC looks forward to your leadership in addressing these challenges through robust oversight of HHS to ensure its continued support for proven public health programs and strategies that detect and eliminate disease and illness in the United States.

National Safety Council

The National Safety Council (NSC) is America's leading nonprofit safety advocate – and has been for over 110 years. As a mission-based organization, we work to eliminate the leading causes of preventable death and injury, focusing our efforts on the workplace and roadway. We create a culture of safety to protect people from hazard and injury in the workplace and beyond so they can live their fullest lives. Our more than 13,000 member companies and federal agency partners represent employees at nearly 41,000 U.S. worksites.

The HHS Mission is Critical to Millions of Workers in the United States

HHS agencies, including the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), are vital to the health of America's workforce. Most recently, the United States saw the havoc infectious disease and illness can cause on the workforce through the COVID-19 pandemic. The COVID-19 pandemic shuttered businesses and was responsible for the death of over one million people in the United States as of March 2023.¹ However, it was the work of the dedicated public servants within the HHS workforce that partnered with private industry and the safety community to facilitate return-to-work policies that

¹ <https://coronavirus.jhu.edu/map.html>



kept America's workforce safe on the job.² NSC implores you to utilize your congressional oversight authority to ensure any forthcoming or previously instituted reductions in force (RIFs) at HHS do not exacerbate the safety challenges businesses and workers are already faced with.

Prioritizing Occupational Safety and Health Within HHS

Created in 1970 by Congress, the National Institute for Occupational Safety and Health (NIOSH) has been the federal government's leading research expert on keeping America's workforce safe and healthy. The Institute has conducted research, facilitated countless on-site inspections and ensured equipment used to protect workers from respiratory threats are safe and properly functioning. No other entity within the federal government is equipped to tackle this worthwhile challenge and NIOSH functions cannot be smoothly integrated into other departments. Additionally, other federal agencies such as the Mine Safety and Health Administration (MSHA) and the Occupational Safety and Health Administration (OSHA) rely on NIOSH research for the promulgation of their safety standards. RIFs cause the enforcement of these standards to be delayed, potentially costing numerous lives.³

Two research functions impacted by the previously announced RIFs at HHS include the National Personal Protective Technology Laboratory (NPTTL) and the Fatality Assessment and Control Evaluation Program (FACE). These programs are exemplary examples of how federal investment in occupational safety and health ensures the safety of America's workforce.

Through NPTTL, NIOSH certifies respirators which are used by thousands of workers including those in the manufacturing, health care, construction and mining industries. For the mining industry, these respirators protect miners from deadly diseases such as black lung and silicosis. Illness from faulty or fraudulent respirators can lead to employees needing to leave the workforce, economic losses in medical expenses and lost wages and painful death. The potential for faulty or fraudulent respirators entering the United States market has greatly increased given NIOSH is no longer accepting new respirators for testing and respirator costs could increase due to potential tariffs.

The FACE Program is another storied program at NIOSH which aims to prevent serious injuries and fatalities at jobsites through investigations, hazard identification and public findings.⁴ By publicizing reports on hazard analysis, NIOSH research is helping to prevent future workplace injuries and fatalities which cost the United States economy \$176.5 billion in 2023.⁵ NIOSH prioritizes efforts for this program by the focus areas of participating states and overall federal goals. Without FACE and

² <https://www.nsc.org/getmedia/f5dfd05d-83bf-4753-8903-538a24157725/safer-framework-summary.pdf>

³ <https://www.safetyandhealthmagazine.com/articles/26676-msha-temporarily-pauses-enforcement-of-siica-final-rule>

⁴ <https://www.cdc.gov/niosh/face/about/index.html>

⁵ <https://injuryfacts.nsc.org/work/costs/work-injury-costs/>



other NIOSH safety programs, America's workers and employers will be more at risk.

NIOSH Areas of Influence

The work of NIOSH does not exist in a silo, instead, it permeates throughout the federal government and private industry alike with a singular focus: protecting America's workforce. NIOSH research has been critical to establishing heat acclimatization recommendations which are currently being used by businesses to prevent heat illness among their workforce population.⁶ NIOSH research has consistently shown a link between "exposure to physical factors at work" and musculoskeletal disorders (MSDs).⁷ NIOSH also established a recommended exposure limit (REL) to prevent hearing loss in occupational settings. While all industries are at risk, specific hazard risks exist for workers in the mining, manufacturing and construction industries.⁸ Furthermore, NIOSH research was critical to OSHA's "Guidelines for Health Care and Social Service Workers" – a framework to prevent workplace violence in the health care industry.⁹ The National Children's Center for Rural and Agricultural Health and Safety (NCCRAHS), a NIOSH-funded Agricultural Center, developed age-appropriate guidelines to prevent injuries from heavy machinery, chemicals and heat stress.¹⁰ Sadly NIOSH-funded research efforts into opioid overdose prevention programs for commercial fishermen have been discontinued.¹¹ Research and practitioner efforts to combat the opioid epidemic have been of great importance to this committee, the Trump Administration, and the employer community. With opioid deaths decreasing in the United States, now is not the time to back away from efforts that will keep employees safe from harm – especially in high-impact industries such as fishing, construction, manufacturing and transportation.¹²

These safety topics are all critical to the success of America's workforce, including the ability to compete in product production on the world stage. When industries see skyrocketing rates of severe injuries and fatalities, it prevents the incoming workforce from seeing that industry as a valuable career option. Today, the industries with the highest number of deaths include:

1. Transportation and warehousing
2. Construction

⁶ https://www.cdc.gov/niosh/heat-stress/recommendations/acclimatization.html#cdc_health_safety_special_topic_types-acclimatization-schedule

⁷ <https://www.cdc.gov/niosh/docs/97-141/default.html>

⁸ <https://www.cdc.gov/niosh/noise/about/noise.html#:~:text=Take%20precautions%20when%20noise%20is,loss%20over%20their%20working%20lifetime.>

⁹ https://www.cdc.gov/WPVHC/Nurses/Course/Slide/Unit5_5

¹⁰ <https://www.cdc.gov/niosh/docs/2011-129/default.html>

¹¹ <https://deohs.washington.edu/pnash/evaluating-opioid-overdose-prevention-program-commercial-fishermen-cdc-program-evaluation-framework>

¹² <https://www.cdc.gov/media/releases/2025/2025-cdc-reports-decline-in-us-drug-overdose-deaths.html#:~:text=New%20provisional%20data%20from%20CDC's,compared%20to%20the%20previous%20year.>



3. Agricultural, forestry, fishing, and hunting
4. Government
5. Professional and business services
6. Manufacturing¹³

NIOSH efforts on critical safety topics are of immense importance to private industry and the safety community. The Senate HELP Committee has, in a bipartisan manner, continued to recognize the importance of a safe and healthy workforce on the United States economy. NSC asks the committee to continue to recognize that truth and ensure NIOSH is positioned to shape the conversations surrounding occupational safety and health within the federal government.

Conclusion

NSC, and our member companies, recognize the importance of NIOSH and the federal workforce that supports the agency's mission. Employers want to prioritize safety, but some do not know where to start. NIOSH resources are a great opportunity for entry for organizations building safety and health programs at their jobsites. Only with a strong culture of safety will American businesses thrive and compete on the world stage.

NSC is grateful to the committee for the opportunity to share this statement for the record and looks forward to continued engagement with the committee and HHS on priority safety topics that affect safe business operations for employers.

¹³ <https://injuryfacts.nsc.org/work/industry-incidence-rates/most-dangerous-industries/>



May 9, 2025

The Honorable Bill Cassidy, M.D.
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bernie Sanders
332 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Susan Collins
413 Dirksen Senate Office
Building Washington, DC

The Honorable Patty Murray
154 Russell Senate Office Building
Washington, DC

CC: Members of the Senate Health, Education, Labor, and Pensions (HELP) Committee and the Senate Appropriations Committees

RE: HHS Restructuring and Proposed Budget

Dear Chairman Cassidy, Ranking Member Sanders, Chairwoman Collins, and Ranking Member Murray:

The National Down Syndrome Society (NDSS) empowers individuals with Down syndrome and their families by driving policy change, providing resources, engaging with local communities, and shifting public perceptions. We write today on behalf of our organization and the individuals and families we represent to express serious concerns about the Department of Health and Human Services' (HHS) restructuring plan and proposed Fiscal Year 2026 budget request. As currently drafted, these proposals could have significant unintended consequences for people with disabilities, including those with Down syndrome, by weakening and potentially dismantling critical protections, programs, and services they rely on to live full and independent lives.

The restructuring plan announced on March 27, 2025, would significantly alter the Administration for Community Living (ACL) and key disability-specific programs by dispersing their functions into broader HHS offices or phasing out funding for them altogether. This reorganization risks undermining decades of progress in ensuring that federal health and human services are responsive to the needs of people with disabilities.

Specifically, we are concerned that the restructuring diminishes the Administration for Community Living (ACL) by reassigning its essential disability programs elsewhere in HHS, potentially diluting the visibility and prioritization of disability issues at the federal level. ACL was created in 2012 to bring together the Administration on Aging, the Office on Disability, and the Administration on Developmental Disabilities. The creation of the

1155 15th Street NW, Suite 540 · Washington, DC · www.ndss.org



ACL demonstrates an intentional effort to make disability and aging related programs and services more efficient and effectively coordinated. Reversing this structure and redistributing these core functions across multiple agencies could lead to greater fragmentation and reduced accessibility for the individuals these programs are designed to support. ACL was created with the intention of streamlining and creating efficiencies in the critical disability programs that HHS oversees. Dismantling this streamlined approach appears counterproductive to the Department's stated goal of achieving greater efficiency.

The pre-decisional Fiscal Year 2026 budget request which became available on April 16, 2025, raises several additional areas of concern related to eliminated or diminished funding for disability programs and services. These include:

- **Significant funding cuts for the National Institutes of Health (NIH).** The NIH conducts vital research to improve the health and wellbeing of millions of individuals with disabilities, including through the INvestigation of Co-occurring conditions across the Lifespan to Understand Down syndrome (INCLUDE) Project, a NIH research initiative on critical health and quality-of-life needs for individuals with Down syndrome. Cuts to NIH funding and caps on indirect research costs could slow the momentum of the INCLUDE project and other vital research projects.
- **Eliminated funding for key programs such as Developmental Disabilities Councils (DD Councils), Protection and Advocacy agencies, University Centers for Excellence in Developmental Disabilities (UCEDDs), Aging and Disability Resource Centers (ADRCs), Voting Access for People with Disabilities, and the National Institute of Disability, Independent Living, and Rehabilitation Research (NIDILRR).** These programs provide essential advocacy, legal protection, leadership development, research, training, and community support that improve the lives of millions of Americans with disabilities and the families and caregivers who support them. Elimination of these programs could result in states losing a vital infrastructure for advancing self-determination, inclusion, and systems change for people with developmental disabilities, loss of legal protection and advocacy services for individuals with disabilities facing abuse, neglect, discrimination, or denial of services, and major cuts to disability research, training, technical assistance, and innovation in inclusive practices.
- **Eliminated funding for Head Start programs.** Head Start and Early Head Start are critical programs that ensure children with disabilities and developmental delays receive inclusive early education, health services, and family support. Head Start is



required by law to ensure that at least 10% of enrolled children are children with disabilities, providing inclusive early education, health screenings, and developmental supports. Reductions in these programs would widen disparities, delay diagnoses and interventions, and risk undermining our nation's longstanding commitment to inclusion under the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA).

NDSS respectfully urges the Senate Health, Education, Labor, and Pensions (HELP) Committee, the House Energy and Commerce Committee, and the House and Senate Appropriations Committees to carefully review and reconsider these proposals and to ensure they do not unintentionally undermine the dedicated infrastructure within HHS that supports people with disabilities. It is essential that these programs are preserved and sufficiently resourced to uphold the principles of community living, integration, and equal opportunity for all Americans with disabilities.

We stand ready to collaborate with you to ensure that any restructuring or budgetary changes continue to reflect the shared goals of inclusion, self-determination, and respect for the rights of people with disabilities.

Thank you for your attention to this important matter.

Sincerely,

A handwritten signature in black ink that reads "Kandi Pickard". The signature is fluid and cursive, with a large loop at the end.

Kandi Pickard
President and CEO
National Down Syndrome Society



NATIONAL HEALTH COUNCIL

**Prepared Written Testimony
Randall Rutta, President and CEO
National Health Council
U.S. Senate Committee on Health, Education, Labor & Pensions
May 14, 2025**

The National Health Council (NHC) appreciates the opportunity to submit this statement for the record as the Senate Committee on Health, Education, Labor & Pensions reviews the Fiscal Year 2026 Budget for the United States Department of Health and Human Services (HHS) and Secretary Kennedy's plans for reorganizing the Department.

For more than 100 years, the NHC has brought together diverse organizations to drive patient-centered health policies and practices that increase access to affordable, high-value, and sustainable health care for all Americans. The NHC's membership includes 181 national health-related organizations, with the majority comprised of the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations representing the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

We are encouraged that Secretary Kennedy's submitted testimony recognizes the urgent need to address chronic disease, promote nutrition and preventive care, and invest in programs that improve the health and well-being of Americans. These are priorities patients share and have been requesting attention for many years. We also support efforts to increase transparency, enhance accountability, and reduce duplication of programs, provided these reforms are implemented in ways that do not compromise access to essential services or undermine the effectiveness of the public health infrastructure.

At the same time, it is essential that the Department's reorganization plan and proposed budget continue to prioritize the needs of individuals with chronic conditions and disabilities and caregivers, including family and professional caregivers. As Secretary Kennedy acknowledged, the United States needs to address chronic illness. Strategic investment in care, prevention, and research is key to reversing this trend. The NHC urges HHS to preserve and strengthen the agencies and programs that are foundational to this work.

Concerns with Restructuring of HHS

The restructuring of HHS, including staff reductions within key health agencies, raises significant concerns. While we understand the need for departmental efficiency and responsiveness, we urge Secretary Kennedy to approach any restructuring with great care to ensure that critical public health functions are not compromised. Reducing or



eliminating the capacity of key federal agencies such as the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Administration for Community Living (ACL), the Health Resources and Services Administration (HRSA), and the Office of Minority Health (OMH) would not only hinder scientific progress but also significantly undermine the delivery of care and services to vulnerable populations. We are also concerned that this reduction in force may lead to the loss of some of the best and brightest minds at the federal level. To mitigate these risks, we recommend that the restructuring process:

- Preserve or enhance staffing levels in key areas that support people with disabilities and chronic diseases.
- Maintain transparency in the restructuring process, particularly about the impact on patient-centered programs and services.
- Maintain the important partnership between nonprofit organizations and the federal government to provide information, education, services, and support to people with chronic diseases and disabilities.
- Engage stakeholders, including patient advocacy groups and health organizations, to provide input into decisions that could affect critical services and support.

Preserve the Federal Research Infrastructure

Research is central to addressing the needs of people with chronic diseases and disabilities. Agencies such as the NIH, the CDC, and the Food and Drug Administration (FDA) are instrumental in advancing medical research, improving public health, and ensuring the safety and effectiveness of treatments.

We support Secretary Kennedy's recognition of the importance of biomedical research to national security and scientific leadership. To strengthen this work, we recommend that HHS:

- Sustain and increase funding for NIH, with a focus on rare diseases, chronic conditions, and underrepresented populations
- Enhance the FDA's regulatory capacity to support timely approval of safe and effective treatments
- Expand the Advanced Research Projects Agency for Health with full transparency and robust patient engagement to ensure that investments align with public needs

While the proposed restructuring calls for workforce reductions and program consolidation, it is imperative that the capacity of NIH, CDC, and FDA is preserved to maintain progress in science and innovation.

Protecting and Strengthening Medicaid

Medicaid is a vital source of coverage for millions of Americans with chronic conditions, disabilities, and limited incomes. We agree with the Department's commitment to preserving core services and encourage Secretary Kennedy to maintain that



commitment by protecting Medicaid from harmful proposals such as block grants or per capita caps, which would reduce access to care.

Maintaining Medicaid's operational capacity during the restructuring process is critical to ensuring continued access to care for Americans, particularly for those with chronic conditions and disabilities.

Conclusion

The National Health Council appreciates Secretary Kennedy's stated commitment to tackling chronic illness, supporting medical innovation, and making the health system more responsive. We urge the Committee to ensure that the proposed budget and restructuring plan reflect these goals without sacrificing the programs that millions of Americans depend on.

We look forward to working with Congress and leaders across HHS to advance these priorities and to ensure that every individual, especially those living with chronic diseases and disabilities, receives the care, research, and support they need to live healthier lives.

Thank you for your attention to this critical issue. Please contact Kimberly Beer, Senior Vice President, Policy & External Affairs with any questions or requests for additional information.





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May 6, 2025

The Honorable Shelley Moore Capito
Chair, Senate Appropriations
Subcommittee on Labor, Health and
Human Services, Education, and Related
Agencies
Washington, DC

The Honorable Robert Aderholt
Chair, House Appropriations
Subcommittee on Labor, Health and
Human Services, Education, and Related
Agencies
Washington, DC

The Honorable Tammy Baldwin
Ranking Member, Senate Appropriations
Subcommittee on Labor, Health and
Human Services, Education, and Related
Agencies
Washington, DC

The Honorable Rosa DeLauro
Ranking Member, House Appropriations
Subcommittee on Labor, Health and
Human Services, Education, and Related
Agencies
Washington, DC

Dear Chairs Capito and Aderholt and Ranking Members Baldwin and DeLauro:

On behalf of the undersigned dental organizations, we respectfully urge you to reject the Administration's Fiscal Year 2026 budget proposal for the Department of Health and Human Services, as it would drastically reduce the Department's discretionary spending, including critical investments in oral health research, prevention, and workforce infrastructure.

It has long been said that "the mouth is the gateway to the body," a phrase that highlights the importance of good oral health to overall health. Federally supported research has established strong connections between oral disease and systemic health conditions, including:

- Endocarditis
- Cardiovascular disease
- Pregnancy and birth complications
- Pneumonia
- Diabetes
- HIV/AIDS
- Oral and throat cancer¹

The President's proposed cuts would place our nation's oral health at risk by defunding, and in some cases eliminating, vital programs that defend against chronic disease, strengthen the dental workforce, and promote a healthier America. These cuts would also weaken our nation's ability to remain a global leader in developing the next generation of treatments and cures for oral diseases and their broader systemic health implications.

¹[Oral health: A window to your overall health - Mayo Clinic](#)

The following oral health investments are at risk:

National Institutes of Health (NIH)

Maintaining trust in the research enterprise and protecting funding for the National Institute of Dental and Craniofacial Research (NIDCR) as a separate and unique institute within NIH is of paramount importance. NIDCR, as the third oldest NIH institute, plays a critical role in advancing oral health and overall well-being through groundbreaking research. NIDCR is the world's largest institution exclusively dedicated to advancing dental, oral, and craniofacial health and has supported research that has led to key discoveries in pain biology and management, reducing opioid use, temporomandibular disorders (TMD), regenerative medicine, and disease diagnostics. Proposed restructuring of the NIH threatens to erode the specialized expertise that has driven these advances. While we welcome a robust discussion about the structure of the federal research system, any reforms must be evidence-based, transparent, and shaped by engagement with a diverse range of stakeholders. Advancing cost-cutting measures in isolation, such as imposing arbitrarily determined caps on indirect costs, could severely weaken the nation's research enterprise and global competitiveness.

CDC Division of Oral Health

The Division of Oral Health (DOH), located within the Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion, supports states and territories in reducing cavities and oral disease rates among vulnerable populations. Oral diseases, which range from cavities to gum diseases to oral cancers, progress and become more complex over time, affecting people at every stage of life, which creates a significant personal and financial burden on individuals and healthcare systems. Studies have shown that about 34 million school hours and 92 million work hours are lost yearly due to unplanned or emergency care, and nearly \$46 billion is lost yearly due to untreated oral disease.² The DOH supports states and territorial health programs, oral disease surveillance, school-based preventive care, medical-dental integration, infection prevention and control guidelines for dental settings and workforce training in public health. Its investment in oral health infrastructure has helped to reduce disease incidence, notably through efforts such as expanding community water fluoridation, which reduces tooth decay by at least 25% in children and adults.³ It is essential that the CDC Division of Oral Health continues to champion effective interventions and care coordination, particularly for chronic diseases associated with poor oral health.

Health Resources and Services Administration

² CDC Division of Oral Health: [About the Division of Oral Health | National Center for Chronic Disease Prevention and Health Promotion \(NCCDPHP\) | CDC](#)

³ CDC Division of Oral Health (2023). <https://www.cdc.gov/fluoridation/basics/anniversary.htm>

Health Resources and Services Administration (HRSA) Title VII General Practice and Pediatric dental programs are essential to expanding and distributing the dental workforce, particularly in underserved and remote areas. In the 2022-2023 academic year alone, these programs supported over 5,500 dental students and professionals, delivering care to over one million patients. According to the FY 2025 HRSA budget justification, nearly 70 percent of program graduates serve in these communities, with another 20 percent working in primary care settings like Federally Qualified Health Centers. Continued support is critical to maintaining and growing this impact. The future of our nation's health care workforce also depends on a robust faculty to guide them. The Dental Faculty Loan Repayment Program is key to addressing the dental faculty shortage by helping academic institutions recruit and retain qualified faculty. This program ensures new dentists are trained to meet the evolving needs of the nation.

Indian Health Service Dental Program

The Indian Health Service (IHS) Dental Health Program (DHP) provided nearly 3.5 million services in FY 2023—a 19% increase from the prior year. Despite progress, American Indian/Alaska Native (AI/AN) communities continue to face an overwhelming burden of oral disease, with more than 80% of AI/AN children aged 6–15 experiencing tooth decay.⁴ Continued support of community-based prevention and education through DHP is essential to reducing the prevalence and severity of oral disease and improving the oral health of the AI/AN population.

Oral health is a critical component of overall health and is foundational to individual well-being and the strength of our economy, which benefits from the \$478 billion annual economic impact of oral health. We urge you to reject the proposed cuts across HHS agencies and programs and instead prioritize investments that protect and advance America's oral health.

Thank you for your consideration and your continued commitment to the health of all Americans. We appreciate your attention to this critical issue and welcome the opportunity to discuss further. If you have any questions or need additional information, please contact Jennifer Fisher.

Sincerely,

Academy of General Dentistry

⁴ Indian Health Service FY 25 Budget Justification (2024): [Fiscal Year 2025 Justification of Estimates for Appropriations Committees](#)

American Academy of Pediatric Dentistry
American Academy of Periodontology
American Association for Dental, Oral, and Craniofacial Research
American Association of Endodontists
American Association of Oral and Maxillofacial Surgeons
American Association of Orthodontists
American Dental Association
American Dental Education Association
American Student Dental Association
Society of American Indian Dentists

April 30, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C.

Dear Secretary Kennedy,

Congratulations on your appointment to the important role of Secretary of Health and Human Services. We, the undersigned members of the Presidential Advisory Council on HIV/AIDS (PACHA), are pleased to share our recommendations for advancing the HIV response both across the United States and globally.

PACHA is composed of nationally recognized leaders in public health, medicine, advocacy, philanthropy, research, and community-based care—including people living with HIV. PACHA and its members play a central role in efforts to make ending the HIV epidemic not just a vision, but an achievable goal. We are honored to serve our country and our communities by helping to shape policy, guide implementation, build community trust, and ensure science translates into impact.

HIV is now considered a chronic disease thanks to the bipartisan efforts of numerous Administrations. As this new Administration charts its course, we believe it is critical not to lose the momentum and progress hard-won over the past several decades. With continued leadership, investment, and collaboration, we have the opportunity to deliver on the promise of an HIV-free future in our lifetime. As the Administration seeks to improve the health and well-being of all Americans in communities across the nation, investing in HIV prevention and treatment is not just a public health necessity—it is a strategic, moral, and economic imperative.

Our key recommendations include:

1) Strengthen the Ending the HIV Epidemic (EHE) initiative.

The Ending the HIV Epidemic (EHE) initiative, launched in 2019 under President Trump’s leadership, is a bold and highly effective commitment to ending one of our nation’s most persistent public health crises. The EHE initiative is already delivering results: EHE jurisdictions have experienced an unprecedented decline of over 20% in new HIV cases in just the last five years. EHE is also a smart investment: by 2030, it has the potential to save the U.S. up to \$125 billion in healthcare costs while improving lives and expanding healthcare access in communities most impacted by HIV. Strengthening and expanding the EHE initiative is an essential part of making America healthier by continuing our nation’s progress on the bipartisan goal of ending the HIV epidemic.

2) Preserve Federal investments in HIV prevention.

HIV prevention is a cornerstone of the EHE initiative and other efforts to curb HIV. At the core of HIV prevention are public health activities funded and conducted by the Centers for Disease Control and Prevention (CDC). These include HIV surveillance, prevention programming, and strategies to expand access to pre-exposure prophylaxis (PrEP). HIV surveillance data provide the roadmap for where we can most impactfully invest prevention resources by identifying areas with growing numbers of new HIV diagnoses. These data also provide an evidence-based mechanism to assess progress in HIV prevention. Maintaining CDC’s nationwide network of highly trained scientists with expertise in HIV surveillance and

relationships with state and local health departments is vital to averting new HIV infections. Initiatives that expand access to PrEP are also prudent investments in good health outcomes and healthcare cost savings, as every HIV infection averted saves an estimated \$500,000 in lifetime treatment costs.¹ Even a 3% decrease in PrEP coverage nationally is estimated to result in over 8,500 preventable HIV infections over 10 years, which would increase costs to the healthcare system by over \$3.6 billion.²

3) Maintain critical HIV infrastructure, expertise, and funding across the Federal agencies and in the Administration for a Healthy America.

Numerous divisions and offices across the U.S. Department of Health and Human Services (HHS) play vital roles in advancing the goal of ending the HIV epidemic. The Office of Infectious Disease and HIV/AIDS Policy (OIDP), for instance, promotes efficiency by coordinating the national HIV response across multiple Federal agencies and departments. Similarly, the Ryan White HIV/AIDS Program provides life-saving care for more than half a million Americans with HIV and promotes the health of our nation as a whole by reducing new HIV infections. Last year, the Ryan White Program set a record by helping patients achieve a viral suppression rate of 90.6%, which far exceeds the national average of 65%.³

An example of the Ryan White Program's essential activities is Ryan White Part F, which has been shown to increase rates of HIV viral suppression through initiatives like the HIV dental program.⁴ Part F also creates innovations in HIV care through the Special Projects of National Significance (SPNS), such as a project ensuring that individuals who were living with HIV while in jail are linked to HIV care in the community within 30 days of release.⁵ In addition, Part F supports the AIDS Education & Training Center (AETC) Program, which provides HIV education and best practices that ensure service providers are confident and effective in managing HIV and other comorbid conditions.

Medicaid is another critical program that supports the health of millions of Americans, including 40% of people living with HIV.⁶ Cuts to Medicaid will impact people living with and affected by HIV, which is likely to lead to a costly increase in new HIV diagnoses. Robust investments in Medicaid are essential to protect and improve the health of all Americans, including those living with HIV.

4) Pursue full implementation of the National HIV/AIDS Strategy (NHAS).

The U.S. National HIV/AIDS Strategy (NHAS) outlines a comprehensive Federal plan to combat the HIV epidemic by coordinating programs, resources, and infrastructure across the Federal agencies. Similar HIV strategies in countries around the world have led to enormous public health and economic successes through substantial decreases in new infections and HIV-related deaths. Achieving the goals of the U.S. NHAS offers a similar substantial return on investment: studies suggest that every dollar invested in working to end the HIV epidemic generates \$6.44 in economic benefits.⁷ Careful stewardship of financial resources through the full implementation of the NHAS is both a sound economic decision and one that will save American lives.

5) Continue the U.S. commitment to the global HIV/AIDS response.

The U.S. has long been a global leader in improving health and generating economic returns around the world through visionary programs such as the President's Emergency Plan for AIDS Relief (PEPFAR). Since 2003, PEPFAR has saved over 25 million lives across more than 50 countries and provided over 20 million people with life-saving HIV treatment. Continued funding for PEPFAR's prevention and treatment efforts is essential not only to sustain progress and reduce new infections, but also to enhance U.S. global standing and improve global health security for all Americans. Moreover, HIV treatment funded by PEPFAR also decreases the risk of the development of new and resistant strains of HIV that would threaten the lives of millions of Americans here at home.

6) Fund HIV research.

Federal investments in the development of innovative new tools to prevent, treat, and cure HIV have made the U.S. a global leader in fighting the HIV epidemic. This Federal research funding ensures new scientific breakthroughs reach the patients who need them. Investment in HIV research also often helps solve other unforeseen challenges. HIV protease inhibitors, for example, were the basis of the fast-track development of a cure for Hepatitis C. Over a half million Americans have been cured of Hepatitis C infection because of investments originally made in the science of new HIV treatments. Continuing to invest in HIV research will ensure that the U.S. retains its stature as the world's greatest driver of scientific innovation not only in HIV but across the spectrum of chronic diseases and other major health challenges.

7) Maintain an active PACHA in its full capacity throughout the Administration.

For over 30 years, the Presidential Advisory Council on HIV/AIDS has played a vital role in the longstanding bipartisan goal of ending the HIV epidemic. We share your desire for the best health outcomes for all Americans and stand ready to work with you in service to our country and our communities. We thank you for your commitment to the health of our nation and look forward to partnering with you to advance America's legacy of domestic and international initiatives dedicated to a future free of HIV/AIDS.

Sincerely Yours,

Violeta Acuna
 Wendy Armstrong, MD
 Kellan Baker, PhD, MPH, MA (PACHA co-chair)
 Philip A. Chan, MD
 Raniyah Copeland
 Mackenzie Copley
 Paul Kawata
 Duvia Lozano
 Tiommi Lockett
 Deondre B. Moore
 Leo Moore, MD, MSHPM
 Marlene McNeese (PACHA co-chair)
 Jesse Milan, Jr., JD
 Jirair Ratevosian, DrPH, MPH
 Natalie Sanchez, MPH
 Patrick Sullivan, DVM, PhD
 Marvell Terry II
 Hansel Tookes, MD, MPH
 Carole Treston, RN, FAAN
 Dafina Ward, JD

CC:

Tom Engels, Administrator, Health Resources and Services Administration

Dr. Dorothy Fink, Director, Office of Women's Health

Heather Melanson, Chief of Staff, U.S. Department of Health and Human Services

Dr. Susan Monarez, Acting Director, Centers for Disease Control and Prevention

-
- ¹ Bingham, A., Shrestha, R. K., Khurana, N., Jacobson, E. U., & Farnham, P. G. (2021). Estimated Lifetime HIV-Related Medical Costs in the United States. *Sexually Transmitted Diseases, 48*(4), 299–304. <https://doi.org/10.1097/OLQ.0000000000001366>
- ² Sullivan, P. S., Wall, K. M., Juhasz, M., Millett, G., Crowley, J., Breyer, C., DuBose, S., Brisco, K., Le, G., & Mayer, K. (2025). Excess HIV infections and costs associated with reductions in HIV prevention services in the United States: Projection using real-world data. Available at: <https://www.medrxiv.org/content/medrxiv/early/2025/04/21/2025.04.17.25324904.1.full.pdf>
- ³ Health Resources and Services Administration. (2024). HRSA's Ryan White HIV/AIDS Program by the Numbers: 2023. Available from: <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/rwhap-hrsa-numbers-2023.pdf>
- ⁴ Smalley, L., West, K., Nortrup, E., & Clark, G. AIDS Drug Assistance Program (ADAP) Performance Measures. Presented at: Ryan White HIV/AIDS Program National Webinar, May 9, 2024; Washington, DC. Available at: https://targethiv.org/sites/default/files/media/documents/2024-05/Slides_ADAP_Performance_Measures_May_2024.pdf.
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- ⁶ Kates, J., Dawson, L., & Horn, T. (2025). Medicaid and People with HIV. Kaiser Family Foundation. Available from: <https://www.kff.org/hiv/aids/issue-brief/medicaid-and-people-with-hiv/>
- ⁷ Lamontagne, E., Over, M., & Stover, J. (2018). The Economic Returns of Ending the AIDS Epidemic as a Public Health Threat. *Health Policy, 123*(1), 104–108. <https://doi.org/10.1016/j.healthpol.2018.11.007>

**To:**

The Honorable Senator Bill Cassidy, MD, Chairman
 The Honorable Senator Bernie Sanders, Ranking Member
 Senate Committee on Health, Education, Labor and Pensions (HELP)
 United States Senate
 Washington, DC.

From: The Undersigned Individuals and Organizations in support of NIH funded research

RE: *Protect Federal Funding for HIV, TB, and STI Research and Prevention at the National Institutes of Health*

Dear Chairman Cassidy, Ranking Member Sanders and Members of the Senate HELP committee,

We, the undersigned **627** organizations, institutions, researchers, clinicians, public health advocates and stakeholders, write to express urgent concern to the committee in regard to devastating cuts to HIV, tuberculosis (TB), and sexually transmitted infection (STI) research at the National Institutes of Health (NIH). These cuts jeopardize decades of progress made through U.S. scientific leadership that have resulted in treatment, prevention, and care innovation. Recent actions to cut and diminish critical research now threatening millions of lives in the U.S. and around the world, abdicates the U.S. leadership as a scientific superpower with profound economic consequences, and challenges the vision of reaching an end to these epidemics through science.

NIH-funded research has fueled lifesaving prevention breakthroughs.

From HIV treatment, PrEP, and cure to promising TB vaccines and STI diagnostics, NIH-supported research has transformed public health. These breakthroughs are not incidental or insignificant, they are the result of long-standing partnerships between NIH, community-engaged research networks, and site-based research infrastructure across the U.S. and globally, and they have improved fundamental health outcomes around the world. Clinical trial sites drive innovation in prevention, serve as training hubs for researchers and providers, and as trusted access points for underrepresented communities. The sudden termination of research grants disrupts these sites, dismantles critical infrastructure, and undermines equity-focused science.

Prevention science is at risk-and so are communities that depend on it.

Recent actions have already eliminated at least \$450 million in HIV research grants, with additional terminations affecting STI and TB studies. These cuts abruptly halted work on long-

acting prevention, microbicides, vaccines, and multi-pathogen approaches. These cuts target communities most impacted by HIV, TB, and STIs: Black and brown populations, LGBTQ+ individuals, people who use drugs, and others facing systemic barriers to care.

Cuts to international research- particularly in South Africa, which has been central to HIV and TB research- are equally damaging. These global sites have produced essential findings that guide U.S. prevention strategies. Disrupting these partnerships directly harms U.S. public health, particularly at a time when TB rates are at a 10-year high and STI incidence continues to rise.

The restructuring of the Department of Health and Human Services and mass staff layoffs must be stopped.

Under the direction of HHS Secretary Robert F. Kennedy Jr., sweeping reorganizations and reductions in force (RIFs) at NIH and across HHS are gutting the scientific workforce, terminating thousands of skilled researchers, and politicizing public health infrastructure. These actions, carried out without Congressional oversight or stakeholder engagement, are dismantling programs that support HIV, TB, and STI research, silencing expert voices, and damaging our nation's ability to respond to both ongoing and emerging public health threats.

The broader consequences are economic, scientific, and moral.

NIH research supports over 300,000 researchers across all 50 states and fuels \$2.46 in economic activity for every one federal dollar invested. Between 2007 and 2022, 86% of the global health R&D funding was reinvested in U.S. institutions, creating 600,000 jobs and \$104 billion in economic growth, and contributing to over 90% of FDA-approved medications and devices. Terminating these programs erodes this return on investment, shrinks our scientific workforce, stifles innovation and makes America poorer, sicker, and less prepared for future health challenges.

We call on members of this committee to:

1. **Reject any proposed cuts** to HIV, TB, and STI research, prevention, and care programs funded by NIH and other federal agencies.
2. **Fully restore all terminated research grants and clinical trial networks, units and sites** critical to innovation in prevention and community engagement.
3. **Oppose any restructuring of HHS** that weakens scientific independence, marginalizes key population research, or bypasses Congressional oversight.

As a nation, we cannot end HIV, eliminate TB, or control the STI crisis without science- and we cannot do science without sustained, equitable investment. Now is the time to defend the research enterprise that protects public health, drives innovation, and centers those most impacted. We urge your leadership to take critical action in protecting and sustaining NIH funding to safeguard American science power and facilitate an end to these epidemics. Should you have any questions in regard to this letter, please contact John Meade, AVAC's Senior Program Manager – Policy.

Thank you.

Sincerely,

Organizations (74)

A Vision 4 Hope, Inc	Georgia
Act Now: End AIDS (ANEA) Coalition	South Carolina
ACTG UCSF	California
Advocates for Youth	Washington, D.C.
Agape Missions, NFP	Illinois
AIDS Action Baltimore	Maryland
AIDS Alabama	Alabama
AIDS Cure Research Collaborative	Pennsylvania
AIDS Foundation Chicago	Illinois
AIDS United	National/DC
American Academy of HIV Medicine	Georgia
Arianna's Center	Florida
Arianna's Center Puerto Rico	Puerto Rico
The Association of Nurses in AIDS Care	Ohio
AVAC	New York
Birmingham AIDS Outreach	Alabama
California Tuberculosis Controllers Association	California
California STD/HIV Controller's Association	California
Callen-Lorde Community Health Center	New York
Case Western University	OH
Chicago Women's AIDS Project	Illinois
Chicago House and Social Service Agency	Illinois
Columbia Research University	New York
End Hep C SF	California

Individuals (553)

A Huang	Illinois
Aadia Rana MD,	Alabama
Adit Dhummakupt	
Aditi Ramakrishnan	Missouri
Aisling Macaraeg	NH
Alan D. Levine	Ohio
Alanna Bergman PhD, RN	Virginia
Alex DiPerna	New York
Alex Perry	Arizona
Alexandra K Mueller, MHS	Illinois
Alexandra Mack	OHIO
Alicia Jaramillo-Underwood	MA
Alicyn Heinrich	Maryland
Alison El Ayadi	California
Alison Hill	Maryland
Alison Hixon	Missouri
Alison Sutton-Ryan	Arizona
Allison Agwu, MD ScM	Maryland
FAAP FIDSA	
Alyssa Carodine	Alabama
Ame stormer	Louisiana
Amesika Nyaku	Illinois
Amita Gupta	Maryland
Amita Gupta	Maryland
Amy Boone	Alabama
Amy Conroy	California
Anastasia McAteer	California
Andrea Weinstein	PA
Andrew F. Angelino, MD	Maryland
Andrew Westfall	Alabama
andrewgarcia57@gmail.com	California
Angela Snyder	Ohio
Aniruddha Hazra	Illinois
Anjali Sharma, MD, MS	New York

Equality Florida	Florida	Ann Avery, MD	Ohio
Fast-Track Cities Institute	National	Ann Cox	Ohio
Fenway Health	Massachusetts	Anna Batz	Illinois
Five Horizon's Health Services	Alabama and Mississippi	Anna Greenfelder	Ohio
Game Changing Men	Georgia	Anna P. Durbin	Maryland
Getting to Zero	California	Anne Efron	Maryland
Getting to Zero San Francisco	California	Anne Rompalo, MD	Maryland
GLMA: Health Professionals Advancing LGBTQ+ Equality	National	Anne Teitelman	PA
Global Black Gay Men Connect	National	Anne-Catrin Uhlemann	New York
Health Services Center, Inc.	Alabama	Annelys Roque Gardner	Georgia
HIV+Hepatitis Policy Institute	Washington, DC	Annie Luetkemeyer, MD	California
HIV Prevention Community Advisory Board	New York	Anupam Pande	Missouri
HIV Medicine Association	Georgia	April Charbonneau	Maryland
Infectious Diseases Society of Ohio	Ohio	April Houston	Georgia
ICAP at Columbia University	New York	Asa Radix	New York
International Association of Providers of AIDS Care	National	Asante Kamkwala	Maryland
Intersectionality Training Institute	DC	Ashley Gordon-Phillips	Maryland
Johns Hopkins University	Maryland	Asiya Abdul-Alim	Ohio
Lambda Legal Defense and Education Fund	New York	Audrey Pettifor	N. Carolina
Latino Commission on AIDS	National	Augustus Klein	New York
Life is Work	Illinois	Ava Dennie	New York
Legal Council for Health Justice	Illinois	Aye Hnin Moe	Maryland
MCOHA	Maryland	Barbara Gripshover, MD	Ohio
Mother and Child Alliance	Illinois	FIDSA	
NASTAD	National	Barbara Van Der Pol	Alabama
National Community Pharmacist Association	Maryland	Barbara Wilgus MSN, CRNP	Maryland
		Becca Mitsos	Illinois
		Benjamin James Burwitz	
		Berlie Dejean	Maryland
		Beth Ryan	Illinois
		Bill Powderly	Missouri
		Bonnie S. King	Maryland
		Brenice Duroseau	Maryland
		Brian Clagett	Ohio
		Brian Greenfelder	Ohio
		Brian Minalga	WA
		Brianne Condron	Illinois
		Bridgette Picou	California

National Working Positive Coalition	New York	Brooke Baffa	Illinois
Neelyx Labs	Illinois, but multistate	Brooke Willis	Ohio
NMAC	Washington, DC	Bryan Gooding	Illinois
Older Women Embracing Life (OWEL) JHU	Maryland	Bulent Turan	Alabama
PfLAG National	National	Caitlin Visek	Maryland
Petersen Clinics of University of Arizona	Arizona	Carey Shive	Ohio
Public Health Institute of Metropolitan Chicago	Illinois	Carlos Malvestutto, MD, MPH	Ohio
PVAMU College of Nursing	Texas	Carly Comins	Maryland
San Francisco AIDS Foundation	California	Caroline McLendon	Illinois
Save HIV Funding	National	Caroline Mullis, MD MS	New York
SEEDS of Healing, Inc	N. Carolina	Carrie Tudor	Maryland
SIECUS: Sex Ed for Social Change	National	Catherine Lesko	Maryland
Tennessee Recovery Alliance	Tennessee	Catherine Schluth	PA
The AIDS Institute	National	Cedric Sturdevant	Mississippi
The Center for HIV Law & Policy (CHLP)	National	Celeste Young	California
The Project of the Quad Cities	Iowa & Illinois	Chad Achenbach	Illinois
Treatment Action Group	New York	Charlene Gamaldo	Maryland
Tulane National Primate Research Center	Louisiana	Charles H. King MD	Ohio
Tuscon Interfaith HIV/AIDS Network (TIHAN)	Arizona	Charles McLendon	Illinois
UCSD	California	Charlotte Ann Gaydos	Maryland
University of Cincinnati	Ohio	Che Matthew Harris	Maryland
The Well Project	National	Cheriko Boone	DC
West Virginia HIV Academy	West Virginia	Cheryl Smith	Ohio
Mentoring Partnership	Washington, DC	Chris Bositis	California
Whitman-Walker	Washington, DC	Chris Goddard	Ohio
		Chris Peterson	WA
		Christiane Hadi	PA
		Christina Liscykesky, MD	OH
		Christina Ochsenbauer, Ph.D.	Alabama
		Christine Barber Alden	Maryland
		Christine Durand	Maryland
		Christine Tagliaferri Rae	Colorado
		Christopher Archiopoli	WA
		Christopher Hoffmann	Maryland
		Claire Berman	MA
		Claire Bloom, MD	MA
		claudia hawkins	Illinois

Clifford Castleberry	Louisiana
Connie Celum	WA
Constance A. Benson, MD	California
Corey Hopkins, PhD	Nebraska
Courtney Schill	Maryland
Craig Fong	Illinois
Cristine Fisher	Maryland
Cynthia K Papierniak	Illinois
Cynthia L Sears, MD	Maryland
Daniel Huan Chao CHEN	Ohio
Daniel Johnson	Illinois
Daniel Lowenstein	California
Daniel R. Kuritzkes, M.D.	MA
Daniel Reeves	WA
Danielle German	Maryland
Danielle Warren	Ohio
Danilo Bacic Lima, MD	New York
Darcy Wooten	Missouri
David Chapman	New York
David Dowdy	Maryland
David Loeb	New York
David Palm	N. Carolina
David Thomas	Maryland
David W Poole	Florida
David W. Haas, MD	Tennessee
Deborah Konkle-Parker	Mississippi
Deborah McMahon, MD	PA
Deborah Theodore, MD	New York
Debra Winters, APRN-BC, AACRN	Massachusetts
Deepak Almeida	Maryland
Denise Jacobson	MA
Diane Havlir, MD	California
Dimple Patel	Ohio
Dominic Dorazio	Ohio
Donna J. Smith	Alabama
Douglas Krakower, MD, FIDSA	MA
Douglas Richman	California

Dr. Alexandre Carvalho, M.D., M.P.H.	New York
Dr. Anthony Bowen	
Dr. Brandi Manning, DO, MPH	Ohio
Dr. Melissa Parkinson	New York
Dr. Ruvandhi Nathavitharana	MA
Drew Lewis, MD, MTM&H, FACP	Maryland
Drew Sayer, PhD	Alabama
Edwin D. Charlebois, MPH, PhD	California
Eileen Hollander	Maryland
Eileen Scully	Maryland
Elaine Abrams	New York
Elena Martinelli	Illinois
Elisa Ignatius	Maryland
Elizabeth Christian	MA
Elizabeth Habat	Ohio
Elizabeth Jaffee	Maryland
Elizabeth Matsui	Texas
Ellen G. Chadwick MD	Illinois
Ellen Morrison	New York
Emily Dauria	Pennsylvania
Emily Lu	Maryland
Emma Meagher	PA
Enbal Shacham	missouri
Eric Nuernberger	Maryland
Erin Cooney, Phd, MSPH, CPH	Maryland
Erin Shirk	Maryland
Ernie-Paul Barrette, MD	Missouri
Eryka Saylor	Maryland
Ethan Honeycutt	Ohio
Ethel D. Weld, MD, PhD	Maryland
Fengchun Ye	Ohio
Florian Hladik	WA
Francisco Rentas	WA
Gayle K Springer	Maryland

Ge Jin	Ohio
Gennifer Kully	California
Giuseppina Impellizzeri	Illinois
Greg Jao	Illinois
Greg Macek	Illinois
Gregg Cassin	California
Gregoire Lauvau	
Gregory M. Lucas	Maryland
GULSEREN Yilmaz	New York
Haleigh Civileto	New York
Harry Breaux	California
Heather Gray	Illinois
Heba Ali	Maryland
Hilary M Babcock	Missouri
Hilary Reno	Missouri
Hong Van Tieu	New York
Hsiang Hong	New York
Ian Frank	PA
Immaculate L Nankya	Ohio
Iryne Zziwa-Kabenge	Maryland
Isabelle Clerc	Illinois
Isabelle Medina	New York
Isadora Salles	Georgia
J Kevin Carmichael MD FIDSA DABFM	Arizona
Jacky Jennings	Maryland
Jacob McLean, DO	New York
Jacqueline Loeb	Maryland
Jade Bell	Maryland
Jaime Robertson, MD	Ohio
Jake Estes	Oregon
Jakob Harrison-Gleason	Illinois
Jaleah Rutledge	CT
James Egan	PA
James England, MD	Ohio
Jami Maxson MD	Iowa
JAMIE WEISMAN	Georgia
Jane Lee	Illinois
Janet M. Turan	Alabama

Janice Chithelen	
Jason Blackard PhD	Ohio
Jason Burnham	Missouri
Jason Farley	Maryland
Jason Halperin, MD MPH	California
Jatin Vyas	New York
Jeanne Baron	New York
Jeanne C Keruly, MS, CRNP	Maryland
Jecca R Steinberg	Illinois
Jeff Taylor	California
Jeffrey C. Hatcher, MD FACP FIDSA	N. Carolina
Jeffrey Segall	New York
Jen Tilly	N. Carolina
Jennifer Cocohoba	California
Jennifer Furin	Ohio
Jennifer Furin	Ohio
Jennifer Jao	Illinois
Jennifer M Fiegel	New York
Jennifer McMillen Smith, MSSA, LISW-S	Ohio
Jennifer O'Neill, BSN, RN	Nebraska
Jennifer Yore	California
Jerrica L. Werner, MD	WA
Jesse Clark, MD	California
Jessica Jaiswal	Alabama
Jessica Marburger	Ohio
Jessica McCann	N. Carolina
Jessica weaver	New Jersey
Jill Blumenthal	California
Joan Cullen	Ohio
Joan Duggan	
Jo-Ann Jose	
Joe Mora	California
Joel Ernst	California
Joel Kammeyer, MD	Ohio
John Bonelli	New York
John Dennis	California

John Dwyer, RN	California
John Koethe, MD	Tennessee
John L. Sullivan M.D.	MA
John M Coffin	MA
John Peller	Illinois
John R. Bassler	Alabama
John Saucedo	California
John Sefakis	New York
John W. Mellors, MD	PA
Jon Weinhold	Nebraska
Jonah Sacha	Oregon
Jonathan Karn	Ohio
Jorge Soler	New York
Jose A. Bazan, DO	Ohio
José Diaz	New Jersey
Joseph Gregory Rosen	RI
Joseph J Eron Jr. MD	N. Carolina
Joseph Liaw	Illinois
Joseph M McCune, MD, PhD	California
Joseph Mudd	Louisiana
Josh Barocas	Colorado
Joshua T Schiffer	WA
Joyce Jones, MD, MS	Maryland
Judith D. Auerbach, PhD	California
Judith Dispenza	Illinois
Judith S. Currier MD	California
Julia Beabout	WA
Julia Rosebush	Illinois
Julian Goodman, MD	Ohio
Julie E Mangino MD, FSHEA, FIDSA	OHIO
Julie Evans	Maryland
Julie McArthur	Maryland
Julie Patterson	Ohio
Julie Whiley	Ohio
K Rivet Amico	Michigan
Kaitlin Poole	Maryland
Kameron Jacobs	WA

Kanika Khanna	California
Karah Y. Greene, MSW	Florida
Kate Gershwin	Illinois
Katharine J Bar, MD	PA
Katherine Knapp, MD, FAAP, AAHIVS	Tennessee
Katherine Luzuriaga	MA
Katherine Wilson	Maryland
Kathleen Hill Gallant	Minnesota
Kathleen Page	Maryland
Kathryn Stephenson	MA
Kawsar Talaat	Maryland
Kayla Hendry	Kentucky
Kelli Williams MD, MPH	Ohio
Kelly Curran	Maryland
Kelly Lowensen	Maryland
Kenneth Mayet	MA
Keosha Bond	New York
Keri Althoff	Maryland
Kevin Hsueh	Missouri
Khalil Ghanem	Maryland
Kim Scarsi	Nebraska
Kira Gritsman	New York
Kisten Nolan	Illinois
Kristen Ellis, PharmD, BCPS, AAHIVP	Arizona
KRISTI LANGSHAW	Ohio
Kristi Vaughn	California
Kristine Erlandson	Colorado
Krystle Kim	Illinois
Ladonna Benning	Maryland
Larry Chang	Maryland
Laura Beres	Maryland
Laura Clark	Maryland
Laura J. Mintz, MD, PhD	Ohio
Laura Renee Marks	Missouri
Lawrence Leonard Lusardo	WA
Lawrence Purpura	New York
Leah Kravets	New York

Leah Woods	N. Carolina
Lee Gilman, CRNP	Maryland
Lee Winchester	Nebraska
Liam Jermyn	New York
Liesl Nydegger	Maryland
Linda M Tate	PA
Lindsay Sheets	Maryland
Lisa Kuhns	Illinois
Liz Salomon	MA
Lizbeth Fabregas Troche	PR
Lizmarie Torres	PR
Logan Benton	Alabama
Louis Catania	Ohio
Louis M Weiss	
Lucy Kalanithi, MD, FACP	California
Luis Dubocq	Ohio
Lustigman sara	New York
Lyndsey Armor	Ohio
Lynn Wardlow	Ohio
Lynne M Mofenson MD	Maryland
Madeline McCrary	Missouri
Madhu Choudhary	PA
Magdalena Sobieszczyk	New York
Maggie Feeney	California
Mandar Paradkar	
Manuel Ocasio	Louisiana
Marc Siegel	District of Columbia
Marci Drees, MD, MS	Delaware
Margaret Ann Sanders	Illinois
Maria Jalbrzikowski	MA
Marie Bakitas	Alabama
Marilia Pinzone	Missouri
Marilyn Hewitt	Illinois
Mario Stevenson	Florida
Marion J Skalweit MD PhD	Ohio
Marisa Brizzi, PharmD, BCPS, AAHIVP	Ohio
Mark Herbert	Ohio

Marlena Petrie	Kentucky
Martez Smith	New York
Martin Rodriguez	Alabama
Mary C Magee, R.N.	California
Mary DeGrazia	Maryland
Mary Glenn Fowler	Maryland
Mary Hawk	PA
Mary K Grabowski	Maryland
Mary Midea	Ohio
Mary Palmer Klawon	Kentucky
Mary T. Johnson	Illinois
Mary Talalay	Maryland
Matthew Adams	Arizona
Megan Rose Curtis MD MS	Missouri
Melissa Osborn Jenkins, MD	Ohio
Melissa Parker	Alabama
Meredith Greene	Indiana
Michael Bianco	New York
Michael Deighan	Ohio
Michael Gierlach	Ohio
Michael Herce, MD, MPH, MSc	N. Carolina
Michael L. Freeman, Ph.D.	Ohio
Michael Lederman MD	Ohio
Michael Louella	WA
Michael Luciano	S. Carolina
Michael Maginn	Illinois
Michael Saag, MD	Alabama
Michael Smallwood	New York
Michele Gaffigan	Colorado
Michele Andrasik	WA
Michele O'Neill	Ohio
Michelle Saemann	Ohio
Michelle V Lisgaris MD	Ohio
Miranda Smith	
Mohamed Abdel-Mohsen	Illinois
Moira Nguyen	Illinois
Moises Agosto	Maryland

Molly Lyons	MA
Monica Gandhi	California
Murray Penner	DC and KS
Nahom Daniel	WA
Nancy L. Haigwood, Ph.D.	Oregon
Natalie Nielsen, PharmD	Ohio
Natalie Wilson	California
Nayck Feliz	PA
Newton Butler	California
Nicole Dister	Ohio
Nicolette Gomez	Florida
Nikki Jacobs	Ohio
Niklas Bachmann	Maryland
Nina Derby	WA
Nora Colburn, MD, MPH	Ohio
Olivia Andres	Illinois
Olivia Van Gerwen	Alabama
Orbit Clanton	New York
Pablo Tebas	PA
Paige L. Williams	MA
Pam Turner	Ohio
Parya Saberi	California
Paul Arons MD	Florida
Paul Spearman	Ohio
Paul Volberding	California
Peter Tran	OHIO
Peter W. Hunt, MD	California
Peter Zimmerman	Ohio
Petros C. Karakousis	Maryland
Philip Bolduc MD	MA
Poonum Korpe	
Preston Kutzner	Illinois
Priscilla Yee	Hawaii
Priya Pal	Missouri
Puneet Upreti	
R. Paul Johnson, MD	
Rachel Calhoun	Ohio
Rachel Tao	Maryland
Rajesh T. Gandhi	MA

Ramona Gonzales-Cardenas	California
Rasima	Illinois
Ravi Jhaveri	Illinois
Rebeca Diaz-Reyes	Maryland
Rebecca Becker	Maryland
Rebecca Brown	
Rebecca Forrest	Ohio
Rebecca Fry	New York
Rebecca L. Becker	Maryland
Rena Patel	Alabama
Renee Heffron	Alabama
Rev. Peter Sean Scie	Louisiana
Reva Datar	Maryland
Richard Ambinder	Maryland
Richard B. Pollard M.D. FACP, FIDSA	California
Richard D'Aquila	Illinois
Richard E. Chaisson, MD	Maryland
Richard Loftus MD	ND
Richard Moore	Maryland
Riley James	Ohio
Rita Lisa Labbett, MPH, CCRC	PA
Rob Camp	MA
Robert C. Bollinger MD, MPH	Maryland
Robert Garofalo	Illinois
Robert Kalayjian, MD	OHIO
Robert Rudolph	Kentucky
Robert T. Schooley, MD	California
Robin K. Avery MD, FIDSA, FAST	Maryland
RoiAnn R. Phillips	Illinois
Romeo Allen III	Louisiana
Ron Swanstrom	N. Carolina
Rumilia Tolentino-Nogueira	Ohio
Ruth Mallowney-Agra	Ohio
Saira Butt	Indiana
Sandeep Tyagi	Maryland

Sandra Wiederhold MD	Michigan
Sara Bares	Nebraska
Sara Gianella Weibel	California
Sara Schenkel	MA
Sara Suliman	California
Sarah Misiano	Florida
Sarah Najera	Illinois
Scott F. Sieg	
Scott Fulton, MD	Ohio
Scott Greenbaum	MA
Scott Hendry	Kentucky
Seun Ibrinke	New Jersey
Shaina Rose Horner	Ohio
Shanett Jones	Illinois
Shanisha Gordon-Mitchell	New York
Shannon Ransom	California
Sharon Hillier	PA
Sharon Lewin	
Sharon Nichols	California
Shashwatee Bagchi	Missouri
Shawnalyn Sunagawa	Nebraska
Sherif Mossad	Ohio
Shilpa Vasishtha	New York
Shobha Swaminathan	New Jersey
Shruti Mehta	Maryland
Skye Opsteen	Alabama
Sonya Krishnan	Maryland
Sreeja Kodali	Maryland
Stacy W. Smallwood, PhD, MPH	N. Carolina
Steffanie Sabbaj	Alabama
Steph Santoro	
Stephanie Creasy, MPH	PA
Stephanie Fabiyi	Illinois
Stephanie Ralich	Indiana
Stephanie Shiau	New Jersey
Stephanie Standlee	Illinois
Stephen Berry	Maryland
Stephen Carpenter	Ohio

Summer Worthington	Illinois
Sunil K. Ahuja	Texas
Suresh Boppana	Alabama
Susan Cohn	California
Susan L Koletar	
Suzanne Queen	Maryland
Sybil Hosek	Illinois
Sydney Agnello	Ohio
Sydney LeBlanc	Ohio
Teresa	Maryland
Teresa Bowman	New York
Termeh Feinberg	CT
Tess Willinger	MA
Thomas C Bailey, MD	Missouri
Thomas Erwes	Arizona
Thomas Nguyen	
Thomas P. Giordano, MD, MPH	Texas
Thomas Quinn, MD	Maryland
Timothy Jackson	Illinois
Timothy M Mykris	Nebraska
Tom Carpino	N. Carolina
Tonia Poteat	N. Carolina
Tracy Wolbach	Colorado
Valeria Cantos	Georgia
Veronica Figueroa	California
Veronica Viar	California
Vicente Planelles	Utah
Victoria Frye	New York
Victoria McDonald	Alabama
Viet Vu	Maryland
Viraj Patel MD MPH	New York
Vivian Chang	California
Willa Cochran	Maryland
Won Kim	Illinois
Xiomara Merced	Ohio
Yesha Patel	Ohio
Yijia Li, MD	PA
Yoelvis Garcia-Mesa	Ohio



May 14, 2025

Senator Bill Cassidy, M.D.

Senator Bernie Sanders

Chair, United States Senate Committee on Health, Education, Labor and Pensions

Ranking Member, United States Senate Committee on Health, Education, Labor and Pensions

Submitted Via email

RE: May 14, 2025, Hearing on Fiscal Year 2026 Department of Health and Human Services Budget

Chair Cassidy, Ranking Member Sanders, and Members of the Committee:

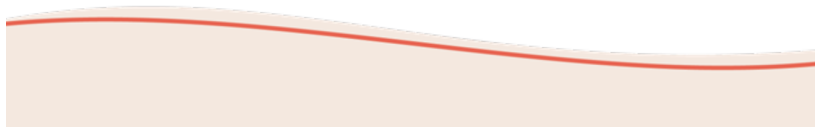
On behalf of the Autism Society of America, the nation's oldest and largest grassroots Autism organization, we respectfully submit this statement for the record regarding the Department of Health and Human Services' Fiscal Year 2026 budget request.

We thank the Committee for its ongoing commitment to public health, science-based policymaking, and equitable access to services for individuals with developmental disabilities. As an organization dedicated to creating connections and empowering everyone in the Autism community with the resources they need to live fully, we are acutely aware of how federal health policy and funding shape the lives of over 5 million adults and 1 in 31 children in the U.S. living with Autism.

1. Support for Robust FY26 Funding for HHS Autism Programs

We urge the Committee to support and enhance funding in the FY26 budget for critical HHS programs that serve the Autism community, including:

- Protect the **Autism CARES Act** programs administered by the **National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and the Health Research and Services Administration's (HRSA) workforce training**. Ensure the Interagency Autism Coordinating Committee is reestablished and guides the work of HHS in Autism policy.
- Expanded investments in **community-based services, early diagnosis, and interdisciplinary training programs** and protect the **Administration for Community Living (ACL)**.





- Evidence-based research support through the **National Institutes of Health (NIH)**, including the **National Institute of Mental Health (NIMH)** and **National Institute of Child Health and Human Development (NICHD)**.
- Protect federal Medicaid funding which enables many with Autism to receive services in their community, to enable them to be contributing members to their community.

Stable and increased funding is critical to expanding access to services, reducing disparities in diagnosis and care, and ensuring a strong provider workforce to meet growing demand.

2. Statement on Causation Misinformation and Vaccine Safety

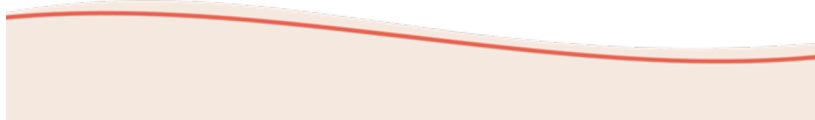
As this Committee considers testimony and commentary from Secretary Kennedy, we strongly urge a clear distinction between evidence-based science and misinformation. Claims that definitive environmental exposures, parenting styles, or vaccines cause Autism not only lack scientific evidence but are incredibly irresponsible. Vaccine causation has been thoroughly discredited by decades of rigorous scientific research involving millions of children worldwide. These unfounded assertions have not only been debunked by the **CDC, NIH, and the World Health Organization (WHO)**, but they have also contributed to dangerous declines in vaccination rates and the resurgence of deadly preventable diseases.

The Autism Society of America unequivocally supports the scientific consensus on vaccine safety and urges all leaders to refrain from perpetuating harmful myths that erode public trust and stigmatize individuals with Autism. The focus must be on ensuring that all research efforts are led by credentialed, evidence-based experts who understand the complexities of Autism and are committed to advancing scientifically valid findings. This includes safeguarding transparency and accountability throughout the process to ensure that research is conducted in a manner that is ethical, inclusive, and grounded in science. Rigorous, peer-reviewed, and analyzed science takes time, funding, and a significant investment of capital – claiming that this can be achieved in incredibly short time frames is misleading and threatens the public's health and decision-making.

3. Commitment to Integrity, Equity and Dignity

The Autism Society envisions a future where all Autistic individuals have equitable access to healthcare, education, employment, and community living. We urge the Committee to ensure that the FY26 budget reflects a genuine commitment to disability equity and that Autistic voices are meaningfully included in policymaking and testimony processes that affect our lives.

Public policy and discourse must recognize the inherent value, rights, and diverse needs of Autistic people. Scientific consensus does not support claims that Autism is "preventable"—such language fosters harmful stigma rather than understanding. Similarly, referring to Autism as a





"chronic disease," a "childhood disease," or an "epidemic" misrepresents the Autistic experience and undermines respect and inclusion.

4. Upholding Ethical Data Privacy and Consent

We also express concern about the increasing use of registries and large-scale data collection efforts. Any such initiatives must prioritize choice, meaning explicit informed consent, transparency, and robust protections for privacy and data security from the outset.

Building trust with the Autistic community must be a central priority—anchored in transparency, accountability, and strong privacy safeguards at every stage of research and policy development. Currently, that trust is fractured, and is fueling fear, confusion and misinformation among the Autism community. In moments when rhetoric or internal disagreement risks division, it is essential to hold space for diverse perspectives and lived experiences. At our core, we share a common goal: to ensure that Autistic individuals and their families have meaningful, equitable access to the resources, supports, and services they need to thrive.

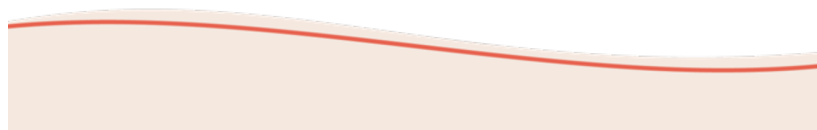
We thank the Committee for its leadership in oversight and urge a continued bipartisan focus on supporting the health, well-being, and dignity of all Americans, including individuals with Autism and their families.

Respectfully submitted,

Sincerely,

A handwritten signature in blue ink that reads "Christopher S. Banks". The signature is contained within a thin black rectangular border.

Christopher S. Banks, President and CEO of the Autism Society





Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

**United States Senate Committee on Health, Education, Labor & Pensions (HELP)
Hearing on Fiscal Year 2026 Department of Health and Human Services Budget**

May 14, 2025

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Committee on Health, Education, Labor & Pensions (HELP) hearing on the Fiscal Year (FY) 2026 Department of Health and Human Services (HHS) budget. We are grateful to the Committee and bipartisan champions in both chambers who have worked together to ensure our country continues to advance policies that improve the lives of people living with dementia and their families.

Just last Congress, this Committee renewed our nation's commitment to the Alzheimer's community by unanimously reauthorizing three critical, bipartisan bills: the NAPA Reauthorization Act (P.L. 118-92), the Alzheimer's Accountability and Investment Act (118-93), and the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Reauthorization Act (P.L. 118-142). We also thank the Committee for reaffirming your commitment to the Alzheimer's and dementia community while sounding the alarm about the impact that cuts to HHS will have on the progress in the fight against Alzheimer's and other dementia. It is crucial for officials to understand the challenges of this fatal disease, the progress we have made, and the hope we have for the future in the fight to end Alzheimer's and all other dementia. Alzheimer's isn't a red or blue issue — it is purple. What unites us all is our shared vision of a world without Alzheimer's and all other dementia. We are at the moment when our knowledge and discoveries are changing the way we fight dementia. Now is the moment to do more, not less.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. The Alzheimer's Impact Movement is the Association's separately incorporated advocacy

affiliate, working in strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease and all other dementia, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Federally-supported health research is a direct investment in the health, economy, and security of the United States. This research, conducted through partnerships involving federal agencies, academic institutions, and industry, produces discoveries that lead to longer, healthier lives, generates significant economic growth, and strengthens our nation's resilience against health threats. We have seen clear results: lower cancer death rates, life-saving vaccines, and effective treatments for many diseases. The National Alzheimer's Project Act (NAPA), enacted in 2011 and reauthorized unanimously in 2024, demonstrates how focused national commitment accelerates progress, particularly in Alzheimer's research.

However, major health challenges remain: Alzheimer's disease and related dementias (AD/ADRD), chronic diseases, the threat of pandemics, and health disparities. Alzheimer's disease illustrates the urgency. As too many of us know from personal experience with family or friends, Alzheimer's is a progressive brain disease that damages and eventually destroys brain cells, leading to a loss of memory, thinking, and other cognitive functions. Ultimately, Alzheimer's is fatal. We have yet to celebrate the first survivor of this devastating disease. According to the *2025 Alzheimer's Disease Facts and Figures*, by 2050, the projected number of people age 65 and older living with Alzheimer's in America will be 12.7 million, and total payments for all individuals with Alzheimer's or other dementias are projected to increase to just under \$1 trillion. These mounting costs threaten to bankrupt families, businesses, and our health care system. Unfortunately, our work is only growing more urgent.

Meeting these challenges and using new scientific opportunities requires a strong, sustained federal commitment. The Alzheimer's Association is gravely concerned by the proposed FY2026 budget released by the Trump administration. The proposal, which includes substantial cuts to HHS, including a 40 percent cut to the National Institutes of Health (NIH), will limit our nation's ability to address the needs of people living with dementia and their caregivers, and set research advancements back decades.

Investing in policies that improve the lives of people impacted by dementia, including robust and sustained research into ways to address the condition, remains a bipartisan priority. Just recently, during the Senate Appropriations Committee hearing, members from both sides of the aisle spoke passionately about the role America — through the NIH — has played in advancing progress on treatments, detection, and diagnosis for Alzheimer's. The Alzheimer's

Association and AIM will continue to work with champions from all parties, our nationwide network of advocates, and our partners in the biomedical research community to highlight the value of biomedical research to all Americans.

Progress Leads to Treatment

The 2011 enactment of the landmark National Alzheimer's Project Act (P.L. 111-375) ushered in a new phase of progress, changing the way our nation addresses Alzheimer's and all other dementia — and resulting in unprecedented progress in Alzheimer's and dementia research, care, and support. In 2024, Congress renewed the nation's commitment with the unanimous passage of the NAPA Reauthorization Act and the Alzheimer's Accountability and Investment Act.

Since the passage of NAPA, Congress has worked in a bipartisan fashion to increase federal research funding more than sevenfold. Current investments at the NIH in Alzheimer's and dementia research are more than \$3.8 billion annually. As a result of this increased investment, scientists have been able to work at a more rapid pace to advance basic disease knowledge, explore ways to reduce risk, uncover new biomarkers for early diagnosis and drug targeting, and develop potential treatments.

Alzheimer's and dementia research has greater momentum now than ever before, largely due to appropriately robust funding from Congress. Recent advances include approval of the first treatments approved by the Food and Drug Administration (FDA) to slow the progression of Alzheimer's disease and more tools for accurate detection and diagnosis, such as amyloid and tau PET imaging, cerebrospinal fluid assays, and blood tests. These treatments change the course of the disease in a meaningful way for some people in the early stages. By slowing progression of the disease in the early stages of Alzheimer's, individuals will have more time to participate in daily life and live independently. Future treatments will need to address the underlying biology that drives all stages and symptoms of each neurodegenerative disease so that all individuals who are affected by Alzheimer's or another dementia have effective treatment options. Our progress must continue.

As Alzheimer's and other dementia science rapidly evolves, we all have a responsibility to ensure the information presented to people facing these conditions is accurate and grounded in the latest science. However, increasingly, influencers in the news media and a very small minority in the dementia field are perpetuating harmful myths about Alzheimer's, including the new FDA-approved Alzheimer's treatments. These inaccurate, highly distorted, and sensationalized attacks on scientific discoveries and the scientific community have begun to

reach the patient community and are impacting their health care decisions and treatment options.

The Dementia Research Community is Strong, Collaborative, Science-Driven, and Exploring a Wide Variety of Pathways

Recently, researchers and investigative journalists highlighted several dementia researchers who have engaged in fraud over the past two decades, resulting in a small number of studies that cannot be relied upon. To be clear — research fraud is unacceptable and must not be tolerated. However, these studies in question were not as pivotal as they have been portrayed, and subsequent research did not depend on them.

Over the past two decades, Alzheimer's research has included research into the "amyloid hypothesis" based on a robust body of scientific evidence. This research has been successful. Through the clearance of amyloid, the two treatments available to patients today have demonstrated their effectiveness in rigorous phase 3 clinical trials and FDA approval, bringing meaningful benefits to patients. Further important progress based on this line of research is currently in clinical trials and highly possible.

At the same time, the NIH, the Alzheimer's Association, and other stakeholders are funding many more projects addressing therapeutic targets such as tau, inflammation, and metabolic pathways. Claims that Alzheimer's research is focused on amyloid to the exclusion of other targets are simply wrong. For example, as of September 2024, the National Institute on Aging (NIA) has 68 active pharmacological trials, only 12 of which focus on amyloid.

Myths about dementia research are harming patients. More than 7 million Americans are living with Alzheimer's disease. Another 11 million are providing unpaid care. On behalf of these individuals and the millions more who may develop Alzheimer's or another dementia in the years to come, the myths about Alzheimer's research must stop. For someone facing Alzheimer's disease, having accurate information and unbiased guidance can mean the difference between seeking care — including obtaining a diagnosis, getting access to treatment, or exploring participation in clinical trials — or not.

Investing in Alzheimer's Research

While the NIH has conducted research to find treatments for Alzheimer's, the agency is also focused on advancing researchers' understanding of the risk factors, genetics, and biological mechanisms that drive dementia and expanding research on dementia care and care partner support. The NIA is currently conducting over 150 early and late stage clinical trials on

non-pharmacological interventions, including exercise, brain stimulation, and cognitive training. Ongoing support also allows the NIH to further study the impact of blood pressure control, hearing aids, and other non-pharmacological interventions on Alzheimer's prevention and care.

While recent NIH funding increases have laid the foundation for breakthroughs in diagnosis, treatment, and prevention, and enabled significant advances in understanding the complexities of Alzheimer's, there is still much left to be done. Recent actions targeting research funding and staffing — such as stalled funding to Alzheimer's Disease Research Centers (ADRCs) — will jeopardize scientific and medical progress. Funding and staffing capacity are critical to effectively and efficiently carry out research and public health programs. Delays and reductions have real consequences for the health of the American people. Alzheimer's Disease Research Centers are a rock solid foundation for the entire Alzheimer's and dementia research field. We are deeply concerned that stalled approval of funding to ADRCs will jeopardize scientific and medical progress. Additional delays to ADRC funding risk reducing or eliminating many research trials and scientific collaborations, training and advancement opportunities for researchers and clinicians, and dementia care throughout the region of each ADRC. We are at a critical moment for Alzheimer's research and treatment. More than ever, we must sustain the momentum we've created as a dementia research field.

As Congress continues to advance the FY2026 appropriations process, the NIH must continue to build upon promising research advances. An increase of \$113.485 million in Alzheimer's research funding at NIH in FY2026 would accelerate our ability to prevent and treat Alzheimer's and other dementia. This funding request is equal to the amount recommended in the FY2026 NIH Professional Judgement Budget for Alzheimer's Disease and Related Dementias Research: Advancing Progress in Dementia Research, as authorized by the unanimous passage of the Alzheimer's Accountability and Investment Act.

Enabling Accurate and Timely Diagnosis

The *2025 Alzheimer's Association Facts & Figures Special Report*, titled "American Perspectives on Early Detection in the Era of Treatment," reveals that four in five Americans consider early diagnosis very important. Nine in 10 Americans would want a simple test to allow for early treatment, and four in five Americans would want to know if they had Alzheimer's before symptoms appear or affect daily activities.

An early diagnosis provides a range of benefits for individuals living with Alzheimer's or another dementia and their families, including better treatment. However, there is no single diagnostic test that can determine if a person has one of the diseases that cause dementia;

instead, health care professionals use a variety of approaches and tools to make a diagnosis. Scientists are developing simple, inexpensive diagnostic tools that can be incorporated into the diagnostic process in a variety of clinical practice settings. With the newest approved treatments being limited to individuals in the early stages of Alzheimer's disease, early and accurate detection is even more critical.

Blood biomarker tests are beginning to revolutionize the detection and diagnosis of Alzheimer's. The funding increases over the past decade have enabled groundbreaking advancements, including improved blood biomarker test accuracy. These blood-based biomarkers indicate the likelihood of amyloid or tau accumulation in the brain and track changes in protein levels in response to treatment. Sustained, robust NIH investment is also advancing researchers' understanding of the risk factors, genetics, and mechanisms of dementia, diversifying and de-risking the therapeutic pipeline, and expanding research on dementia care and care partner support. This progress must continue as there is much farther to go and the population of those affected by this disease only continues to grow.

Progress Toward Effective Means of Prevention Through Lifestyle Interventions

Researchers in the United States and around the globe are working to uncover ways to prevent Alzheimer's and other dementia. Identifying methods of prevention could save millions of lives and greatly reduce health care costs for families, Medicare, and Medicaid. While we have no definitive means of preventing dementia, research has shown us that we can take action to reduce the risk of cognitive decline. Lifestyle interventions combining multiple behavior components show promise as a therapeutic strategy to protect brain health.

Many chronic diseases, including heart disease, stroke, diabetes, and dementia, share modifiable risk factors like hypertension, physical inactivity, and diet. Recent research indicates as many as 40 percent of dementia cases worldwide may be attributable to such risk factors. Research targeting these shared pathways offers broad benefits. In order to identify a more precise "recipe" to reduce a person's risk of cognitive decline and dementia, the Alzheimer's Association, along with partners, is leading the Protect Brain Health Through Lifestyle Intervention to Reduce Risk (U.S. POINTER) study. It is a two-year clinical trial to evaluate whether lifestyle interventions that simultaneously target many risk factors protect cognitive function in older adults who are at increased risk for cognitive decline. U.S. POINTER is the first such study to be conducted in a large group of Americans across the United States. With recruitment complete, more than 2,100 people were enrolled via study sites in Chicago (Advocate Health Care, Rush University Medical Center), Houston (Baylor College of Medicine

in collaboration with Kelsey Seybold Foundation), Providence, Rhode Island (Butler Hospital in collaboration with LifeSpan), Sacramento, California (UC Davis School of Medicine), and Winston-Salem, North Carolina (Wake Forest School of Medicine). Data from the U.S. POINTER study is expected later in 2025, and we are looking forward to sharing the results with Congress.

Addressing Alzheimer's as a Public Health Crisis

In 2018, Congress acted decisively to address Alzheimer's as an urgent and growing public health threat through the passage of the bipartisan BOLD Infrastructure for Alzheimer's Act (P.L. 115-406). This law directs the Centers for Disease Control and Prevention (CDC) to build a robust Alzheimer's public health infrastructure across the country focused on public health actions that can allow individuals with Alzheimer's to live in their homes longer and delay costly long-term nursing home care. Congress solidified this commitment to addressing Alzheimer's as a public health threat when the BOLD Infrastructure for Alzheimer's Reauthorization Act of 2024 was passed with unanimous support in both chambers. The funding appropriated for BOLD's implementation over the years has allowed the CDC to award funding to three Public Health Centers of Excellence and funding 66 awards to 43 state, local, and tribal public health departments. The Alzheimer's Association is grateful to be leading the Public Health Center of Excellence on Dementia Risk Reduction, focusing on community-level actions to reduce the risk of developing Alzheimer's and other dementia. Although risk factors like age, genetics, and family history cannot be changed, other risk factors can be modified to reduce the risk of cognitive decline and dementia. Examples of modifiable risk factors are physical activity, smoking, education, staying socially and mentally active, blood pressure, and diet.

While these BOLD implementation efforts have been important steps forward, we are alarmed that the Cooperative Agreements for the Healthy Brain Initiative (HBI) and the three Dementia Public Health Centers of Excellence under the BOLD Act are set to expire at the end of September. These programs have been vital in supporting successful state and local public health efforts to address the growing dementia crisis in the United States. Congress recognized this by reauthorizing the BOLD Infrastructure for Alzheimer's Act through 2029. A funding forecast by the CDC indicated that the Notice of Funding Opportunity (NOFO) to continue the HBI and Centers of Excellence was to be issued in early 2025. But to date, no NOFO has been issued, even though the BOLD Act was just reauthorized and funding is available under the full-year continuing resolution passed by Congress in March. The Alzheimer's Association and

AIM urge Secretary Kennedy to ensure these programs continue to be effectively implemented, consistent with congressional intent.

In addition to ensuring that current funding is allocated for fiscal year 2025, the Alzheimer's Association and AIM also urge Congress to include \$35 million for BOLD's continued implementation at CDC in fiscal year 2026. Activities supported by the requested \$35 million in FY2026 would enable state, local, and tribal public health agencies to implement the Healthy Brain Initiative Road Map, most recently released in Fall 2024. This funding will also help these jurisdictions create, update, and implement their strategic Alzheimer's plans by using the HBI Road Map.

Programs like HBI and BOLD, both of which had staff placed on administrative leave as part of the reduction in workforce at HHS, have a meaningful impact on Americans every day. These public health programs are critical to Alzheimer's and related dementia awareness and brain health in communities across the nation. Among other things, they ensure that people living with dementia, caregivers, and health providers have the information, resources, and support they need. We remain concerned that continuing on a path of reducing staff and resources could cause irreversible damage. Without these programs, people may not have the information to make brain-healthy choices to reduce their risk of Alzheimer's, and be less likely to get a diagnosis or seek treatment.

Investing in Accelerating Dementia Workforce Preparedness

As we enter a new era of Alzheimer's treatment, access to a timely and accurate diagnosis is more critical than ever, and so is the need for health care professionals trained to meet the unique health needs of people living with Alzheimer's and other dementia. Today, only half of those living with Alzheimer's disease are diagnosed and, of those, only half are told of their diagnoses. In 85 percent of cases, primary care providers make the initial diagnosis of Alzheimer's. But because they are not dementia specialists, most report they do not feel prepared to provide care for these diagnosed individuals. Too often, overburdened primary care providers are unable to access the latest patient-centered dementia training.

Technology-enabled collaborative learning and capacity-building models, often referred to as Project ECHO, use a hub-and-spoke approach by linking expert specialist teams at a 'hub' with the 'spokes' of health providers in local communities to increase on-the-ground expertise. Using case-based learning, Project ECHO models improve the capacity of providers, especially those in rural and underserved areas, to best meet the needs of people living with Alzheimer's, other dementia, and many other chronic diseases.

The Alzheimer's and Dementia Care ECHO program, led by the Alzheimer's Association, has trained more than 2,000 health care professionals since 2018. Ninety-five percent of those professionals made changes to the way they care for patients as a result of what they learned from ECHO. Quality care delivered by trained providers leads to better health outcomes for individuals and caregivers and puts less strain on health systems. Project ECHO programs have shown they can address the knowledge gaps shared by many primary care providers. The Alzheimer's Association and AIM respectfully request \$10 million to provide full funding for the authorization contained in the Consolidated Appropriations Act, 2021 (P.L. 116-260) to expand the use of Project ECHO models.

Conclusion

Investing in federal health research is one of Congress' most important means to improve the lives of people in every community across the country. This research produces longer, healthier lives, a stronger economy, and continued global leadership. We face serious health challenges. Yet progress, especially in Alzheimer's research fueled by past bipartisan Congressional action, shows what focused, sustained federal commitment can achieve. The cost of inaction — in lives, health care dollars, and competitiveness — is far greater than the cost of investment. By providing robust, predictable funding across the entire health research ecosystem, Congress empowers researchers, clinicians, and public health professionals working to solve our most pressing health problems.

The Alzheimer's Association and AIM look forward to continuing our longstanding bipartisan collaboration with Congress to combat Alzheimer's and all other dementia. Working together, we can support ongoing research, translate science into meaningful care and support, promote brain health, and ultimately find cures. We urge you to continue to make federal health research a top priority and enact the funding increases needed to accelerate discovery, improve health, and secure a better future for all Americans.

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Health Secretary RFK Jr. falsely claims that measles vaccine protection 'waned very quickly'

MEASLES OUTBREAK

Robert F. Kennedy Jr. falsely claims measles vaccine protection 'waned very quickly'

Though he endorsed measles vaccines, Health and Human Services Secretary Robert F. Kennedy Jr. continues to sow doubt about vaccine safety.



— “We’re always going to have measles, no matter what happens, as the vaccine wanes very quickly,” Kennedy said. The measles virus had been declared eliminated in the U.S. in 2000. Getty Images

April 11, 2025, 5:00 AM EDT

By Aria Bendix

<https://www.nbcnews.com/health/kids-health/health-secretary-rfk-jr-measles-vaccine-falsely-claims-wanes-rcna200636>

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Health Secretary RFK Jr. falsely claims that measles vaccine protection 'waned very quickly'

Health and Human Services Secretary Robert F. Kennedy Jr. called for people to get the measles vaccine while in the same breath falsely claiming it hasn't been "safety tested" and its protection is short-lived.

Kennedy, an anti-vaccine activist now overseeing federal health agencies, including the Food and Drug Administration and the Centers for Disease Control and Prevention, had shied away from a full-throated endorsement of measles vaccinations, instead claiming the vaccine is the "most effective way" to prevent the virus' spread.

In an [interview](#) Wednesday with CBS News, Kennedy said the Trump administration was focused on finding ways to treat people who choose not to get vaccinated. However, there [are no approved treatments](#) for measles, which [kills almost 3 out of every 1,000 people](#) diagnosed.

Many medical experts have [taken issue with his approach](#) to the current measles outbreak, which has included [emphasizing unproven treatments](#) and framing vaccination as a personal choice (which some doctors view as a nod to his anti-vaccine supporters).

Kennedy also suggested that measles cases are inevitable in the United States because of ebbing immunity from vaccines – a notion doctors say is false.

"We're always going to have measles, no matter what happens, as the vaccine wanes very quickly," Kennedy said.

Dr. Paul Offit, director of the Vaccine Education Center at Children's Hospital of Philadelphia, said two doses of the measles, mumps and rubella (MMR) vaccine offer lifelong protection. That's because the vaccine stimulates the production of memory cells, he said, which can recognize the virus over a lifetime.

"We eliminated measles from this country. That could never happen if immunity waned," said Offit, who serves on an independent vaccine advisory committee for the FDA.

Aside from occasional outbreaks, measles hasn't been constantly present in the United States since before 2000. It is introduced locally by international travelers, and from there it can spread among undervaccinated communities.

"The federal government's position is, my position is, people should get the measles vaccine. But the government should not be mandating those," Kennedy told CBS News.

The federal government doesn't mandate childhood vaccines; rather, all 50 states require them for children attending public school. The FDA approves vaccines based on safety and efficacy,

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Health Secretary RFK Jr. falsely claims that measles vaccine protection 'waned very quickly'

and the CDC makes recommendations about who should get them, which states often choose to follow.

According to the National Conference of State Legislatures, [all 50 states have exemptions to vaccine mandates](#) for medical reasons, and all but five have additional exemptions for other reasons, such as religious or personal objections.

The current outbreak was fueled by transmission in a primarily Mennonite community in Gaines County, Texas, where vaccine hesitancy is prevalent. There have been 668 total cases since January, according to NBC News' tally, including two pediatric deaths and [one suspected death in an unvaccinated adult](#). Before those deaths, the United States hadn't had a measles death in a decade, and a [child hadn't died of measles](#) since 2003.

Kennedy has [pointed to higher case numbers in Europe](#) as evidence that the United States is responding appropriately to the outbreak. But the figure he has cited recently – roughly 127,000 measles cases in Europe – is [the total for last year across 53 countries](#). Low vaccination rates in southeastern Europe were a major contributor, according to the World Health Organization.

"He has this way of kind of twisting things," said Dr. William Moss, director of the Johns Hopkins International Vaccine Access Center. "We should be comparing measles in the United States this year to measles in the United States in prior years. To say Europe has more cases over one year than we've had in three months this year, it's just a false comparison."

This year's count in the United States is the [highest since 2019](#), when there was a major outbreak in Orthodox Jewish communities in New York. Doctors fear the United States could be [on the verge of losing its measles elimination status](#) as Kennedy continues to sow doubt about vaccine safety.

"Right now we don't know the risks of many of these products because they're not safety tested," Kennedy told CBS News. "Many of the vaccines are only tested for three or four days with no placebo group."

Dr. Ofer Levy, director of the precision vaccines program at Boston Children's Hospital, said vaccine development usually takes 10 to 20 years, with the notable exception of Covid shots, which were brought to market in less than a year thanks to mRNA technology and a coordinated, worldwide effort. (Even then, the [foundational research behind mRNA vaccines](#) dates to 1997.)

When it comes to childhood immunizations, many of which were approved decades ago, there may not have been placebo controls or long-term safety follow-ups for each one, Levy said. However, he noted that even after vaccines are approved, various government-led surveillance

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Health Secretary RFK Jr. falsely claims that measles vaccine protection 'waned very quickly'

systems monitor for adverse reactions. And in the [rare case they find anything](#), that vaccine is pulled from the market, he added.

Moss agreed that the types of clinical trials for vaccines have changed over time. However, "I don't think there's any other product we use that's more rigorously evaluated for both safety and efficacy," he said.

Offit said Kennedy "just keeps picking and picking" at vaccine safety with statements that aren't scientifically valid – for instance, by suggesting that [all childhood vaccines weren't tested against placebos](#), when, in fact, many were.

"The problem with RFK Jr. is his definition of 'placebo,'" Offit said. "His definition of placebo is either water or saline, meaning just normal sodium chloride, but that's not the FDA's definition. The FDA's definition is something that's inert."

A spokesperson for the Department of Health and Human Services said Kennedy "raised valid concerns about vaccine trial practices, including the use of active comparators instead of inert placebos and short observation windows – issues backed by public data."

But doctors said there's a legitimate reason to use active comparators – vaccines that have already been approved for given infections – instead of placebos: It would be unethical to withhold the benefit of a vaccine from study participants, so trials often test new vaccines against older versions.

Levy said there's always room for more safety studies or longer-term follow-up.

"I think the secretary is right that we could do more to study vaccine safety," he said. "By all means, let's dig in. Let's see, did we miss anything? Should we learn more? But let's not forget that these vaccines in childhood have averted severe disease in children."



Aria Bendix

Aria Bendix is the breaking health reporter for NBC News Digital.



4 hours ago - Politics & Policy

RFK Jr. says he would "probably" vaccinate his children for measles today



Avery Lotz



Hearing on May 14, 2025. Photo: Bill Clark/CNN/Corbis, Inc. via Getty Images

Department of Health and Human Services Secretary [Robert F. Kennedy Jr.](#) said during Wednesday testimony before a House panel that he would "probably" vaccinate his child for [measles](#), if he had one today.

The big picture: As measles cases continue to spread throughout the U.S., critics have highlighted Kennedy's history of vaccine skepticism.

- While Kennedy has recently [advocated for](#) the measles, mumps and rubella (MMR) vaccine, he has in the past [elevated vaccine misinformation](#).

Driving the news: Asked by Rep. Mark Pocan (D-Wisc.) during Wednesday's [budget hearing](#) if he'd vaccinate his kids today for measles, Kennedy paused before saying, "probably, for measles."

- Kennedy contended his opinions on vaccines "are irrelevant." He continued, "I don't think people should be taking ... medical advice from me."
- Pressed by Pocan, Kennedy said he thought if he answered the question "directly" that it would "seem like I'm giving advice to other people, and I don't want to be doing that."
- Pocan replied, "That's kind of your jurisdiction because CDC does give advice." To that, Kennedy said his team would "lay out the pros and cons."

Zoom out: Asked if he'd vaccinate his children for chickenpox, Kennedy said he did not want to "give advice" but added that "In Europe, they don't use the chickenpox vaccine."

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RFK Jr. says he'd "probably" vaccinate his kids for measles

AXIOS



Go deeper: [RFK Jr.'s latest vaccine plan threatens future of shots, experts say](#)



Go deeper



Avery Lotz
Updated 2 hours ago - Politics & Policy

House Dems blitz RFK Jr. on vaccine record, HHS cuts



Health Sec. Robert F. Kennedy Jr. testifies before a House panel on May 14 in Washington, DC. Photo: Samuel Corum/Getty Images

Wednesday, where he's been pressed on [mass layoffs](#) at the Department of Health and Human Services, billions in cuts to the agencies he oversees and the ongoing [measles outbreak](#).

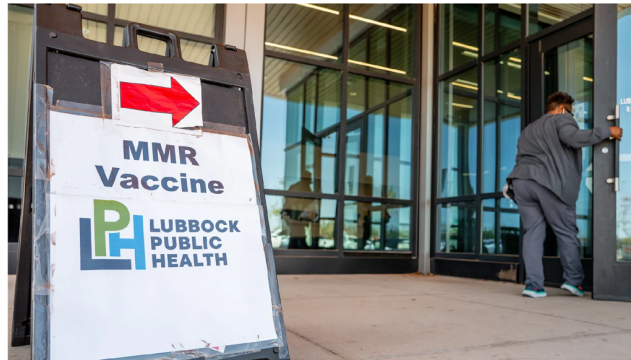
Why it matters: Kennedy's testimony before a House panel and the Senate Health, Education, Labor, and Pensions (HELP) Committee marks his first time testifying before Congress since he was sworn in earlier this year.

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Tina Reed
May 1, 2025 - Health

RFK Jr. calls for CDC plan for alternative measles treatments



Health and Human Services Secretary [Robert F. Kennedy Jr.](#) is directing the Centers for Disease Control and Prevention to come up with treatments for [measles](#) using "existing drugs in combination with vitamins and other modalities."

Why it matters: The plan comes days after Kennedy [downplayed](#) the threat from the highly contagious disease and repeated [misleading](#) claims about measles vaccines.

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Caitlin Owens
Apr 18, 2025 - Health

RFK Jr.'s medical skepticism goes beyond vaccines



Photo illustration: Allie Carl/Axios. Photo: Rebecca Noble/Getty Images

hallmark of his public persona, but his and his followers' questioning of the medical and pharmaceutical establishment goes much deeper.

Why it matters: In recent weeks, it's become pretty clear that Kennedy's views haven't changed all that much from his pre-HHS days. That could have implications that go far beyond vaccines and put him at even greater odds with the industries he's charged with regulating, let alone mainstream science.

- If his past views hold up, antidepressants, ADHD medication and drugs that use mRNA technology — both those on the market and those under development — could end up as his next targets.
- In fact, some of his words and actions since being nominated and confirmed as the nation's top health official suggest [they're already on his list](#).

Driving the news: Kennedy may not have mentioned vaccines at Wednesday's press conference on autism, but that's where many people's minds went because of the way he's consistently linked the two.

- He notably [contradicted CDC researchers](#) about why autism diagnoses are rising, pointing to what he called toxins in the environment, not better diagnostics (another familiar talking point).
- He's also pledged to have results of a government-led effort to identify the cause of autism by September, a timeline that's stoked deep suspicion in the public health community about his commitment to scientific rigor or accurate conclusions.
- And his [recent remarks to FDA staff](#) reinforcing his belief in the "deep state" caused enough alarm that Leerink Partners warned clients in an investor note that his agenda "is likely to negatively

What they're saying: "He's still pressing his pseudoscience agenda, he still shows no interest in understanding the complexity of autism and how it operates through autism genes with environmental factors, he still talks in childlike terms about how to deal with autism," said professor and vaccine scientist Peter Hotez.

- "Everything I've seen him say in public is as unhinged as it's ever been."

In light of Kennedy's recent comments, I spent part of the week reading a book recently published by the Children's Health Defense, the anti-vaccine group Kennedy founded, titled "The Medical-Pharmaceutical Killing Machine."

- The book was published after Kennedy took leave from the organization, but the group remains aligned with his agenda and is a useful proxy when attempting to understand Kennedy's worldview.
- "He's the same Bobby Kennedy, 100%," Mary Holland, CEO of Children's Health Defense, [recently told Stat News](#).
- An HHS spokesperson did not respond to a question about how closely the book does or doesn't reflect Kennedy's current views.

Reality check: For any of the book's major assertions to be true, there would have to be a massive coverup occurring at the highest levels of science, medicine and government (which is pretty much what the book says is happening).

- Many of them are directly contradicted by established scientific evidence, and others defy logic.





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[Whereupon, at 4:02 p.m., the hearing was adjourned.]

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