Hearing Transcript

House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies Hearing on President Obama's Fiscal 2017 Budget Request for the Department of Health and Human Services

February 25, 2016

COLE:

Thank you very much. It appears -- and now you can hear open up the hearing, so that's wonderful. I just want to begin by telling what a personal pleasure it is to have you here, and I mean that with all sincerity. I think you have -- you're an exceptional public service -- servant in your skill and your dedication and your bipartisanship. And so, I look forward to working with you. We'll certainly have some, you know, challenging question for you this morning on both sides of the aisle as we always do, but again I know how seriously you approach the job and the effort that you put in. I appreciate it personally very, very much.

My pleasure again to welcome you to the Subcommittee on Labor, Health and Human Services, Education for our first hearing of the year. Looking forward to hearing your testimony. Madam Secretary, your responsibilities are many. There are many things in your budget that I think that we can all agree are priorities and that we can collectively support. There are other areas, we may disagree upon. Now, the challenge that will be facing the subcommittee is how we can support the most critical programs and make the very best use of every taxpayer dollars entrusted to us.

Unfortunately, your budget assumes many areas of tax increases, new user fees, changes in mandatory spending and other spending sources that are beyond the purview of the subcommittee. I was especially disappointed to see your proposal to cut the National Institutes of Health, the proposal to divert $1 billion of biomedical research funds to the mandatory side budget ledger and rely on new and perhaps unlikely authorizations to continue the advances we've made in increasing research funding were disheartening.

I look forward to having a discussion with you this morning on the impact of these proposed cuts. I'll also be asking some tough questions this morning about the ongoing management challenges at HHS, problems of substandard quality in hospitals within the Indian Health Service, the continued slow walking of investigations into alleged violations of law as it relates to conscience protections continue to concern me greatly. I hope to learn more this morning on what you're doing to take positive steps in these areas.

Finally, we're all keenly aware of the many external challenges facing your agency, worldwide concern surrounding the Zika virus is but the latest example of this. I hope you will be able to update us on this situation as well.

As a reminder to the subcommittee and our witnesses, we will abide by the five-minute rule so that everyone will have a chance to get their questions asked and answered. Before we begin, I would like to yield the floor to my good friend from Connecticut, my ranking member, Ms. DeLauro.

DELAURO:

Thank you very much, Mr. Chairman. And I'll first say that this is very impressive, the dais and the high-tech communication. I'm looking around the room and the re-do here. I like it, but it's very safe (ph), Mr. Chairman, and -- but it's good. It looks good. It's got a nice tone to it. I'm -- deal with a little bit more color, but it's very good. It's common. So, anyway, thank you again, Mr. Chairman.

Madam Secretary, welcome back to the Labor, HHS Subcommittee. I believe it's exactly one year to today since you last appeared here. I, too, want to express my gratitude for the great work that you do and the commitment that you have to the mission of health and human, but also you your commitment to this country and making sure that people are (inaudible). I think together we were able to make many great investments in the Labor, Health and Human Services bill last year.

In any way, last year's omnibus move to federal budget in the right direction began to be behind the shortsighted policies of austerity and have slowed our economic recovery. We made real progress on funding for NIH research, the antibiotic resistant bacteria initiative, medical countermeasures, and access to high- quality early childhood education.

I do continue to be disappointed that we did not do better for other programs under this subcommittee's jurisdiction and I'm troubled that Labor HHS bill received only a fraction, about one-half of its fair share of the $66 billion increase provided by last year's budget deal. While the other non-defense subcommittee received an average of 6.9 percent last year, the Labor HHS bill increased by only 3.4 percent. In my view, that needs to change this year.

One year ago, we were in the midst of a worldwide response to the Ebola outbreak in West Africa. Now, we find ourselves confronting two public health crises, Zika virus and the tragedy in Flint. First, the Zika virus was found (ph) causing thousands of babies in Latin America to be born with severe birth defects. It's infecting travelers returning to the United States and is even being transmitted sexually. We should act quickly on the administration's request for emergency supplemental appropriations to defend against this serious threat.

Some of my colleagues have expressed a desire to shift unobligated funds that Congress provided for Ebola to respond to Zika. I strongly oppose the idea. The threat of Ebola is not over. I would be anxious to know what activities we would have to forgo if we shift funds away from Ebola to Zika. We need to be able to respond to multiple health threats at the same time and Congress must act quickly to protect Americans from the Zika virus.

At the same time, HHS is the lead federal agency on the ground in Flint Michigan where we have learned that thousands of children have been exposed to lead poisoned water for more than a year. Not only did the state of Michigan fail to protect its people from lead poisoning, the government created this crisis and magnified its effects with delayed response.

I will just give you -- this was an article at 9/25/05. This is Katrina. The reporter is Michael (inaudible) at (Hart). He says the broken contract it was not black suited (ph) for but citizens whom

the government betrayed in New Orleans. One can make the same application here and he says a contract of citizenship defines the duties of care that a public official owes the people of the democratic society. It's a tacit understanding that citizens have about what to expect from their government. It's basic turn is protection, helping citizens to protect their families and possessions from forces beyond their control.

When the state made the decision to turn off the spigot and turn it on in the Flint River, they broke that contract with the people. And now, it is our responsibilities to provide people with the kinds of health that they need in order that they may succeed. It's imperative that we resolve the crisis immediately, provide health and education interventions that these children and families will need going forward.

It's my hope that the state, the administration and the Congress will do that. These emergencies demonstrated our federal system needs to respond more rapidly as threats arrived, which is why this Congress and last Congress I proposed funding for public health emergency fund to enable the federal government to immediately respond to public health threat. It is modeled on the disaster relief fund, which we have, which is $8 billion. It enables a rapid federal response following a natural disaster.

If we can act quickly to respond to floods, fires, other natural disasters, we should be able to act quickly to respond to public health emergencies. We also need to strengthen our investment in HHS programs through annual appropriations, triggering (ph) to the topic of today's hearing, your budget, HHS budget request for fiscal 2017.

I strongly believe, as you know, that programs in the HHS budget are among the most important responsibilities that the federal government has. They support lifesaving research, state and local public health infrastructures, community health centers and home heating assistance for low-income families. Literally, you work at saving lives.

Madam Secretary, there a lot of good proposals in this budget, particularly I applaud the president for his continued commitment to head start childcare, preschool. I will say that I was disappointed to see cuts to cancer screenings and public health programs at the CDC and that funding for HIV research remains level at $3 billion for 2016 and 2017.

I am also concerned that other important programs rely on mandatory funding. The budget includes $1.8 billion in mandatory funding for NIH research, $115 billion in mandatory funding to support early interventions for individuals with serious mental illness, and $500 million in mandatory funding to help individuals who are addicted to prescription drugs and opioids.

We need to increase this committee's allocation. That is the answer to this issue, to support NIH research, to address the opioid epidemic in this country, rather than to relying on mandatory funding that mat not materialize, which is why the subcommittee allocations that will be released next month will be so critically important. And I hope my colleagues on my side of the aisle and on the other side of the aisle will join us in making sure that we have an increase for Labor HHS in 2017, and that is for the good of the children and good of the family that depends on these services. We need to make this increase in its allocation a priority.

Thank you very much for being here and I look forward to the discussion.

COLE:

Thank you very much.

DELAURO:

Thank you.

COLE:

Before we begin with your testimony, we've been joined by our ranking member, Ms. Lowey, from New York.

LOWEY:

And I want to thank Chairman Cole, my good friend, and my good friend, Rose DeLauro, for your hard work on this committee. It's been an honor for me to be part of this committee for a long time, from almost my whole congressional career, and we know how important this is. And this may be your last occasion to testify before this and I want to first thank you thank you for your service as director of OMB, now as secretary of Health and Human Services. And I must say with every person in government who put their heart and soul and their brains to work the way you do, we would move forward much more quickly. So I really do want to thank you very much. It's been a pleasure for me to work with you and to know you.

Now, in terms of the substance with recent emerging threats, your remaining year as secretary will not be easy. Our mission to eradicate Ebola is not yet complete. New outbreak of dangerous diseases such as Zika is pushing federal public health infrastructure resources to the breaking point. Congress has a request for supplemental funding to combat Zika. I urge this committee and Congress as a whole to meet this need without delay.

While outbreaks require significant attention, we cannot turn our backs to man-made public health emergencies at home, and I struggle to find the words to describe the criminal incompetence that jeopardized thousands of Americans citizens in Flint, Michigan. I look forward to hearing about actions the department is taking and coordinating with federal response to address the short-term and long-term healthcare needs that will be required.

It's truly amazing to me because this is an issue I've been working on again for a very long time and how this could have been ignored, the incompetence of the officials involved is really quite extraordinary. So I'm hoping we can take action very quickly.

The budget request includes increases for vitally important initiatives such as early childhood education, biomedical research, substance abuse treatment and prevention has been appropriated. The department's request for substantial some and mandatory funding is of concern, particularly

the fact that without this mandatory request your budget amounts to a decrease in discretionary funding of 1.5 percent.

With that said, there is significant improvement that I would like to highlight. One of the major obstacles to economic security to low-income working American is access to affordable, high quality childcare and early learning, such as Head Start. While this committee has increased funding for these initiatives in recent years, we are not meeting our commitments to the public. In fact, the value of federal funding for child care has lagged well behind inflation and increases in childcare costs.

As a result, the federal share for childcare has decreased by approximately 20 percent since 2003 and there are more than 14 million American children that are eligible for childcare subsidies, yet only 15 percent receive child care and development fund assistance. These funding constraints do not exist in a vacuum. And by not making investments to childcare, hard-working parents may have to reduce their hours, leave their jobs altogether or delay education programs that could allow them to invest in their family's economic security.

An increase of $201 million for childcare is desperately needed, but this alone will not be enough. Federal support for child care and early learning programs for low-income Americans must be increased nationwide to meet this demand and start our children on a path to success from an early age. Your budget includes targeted investments in biomedical research, which to me must continue to be a top priority and I was so pleased with the work of this committee increasing the money for the National Institute of Health. The Cancer Moonshot is very exciting, increases in the brain initiative that would deepen our understanding of the human brain to combat diseases and disorders including Alzheimer's, Parkinson's and autism. These investments not only fund research that eases suffering for patients. They could greatly reduce ballooning costs associated with treatment down the line.

So again, thank you for your leadership and thank you to the chair and our ranking member for your important work on this bill, and I look forward to your testimony. Thank you, Mr. Chairman.

COLE:

Thank you. It's always a pleasure when our good friend is able to join us. And with that, Madam Secretary, the committee would love to hear your testimony.

BURWELL:

Great. Thank you so much, Mr. Chairman, Ranking Member DeLauro, Ms. Lowey, and members of the committee. I want to thank you all for this opportunity to discuss the budget and the Department of Health and Human Services.

I think, as many of you know, I believe that all of us share common interests, and therefore, we can find common ground. And last legislative session, as has been mentioned, this Congress may timely investments in programs to improve the health and welfare of the American people, and thank you for the world that you all played in that.

The budget before you today is the final budget for this administration and my final budget. It makes critical investments to protect the health and well-being of the American people. It helps ensure that we can do our job to keep people safe and healthy. It accelerates our progress in scientific research and medical innovation and expands and strengthens our healthcare system, and it helps us continue to be responsible stewards of the taxpayer dollars.

For HHS, the budget proposes $82.8 billion in discretionary budget authority. Our request recognizes the constraints in our budget environment and includes targeted reforms to Medicare, Medicaid, as well as other programs.

Over the next 10 years, these reforms to Medicare could result in an -- dollars. Let me start with an issue that we've been working on here at home and abroad, and as we work aggressively to combat the spread of Zika. The administration is requesting $1.9 billion in emergency funding, including $1.5 billion for HHS to enhance our ongoing efforts, both domestically and internationally. We appreciate Congress' consideration of this important request as we implement essential strategies that are time sensitive to prevent, detect, and respond to this virus.

And in the rise in opioid misuse and abuse and overdose, it has affected many of your constituents. Everyday in America, 78 people are dying opioid-related deaths. And that's why this budget proposes a significant increase in funding over $1 billion to fight the opioid epidemic.

Research shows that early learning programs can set a course for child success throughout his or her life. And that's why over the course of this administration and together with congressional support, we have more than doubled access to early Head Start and services for infants and toddlers.

Our budget proposes an increase of $434 million for the Head Start Program, and investment in childcare services that would allow us to serve over 2.6 million children. Today, too many of our nation's children and adults with diagnosable mental health disorders don't receive the treatment that they need. So the budget proposes $780 million in new mandatory and discretionary resources over the next two years to try and close this gap. While we invest in the safety and health of Americans today, we must also relentlessly push forward on the frontiers of innovation and research.

Today, we're entering a new era in medical science with a proposed increase of $107 million for the Precision Medicine Initiative and $45 million for the administration's BRAIN Initiatives. We continue that progress. But for all Americans to benefit from these breakthroughs in medical science, we need to ensure that all Americans have affordable healthcare.

And the Affordable Care Act has made progress - historic progress in that space. Today, more than 90 percent of Americans have health coverage. That's the first time in our nation's history that that has happened. The budget seeks to build on that progress by improving the quality of care that patients receive, spending our health dollars more wisely, and putting an engaged, empowered and educated consumer at the center of their care. By advancing and improving the way we pay doctors,

the way we coordinate care and use health data and information, we can build a system that is better, smarter and healthier.

Finally, I just want to thank the employees of HHS in the past year that helped in the Ebola outbreak in West Africa. They have advanced the frontiers of medical science. They helped millions of Americans to enroll in health coverage and have just done the day-to- day quiet work makes our nation healthier and stronger, and I am honored to be part of that team.

As members of this committee I think know, I personally am committed to working with you all closely with you and your staff to find common ground so that we can deliver impact for the American people. And with that, I welcome your questions. Thank you.

COLE:

Thank you very much, Madam Secretary. And again, it's a pleasure to have you here. The president's budget is being touted as appearing to spending caps agreed on last year, but it does so by the inclusion of gimmicks with shift funding onto the mandatory side of the budget ledger. For example, as you know and as has been mentioned here actually by both sides, NIH discretionary level is reduced by $1 billion from FY 2016 level. Let me just tell you upfront, that's not going to happen. We're not going to be cutting $1 billion out of the NIH. And frankly, we're unlikely to be able to get mandatory funding of $1.8 billion. Again, we have no jurisdiction in that area. We'll make a prediction that we're unlikely to be able to give that.

Having said that, that means -- and that would probably apply to the other mandatory areas that you called on as well, although we'll look at each of them individually obviously. Given that, you know, we're going to have to shuffle money around to maintain programs because we're -- we don't have our allocation yet, but the entire discretionary side of the budget I think was increased by 1/10 of 1 percent under last year's agreement. So there's not a lot of extra there. So we're going to have to make some really tough decisions.

It would be very helpful to us if you would tell us what are your top three or four priorities within the budget that you think are absolutely critical to being funded?

BURWELL:

So as we think about the issue of tough decisions, I think you appropriately reflected when we look at the second year of the deal it's a very, very small increase and with other things that happened naturally that, you know, the question of is it an increase at all. For most of the bills, I think is an important one and I think that's a reflection of the fact that where our discretionary levels are.

In this budget, by 2019, we will have one of the lowest levels of our discretionary to GDP ratios that we've seen as a nation. And so, I think the question about priorities and tough decisions, I think, we feel we made those because everything is paid for and that's the issue when we talk about the budgeting in terms of the mechanisms that we use discretionary or mandatory. I think what we are all focused on is how much we spend and how that affects and impacts the deficit.

And the budget, overall, keeps us on a downward trajectory. We made decisions that may not be the ones that folks agree with and we understand and appreciate that, but we do pay for everything and we do continue on our path deficit reduction and making sure our debt to GDP ratio is on a declining path as well as our deficit. So in making the tough choices and the prioritizing, we've done that in the means by which we pay for these things.

COLE:

I'm the last person to cross swords with former OMB director about the budget, but I don't think we're on a downward trajectory. Certainly, in gross dollar term, the deficit is going to be higher this year than it was last year.

And I think this is off our topic, but I think one of the great missed opportunities of the president's second term was real entitlement reform. There were a couple of times he was close. I mean he put, to be fair, and change (ph) CPI on the table and he put (inaudible) for Medicare on the table, but he also put and demanded tax increase and a lot of other things. We could have probably passed those things and I think they would have been a material improvement on where we are now.

But that aside, we're unlikely to be able to do that in the short term and the amount time that we have left. And what we do have to do and want to achieve is to actually give you a real budget. So I'm going to return again of the budget that you think are absolutely critical functioning of health and human services.

BURWELL:

So as I said, I think we put together the budget in a way that reflects the priorities. I think we've heard criticisms and I'm sure I'm going to hear them today in terms of the cuts that we've made to other areas, places where we have not in its totality, but we fund it and had to make choices, and I am sure we're going to talk about those, whether that is, you know, the issues of REACH (ph) or the issues of BARDA. I am sure that will talk about this today and have made a number of those choices.

The other thing I would just reflect as we think about the overall budget picture is the question of demographics in our country. And we know that healthcare is one of the most fundamental drivers of the cost of -- that are causing these issues, but I think we also know that the basic demographics in our country with regard to we're going to have more people who are in that Medicare band.

And so, how we think about a balanced approach and that's -- you know, gets to this question of revenues versus cuts because the problem isn't simply a problem of a set number. You know, it's that increase. And you know, I keep my eye on per capita healthcare cost. And in Medicare, we've seen as the very low for six consecutive years. And so as we continue to think about, I think that's an important part of the conversation, which I think you know I welcome in my OMB job and I welcome here.

COLE:

You did and you've always been a good person to have that dialogue with. With that, I want to move to my ranking member for whatever question she cares to put to you. Thank you.

DELAURO:

Thank you very much, Mr. Chairman. I just would like to remind everyone that Labor HHS is 32 percent of the non-defense discretionary budget. If we had received an allocation that was commensurate with our portion of discretionary spending, we would have received an additional $5.2 billion to what we have had if happens this time with our allocation. Yes, in fact, we can accomplish what we want to accomplish in this budget. And that is our portion of discretionary spending and we were shortchanged last time and we should not be shortchanged this time.

And with that, Madam Secretary, let me just say that -- let me talk about Flint for a second. Unbelievable tragedy, 8000 kids, doctors, everyone tells us lead poisoning is irreversible, OK? But it's -- the short-term, we need to ensure Flint's drinking water is safe. We need to think about medium-term and long-term and I know you're the lead agency here and I just want to run down a few things to find out where you are overall in addressing this issue. What is HHS doing to ensure that every child that's been exposed to lead has a case manager to ensure they receive the services they need? You gave $500,000 to two community health centers. That's a start.

I'd like to know how we're going to ensure that Flint have sufficient capacity to treat the kids for years to come. It is the longevity of the federal response here. Head Start serves about 1,000 kids in Flint. Another 150 are enrolled in Early Head Start. According to the Administration for Children and Families, more than 1,000 income eligible children are not enrolled in a Head Start program. Nearly 3,000 income eligible children are not enrolled in Early Head Start.

How do we ensure that these kids when the two areas that we have been told by doctors and scientists that where we can make a difference in mitigating this lead poisoning for these children is in good nutrition and early nutrition and in early childhood education. These are the two areas where we can play a role. So how do we ensure that they don't fall behind and suffer the effects of lead exposure for the rest of their lives? Let me ask you to answer that question.

BURWELL:

So as you mentioned, the Department of Health and Human Services has been asked to lead the federal response in Flint. As we lead that response with our objective of supporting the state and local community and getting to a better place, there are two main goals. The first is clean and safe water in the short-term, in the medium-term, and in the long term. And then the second is understanding the damage that has occurred and then working to mitigate that in support of the state and local community.

With regard to the specifics of your question, a number of them -- two of them I think come together, the case management question as well as the question of the capacity and how things come together for those children who may have damaged. And I think probably the most important thing and we are in the process and I have indicated that we will approve a Medicaid waiver in

Michigan. The governor has asked. I met with the governor. I was in Flint last week. I was in Flint, met with the governor, had these conversations.

There are two very important elements to the Medicaid waiver. The first is expansion to pregnant women and children in terms of the expansion that we'll do. The second though is comprehensive case management, which will be a very important part and the funding to do that will help us in that space.

With regard to the issues of the programs that you mentioned, a number of those programs had conversations also with the governor and others about how we make sure that those services are going to reach those children.

DELAURO:

Are we examining the opportunity for Head Start for...

(CROSSTALK)

BURWELL:

That has been a part of the conversation.

DELAURO:

I had a question with regard to -- let me just. We got about 38 seconds. So we're going continue this I think for a while. I won't overstep my balance and back on some other things.

COLE:

I thank the gentlelady greatly for staying within the time limit. With that, we'll go to my good friend from Arkansas, Mr. Womack.

WOMACK:

Thank you, Mr. Chairman and my thanks to the secretary also for her service to our federal government and our friendship that dates in the years.

Secretary Burwell, Congress enacted the High-Tech Act with the intention of -- to encourage providers to adopt electronic health records. And today, over 80 percent have them. However, as the Meaningful Use Program has been developed, its regulations have grown far beyond the intent of Congress and put layers of new requirements on the backs -- onerous that it is darn near impossible to comply but ultimately they force providers to spend more time on the computer than with the patient.

It seems to me that there has been more of an emphasis on ensuring compliance by providers in achieving meaningful use than there has been on ensuring our providers can comply and that EHR

use is actually meaningful. That's very concerning to me. I have heard these concerns, marked (ph) and saw providers frequently.

In fact, as of yesterday, another round of visits yielded the same and I am -- was encouraged to learn that the CMS acting administrator and the national coordinator of health IT are using the tools provided by the passage of the Medicare Access and CHIP Reauthorization Act of 2015 to transition the Medicare EHR Incentive Program for physicians towards reality of where we want to go next.

On the eve of these changes to electronic health record meaningful use, can you help me understand how the changes will shift emphasis from the rigid enforcement to making the program truly meaningful to patients and providers? Will the changes provide flexibility for providers? Will they ensure EHR interoperability? And when can we expect these improvements to be released and implemented?

BURWELL:

So I think, is you have heard, we have taken the comments and feedback that we received and even as we were doing rulemaking in the fall announced changes Acting Administrator Slavitt as well as Karen DeSalvo at the Office of National Coordinator (ph) have talked specifically about that.

In terms of the specific things that we'll do, MACRA is giving us an opportunity to make changes as we go forward. Some of those though we already have put in place. One is we have put out standards. And historically, we hadn't taken the step to articulate what we believe are the correct standards that people should use because that gets us to interoperability.

The second thing -- and you will be seeing more on this as soon as Monday. I will be -- I'm trying to think which day but I will be speaking to a gathering of 4000 technology providers in the private sector that people are providing the software and we will be talking specifically to steps that we are taking forward together forward in partnership with those companies. And so, what we're trying to do is in the places where we can lead and we get directions such as that setting standards and interoperability roadmap that we take those actions and where we can work with the private sector and where they need to lead to do that. So it's the combination of the two things.

And part of that will also be the implementation of MACRA, which we're please to do. It is aggressive. Everyone I think should know what you all passed as aggressive. We're excited about that and thinks that gives us a tool. At the same time, we need the private sector with us and we are working with them and you'll hear about that on Monday.

WOMACK:

How soon can we see change on this front? How soon can the wheels of progress turn and actually bring some relief to the -- to the essence of my question?

BURWELL:

So this was a meeting I had actually with the team on Tuesday in specific terms because for me the answer to that question has to be 10 months and 20 some days in terms of real change that providers can feel. And I think what providers and consumers are both going to feel and this is something that you all will probably also work on, is that a minimum, when we take away data blocking and -- two things have happened. We have been clear that we're going to take action in any way we can against data blocking and that we are articulating it.

When the Congress articulated that it would act and data blocking is where these providers the technology they can do it either, it can be omission or commission. They can actually do things that block an ability of consumers to get that data or they can do things that don't really completely back it and make it just harder in terms of not providing. There things that are happening in that space that we're going to feel a difference within the year.

WOMACK:

One of the real concerns I have, we have a number of providers that fall into this category that are getting to the age now where they either have to comply or they may choose to just leave the profession. There are a number of providers out there that still have a lot to offer in terms of medicine but yet are just leaving the enterprise. So is that of concern to you?

BURWELL:

It is. And that's why -- yes, it is, which is why we got to get it to where the value of this outweighs the difficulty in doing it. And I would just ask everyone to watch for it. When you (inaudible) 21st Century Cures, the Senate side will put in provisions that are related to this very issue. And as it comes back, you know, my expectation there will be a conference. Please watch there because that's a place where legislation may help us.

WOMACK:

Thank you. Mr. Chairman, I yield back.

COLE:

Thank you. With that, I'll move to my good friend, the gentlelady from New York.

LOWEY:

Thank you again, Mr. Chairman. Thank you, Secretary Burwell. According to the Brady (ph) campaign, 31 Americans are murdered with guns each day, 151 are treated in an emergency room due to a gun assault. That's not all. The U.S. firearm homicide rate is 20 times higher than the rates of 22 of our peers in wealth (ph)and population combined.

So I really think about it and wonder why. For instance, is it possible their societal trends are at the factors unrelated to gun purchases and ownership that may be important to study to reduce gun deaths? The federal government, and in particular, agencies within your department such as

National Institute of Health, the Centers for Disease Control, are some of leading public health research institutions in the world. So I'm baffled that rather than on them with the scientific knowledge save lives, some on the other side have supported efforts to stifle this research.

Now, I just want to say I worked with former Representative Dickie and I remember when that amendment about 20 years ago was put on the bill and he has already spoken out against it and said we should do the research. So I'd like to ask you. Are there public health reasons why CDC should not be conducting research into injury prevention due to gun violence? If the committee would have fund the president's request of $10 million to study injury prevention due to firearms, what type of research could be funded?

BURWELL:

We believe that we should do the research and it is a matter of funding. So for us at the Center for Disease Control and Prevent -- described in terms of trying to understand why they occur. And as you said, it can be a range of reasons, societal reason, and other reasons, but we actually don't know because we haven't been able to do the research. So as we have proposed in our budget, we'd like to see that money so that we can start that work.

LOWEY:

Thank you and I hope we can make that happen, Mr. Chairman. It would be a good think for the country. We made great progress since the Ebola epidemic reached historic proportions in 2014. But we're not yet done combatting the Ebola threat and our public health infrastructure including researches, hospitals, physicians on the front line had not yet completed the mission to eradicate this deadly disease and protect the public.

In short, rather than continue to wipe out Ebola, my friends on the other side came prepared to declare mission accomplishment cases may still emerge. What remaining Ebola efforts would be prevented or delayed if funding would have been used for the Zika virus? And in particular, are there medical countermeasures that could be impacted as a result of using Ebola funding for the Zika virus?

BURWELL:

With regard to the countermeasures, yes, there are a number of things. We should be hearing from the WHO. I'll be meeting with Margaret Chan tomorrow morning at 7:00 a.m. because we need the results of the ring trial that was done on the Ebola vaccine. We're also seeing the work on ZMapp, which was one of the issues.

And I read this morning there will be another study coming out in terms of some of the types of tools that we can use even in the treatment space, which we haven't historically seen. So we are going to be seeing a number of things that would come online that we will use those moneys and ask for BARDA and BioShield to move forward if we have.

The other thing I think is extremely important in terms of those monies are the global health security agenda. Right now in Nigeria, we have Lassa and measles. But because we are investing those moneys in prevention, detection and response, that's what the global health security money that you gave us suspended for five years for countries to put together plans, we are exercising this money.

300 individuals were at CDC and I will not go through all of the outbreaks that are occurring or the fact that last year we had the most cases of Middle East Respiratory Syndrome, coronavirus, respiratory. These are the ones that really spread quickly out the Middle East, Saudi Arabia, that we ever had as a nation. It was controlled because Korea had the capability to do it. We supported them. We sent people from CDC, but it happened. And no one even knows about that, which would have been like Zika if it had grown. And so, those are the things the money is being used for. And we think those are priorities.

As you probably know, yesterday we sent out letters. I have done reprogramming of existing moneys from the prevention fund to keep CDC going and we have sent you all a letter on two transfers. And so, we're doing everything we can to keep our efforts going right now on Zika, but the demand is great. Today, I got my numbers this morning. There 155 cases in the United States. You have seen the numbers and you have seen the sexual transmission. In Puerto Rico, we think those cases because we depend on a set number -- I think cases are actually higher. So those numbers will continue to rise quickly.

LOWEY:

Thank you. Thank you, Mr. Chair.

COLE:

Thank you. Gentleman from Tennessee, Mr. Fleischmann, is recognized.

FLEISCHMANN:

Thank you, Mr. Chairman. Madam Secretary, thank you for being before us today. I appreciate your phone calls and all of your hard work and hard efforts. Thank you.

Madam Secretary, I've got some questions. I'm concerned that the recent news indicates too much instability in the individual market. Although you're highlighting 90 percent coverage rate, enrollment expansions in the individual market are far below initial projections. Consumers who are willing to do their part by paying the full year of premiums are paying higher rates because the exchanges allow people to sign up for just in time medical services during what are designated as special enrollment periods.

I'm also concerned about the ever moving and expanding open enrollment period. Originally, CA regulations had open enrollment periods that ended in early December, allowing individuals to continue to enroll after the current policy year and encourage anti-selection and letting purchases pay for only partial year of coverage while still receiving the full year of coverage.

My two questions, Madam Secretary, are, does the HHS plan to significantly eliminate more SEPs in the near future and does HHS plan to limit or expand the open enrollment period? Thank you.

BURWELL:

So with regard to the issue of the special enrollment periods, we have announced that we have gotten rid of a number of those special enrollment periods as your question reflects. So, yes, we have gotten rid of them. In addition to that, we have put out clearer guidelines with regard to making sure people know so that we narrow that frame in terms of people doing it. And yesterday, we actually put out information that you will have to provide documentation, which is one of the issues of the issuers have talked to us about in order to promote a more stable market, so taking those steps and terms of those that were in your suggestion.

With regard to the broader question of numbers, I do think it is important that when we think about what the objective here was, the objective was access to insurance and then moving to coverage when we think about the Affordable Care Act. And with regard to the CBO numbers and the original CBO numbers, as we look at the tracking of the number of uninsured, we're actually -- the reduction is slightly higher than CBO projected.

What we know is that not as many people have moved from employer- based care into the marketplace and we actually think that's fine in terms of the marketplace not growing by taking employer-based care in. And so, we think that is an acceptable thing.

Having said that, we want to make sure we're listening. And that's why, the issues you raised or a number of issues the issuers have raised with us and we take action on those as they go into this period to determine their participation in the next open enrollment.

FLEISCHMANN:

Thank you. I'd like to shift to community health centers, if I may. Madam Secretary, I'd like to discuss the funding cliff the community health center face. As you know, mandatory funding is due to end after fiscal year 2017. It's my understanding the large portion of this funding supports basic ongoing health center operation.

Can you share with us what the alternatives are if the authorizers do not act on your request for an additional two years of mandatory funding? I know these centers have been a source of medical care for the uninsured. Can you explain to us the implementation of the Affordable Care Act how it is affecting health -- ought to have some form of insurance coverage by now that the health centers can bill?

BURWELL:

So, we are hopeful that we can get the extension because it serves so many people as you articulated in terms of the millions and millions of folks. I think it is 1 in 14 Americans are served by

community health center in the country. And so, the amount of services we're providing is extremely important.

With regard to the issue of the finances, when I go and meet with federally qualified health centers, their finances are improving. They're improving in two cases. One, they're improving because people are -- have coverage now and they use that to expand their services and whether that is in the issue of dental or other services that they can provide, behavioral health and that sort of thing. So they're using that money -- and in Medicaid Expansion states. That is the other place where they're getting those benefits.

These health centers are going to be the backbone of everything from some of our behavioral health work to increasing our medication- assisted treatment programs with opioids. And in our budget right now, we propose that we can start using telemedicine so they can be the centers. And this is important for rural America in terms of issues in rural settings where telemedicine can be a real opportunity for both quality improvement and cost reduction.

So those are some of the reasons we think it is extremely important to continue.

FLEISCHMANN:

Thank you, Madam Secretary. Mr. Chairman, I yield back.

COLE:

I thank the gentleman. Now, my good friend from Philadelphia is recognized next, Mr. Fattah.

FATTAH:

Thank you. And Madam Secretary, it's good to see you this morning. Your focus on the Affordable Care Act and its implementation has led to an historic level of participation, in particularly in Philadelphia, and you came personally to my district and launched an enrollment effort. And I think we lead the country. We might still be in a competition with Miami. I'm not sure. But I'll just claim the victory and credit your great leadership with it.

There's so much that I want to ask about. We only have a few minutes. Let me start with our work on the neuroscience front, on the BRAIN Initiative. NIH's participation and leadership in it is obviously critical. I want to thank the chairman on working with us. Last year, we were able to fully fund these initiatives.

And as the administration comes to the end of this period, it's going be important that this work not be interrupted. We have some 50 million Americans suffering from a brain-related illness. The efforts of NIH along with the National Science Foundation offer and a host of dozen other federal agencies, the VA and so on, its work is critically important.

So, I'd be interested in your thought about how to make sure that we can structure the compass correctly and that this work can go forward?

BURWELL:

So I think one of the most important thing is that is housed in NIH, which I think under any administration will continue. And I think the brain worked in the demand around the brain work, whether that's concussions, Alzheimer's. It is great. And so, I think we're hopeful that this will continue to be a priority.

I think the other way we get the continuity is al ready. Thank you all for the support that you provided last year. We have already issued 125 awards. So those scientists are doing their work to provide the input. And I think as you know, it's not one effort. It is about research in a number of different efforts and places because the brain -- right now, our knowledge is pretty limited and there are so many conditions and diseases that are related. And so, 125 awards are out, and I think that is the other place and way that we'll be able to continue this effort and get results.

FATTAH:

Thank you. And the -- in your testimony, you talked about community health centers and my colleagues already asked you because we are going to arrive at an important challenging moment for the community health centers. Now, this is my priority and a number of our other colleagues in the floor are the (inaudible) in the Affordable Care Act. We provided a very significant ramp up to fairly qualified community health centers.

The last thing we want to do is have one out of ever nine Americans being able to use those centers now and then get to a point in 2017 to have a problem. So we want to work with the authorizers and the administration and get what we think is a modest request. Your request for two-year?

BURWELL:

Yes.

FATTAH:

Right -- to make sure that that happens. So this is very, very important. And then you have a very significant increase in the precision healthcare portion of the budget. We provided money last year. And this is an area that's vitally important and builds on the work of the human genome project and a host of things. If you could talk a little bit about how you see the progress from last year's funding. I know you just started to move that money, but can you talk to us a little bit about that?

BURWELL:

So two places in terms of specifics for the precision medicine initiative -- and thank you all for the support for the funding --in terms of where the progress is being made. The first is I would say in the cancer area. That is the place that is the most ripe and where we are moving the dollars through the national cancer institute to continue to do research in the genomic space and this is about the genomics of the tumor and so that we can actually -- instead of saying you have kidney cancer, we

look at your tumor -- and I met the gentlemen at NIH who -- his family had had a number of members die. He lost one kidney. He had had over 30 tumors removed and they kept growing back. But once we analyzed his tumor genetically and treated it in that form versus treating kidney cancer, we were able to make progress. And so, those are the kinds of types of examples.

The other place where that money is going to come to fruition is -- and I think the president is doing event either now or this afternoon -- on precision medicine. We will be working with the private sector on some of their engagement. But I think the big thing is getting the cohort, the group of people who will come in and be a part of creating a broad group of people where research can be done. And so we put in place some of the privacy recommendations, some of the security recommendations, so that we build the right platform as people want to and cannot come in.

FATTAH:

Thank you. Thank you, Mr. Chairman.

COLE:

Thank you. And we next move to Dr. Harris.

HARRIS:

Thank you very much and thank you, Madam Secretary, for being here today. First, I just got to clear up a question I've got because somehow you talked about budget being a showing deficit reduction. And I got to tell you I -- because I just pulled up the president's budget and my (inaudible) deficit in 2026 is $793 billion?

BURWELL:

With regard to the specifics of that that number, I will trust if you have the budget in front of you because...

HARRIS:

So $793 billion, Madam Secretary, and the CBO estimates this year's is $541 billion. I got you tell you this is why people don't trust Washington. This is why we look at the presidential race and we wonder. We scratch our heads like why is it going the way it is because only in Washington, honestly, could a secretary come before a committee and say that raising the deficit from $541 billion to this year, $793 billion in 2026 is deficit reduction.

This is the problem -- and this is not a question. It's just a comment. This is the problem with Washington. That being said, we got a problem because we project -- and the president's budget actually projects a debt of $21.3 trillion in 2026 -- $21.3 publicly held debt. This is the real problem. So we got to look at how we fund things.

The first question is the Zika funding request. Is that above the caps?

BURWELL:

It is an emergency supplemental, yes.

HARRIS:

So it's above the caps. So actually, sitting on a $541 billion deficit and where the administration comes in and says, "This is emergency funding." I'll tell you when I was in the Navy we got a saying that the Navy went from crisis to crisis unimpeded by plans. Within one year, it had requests -- I think the last request for Ebola (inaudible) $6 billion -- I mean it's just billions and billions of dollars. That was an emergency request.

Now, we got an emergency request. Is there a plan somewhere? And then I go, "Oh, my gosh. There is a plan. It's called BARDA (ph)." It's actually called -- we actually have a plan to fund projected problems into the future. And what did the administration do? They come and say, "Yes. We got a plan and we need a certain amount of money and we're only going to spend half of that. We're going to ask you for emergency funding for actually one of the plans we have." So we're not going crisis to crisis.

So for instance, when there was an anthrax outbreak we actually have the medications to treat it. When there -- or the -- and I can go down the whole list of BARDA -- so that actually we don't end up with a crisis. The administration chooses to underfund that program.

Where's the plan? Because Zika and Ebola are actually -- you know, although they're different virus, they're actually the idea that we should have a plan and say, "We have to develop a method to rapidly react without emergency funding." So for instance, could you describe the plan to rapidly develop vaccines and get them approved and how much we're spending on that plan?

BURWELL:

So Dr. Harris, I think that the fundamental cost in both Ebola and in Zika actually have to do with public health for the American people and not the actual cost. The amounts of money needed in terms of vaccine development and deployment if you have them, the deployment will be. But with regard to the cost for both Ebola and Zika, right now, what we need to do is make sure that we are getting the right information and doing the diagnostic testing.

Right now, the governor of Florida I read this morning in the newspaper he has asked me for more tests. Right now, with regard to it, that is a CDC function. The questions of Ebola and Zika, right now, we know in this country 14 women are pregnant who have the virus. We don't want that to continue. We don't want more. We don't know. I can't tell you how long Zika lasts in semen, neither can Dr. Frieden (ph), neither can Dr. -- those are the funds...

(CROSSTALK)

HARRIS:

Madam Secretary, I absolutely agree, and I have a list of questions. I'm just going to keep on going.

BURWELL:

Those are the funds that I think you're asking for.

HARRIS:

Is the public health -- you have a public health prevention fund in your department, don't you -- started by the ACA?

BURWELL:

We do.

HARRIS:

How much did that money is appropriated to Zika the next year?

BURWELL:

In terms of that fund, as I mentioned earlier, we have asked in terms of the prevention fund.

HARRIS:

That's right. How much in your budget that prevention fund is going towards that...

(CROSSTALK)

BURWELL:

That prevention plan I just set up a letter saying that actually we are using some of the money for those in terms of other carry over balances. Now, which prevention fund are you talking about because there is a prevention fund that you all told us?

(CROSSTALK)

HARRIS:

The public health and prevention fund that's funded -- that was established by the ACA for the purpose including vaccines. So we're told, well, we have to develop for the Zika vaccine. Are we using currently available funds before we asked for emergency funds?

BURWELL:

Those funds have been allocated by Congress. It happened two years ago. In the first year, I was in the administration. The administration had choice. After that, the Congress in the last two -- maybe three years -- I'll ask the chairman -- but in the last two at least years you all have given us very specific allocations for that money.

HARRIS:

Have you asked for the Zika funding to come from that allocation instead of an emergency allocation that is outside the budget caps?

BURWELL:

Dr. Harris, we believe in terms of the trade-offs to we need to make in an emergency situation where babies are being born with microcephaly that we believe it is an emergency.

HARRIS:

I yield back.

COLE:

Thank you very much. We'll next move to my good friend from California, the gentlelady, Ms. Lee.

LEE:

Thank you very much. Good to see you, Madam Secretary. I just want to remind this committee, you know, I think our allocation right now continues to be one of the 10 percent below pre-sequestration levels. And so, we need to really recognize that in and try to understand the fact that this allocation at this level continues to really hamper our ability to address our nation's current and emerging health needs. It is really too bad and hopefully we can get a better allocation this year.

A couple of things, I'd like to ask you about. Of course, you know, the Health Careers Opportunity Program. I have been calling for years now to make sure that we fund it. So I'm really glad to see that there are resources in this budget for that. But I want to ask you about why you're eliminating the area health education centers, which are really critical for minority and low income families according to -- in terms of ensuring medical school training and healthcare training.

There is a statistic I want to raise at this committee during this hearing that the Association of American Medical Colleges there were fewer African-American males enrolled in medical school now than in 1978. And so, by eliminating this program, I want to see how you're going to really address the emerging needs of diversity in the health workforce and all disturbing plan.

Secondly, as it relates to the Asian Pacific American Caucus, I served as the co-chair of APAC and we have many, many issues we've been addressing, and thank you for your assistance and

leadership on this. But the racial and ethnic -- it has historically provided direct support to the AAPI community, of course, with higher rates of health morbidity and mortality.

This initiative is so important. It reaches and documented success in engaging Asian Pacific Americans in healthcare prevention but yet this budget proposes to cut $20 million out of reach. And so, this is a very specific unique program that really helps with the healthcare needs of the AAPI community. So I wanted to ask you, why the cut and do we see that somewhere else in the budget at this point and just emphasize the importance of that to the AAPI community?

BURWELL:

So the issues of diversity can turn (ph) to forms in terms of making sure we have healthcare providers that are diverse as one of our priorities as well as the issue of making sure we're serving communities and communities that sometime have disproportionate needs.

With regard to the overall educational issue, I think you know and as you stated in your beginning comment we are in a state of a limited budget. And with regard to the specifics of the program, what we have chosen to do to try and work on those numbers that you said, the 1978 to now, what we're hopeful is by focusing on the programs that actually are closer to that point of getting the people in.

And so, the funding that you see in terms of our public health core -- and that's not the commission core but the public health service core -- in terms of that has over one-third minorities. And by investing there, we're getting those folks in at that point at which they are so close and they are at the point in which they are making decisions. And so, trying to focus on the point where we would have the most leverage with limited resources.

LEE:

Is that why you eliminated the area health education centers?

BURWELL:

Yes. Because in terms of trying to figure out in a world of limited resources where our dollars can have the most impact. Those were the choices that we made.

With regard to the broader overall issue, our investments and community health centers have been articulated as well as that are very important to serving and providing moneys for diverse communities. In addition, with regard to that, the Affordable Care Act and the issue of getting people insurance is one of the most important things that we believe are deeply focused on in terms of changing the dynamic of the disproportionate and the inequities in minority populations. We know that getting people coverage is not enough and we have to move that coverage to care. And in the last year, you've seen efforts in that place through CMS as well as through the center.

LEE:

OK. But the cut, the $20 million cut in terms of the REACH Program because it's been so successful in addressing the Asian Pacific American community. Why the cut and where do we see that focus (ph) again in another line item?

BURWELL:

I think what we want to do with the proposal that we have in front of us is to be able to do some of that evaluation to understand how we can make that program as strong as we possibly can. And when we do that, think about then where and how are the places that we can expand it.

LEE:

OK. Not expanded, but why would you cut it? I'm just trying to understand...

BURWELL:

I a world of limited resources as I said...

(CROSSTALK)

LEE:

... once again, so ethnic minorities again are getting cut and...

(CROSSTALK)

BURWELL:

Across the board I think -- well, like everyone because I think what we've tried to do in terms of care for these populations, there are number of other areas where we've tried to make sure that we have either maintained or increased because we know the disparities are great.

LEE:

OK. And then viral hepatitis have -- I don't have any more time. OK. I'll get it back in time.

COLE:

Thank you. Just with the indulgence of the members of the committee, I will say for the record I know 12 cardinals and 12 ranking members. They are convinced that their allocations are too low and I can say with certainty that the cardinals and ranking members on interior, defense and this committee are absolutely correct.

So, with that, I want to go to my good friend and sadly retiring member. So it's also his last appearance here, and Mr. Rigell, you've made great contributions to this committee. You will be greatly missed...

(CROSSTALK)

RIGELL:

Thank you. You know I'm way down here on the end. And listen, what a privilege it is to serve on your committee and with the ranking member and just the individuals that we get to interact with. I joined the others in thanking you for your service.

I want to talk about something that's affecting so many American families, Alzheimer's. I have a -- kind of a little window into it just because of the fact my parents are still living. They're doing so well. They're 93 and 88. We Facetime every Sunday morning at 8:00 a.m. and sometimes the conversation pivots over to their friends and they start describing and they start naming names. And well, they're the names of my childhood friends, their parents, of course, their parents.

And so I know them and they just -- they have to talk about how painful it is because they don't know where they are and all these other symptoms of that horrific disease. And I know that we increased the research by 60 percent. I am so supportive of that.

But as I think about how we have extended the length of life but not quality of life and I think about how organizations from time to time missed real critical moments like the housing crisis of 2008- 2009, you know, we missed that. We didn't really see that coming, at least most people didn't and it's like the challenger disaster. If you look back at it from a managerial standpoint, they could see where they went wrong. And I feel like we're in that same boat with respect to Alzheimer's.

I'm a fiscal conservative, and yet, embraced in all of this. And I also brought my heart to Washington, my mind, and my calculator and everything else, but I really would submit to the committee that I think we're far lower than we need to be, and I say this as a non- medical professional but -- so I have two questions for you.

The first one is how we managed that 60 percent increase -- and please don't spend too much time on that because our time runs out so quickly -- but I want to ask a hypothetical -- a question. I think you will appreciate the question, but if you could invest in that particular area, not to the detriment of the other areas -- I'm giving you a hypothetical.

If you could just -- because at some point, the water starts to flow out of the glass. I mean there's just more money that we can really apply to the research, but what is that theoretical limit of what you would want to apply to research to Alzheimer's because I think this is the number one challenge facing our country for a host of reasons, quality of life, and indeed -- and indeed, physical -- the fiscal aspect of it. So could you walk us through that, please?

BURWELL:

So with regard to that answer, I actually would want to consult with NIH. And here is why? And it actually gets to the part of what Dr. Harris raised. In terms of our BARDA money, in terms of managing the taxpayers' money well, those moneys that we took down were BioShield money and

it's because the science is not ready and our contracting ability in terms of negotiating, we won't negotiate more.

And so -- actually it's related to where the science is because I wouldn't just want to put out a number. I actually would want to know that we believe that we could spend the money well. And so, I'm happy to talk to our colleagues at NIH and get back to you with that because I actually think that is important that when we care deeply about things and our passion is about them I still think we have to use some methods of standards with regard to spending the money.

RIGELL:

I absolutely...

(CROSSTALK)

RIGELL:

... and whether in office or out of office, I'm going to continue to advocate for this because I think it's the right thing for our country and I think I'll do so as a fiscal conservative. It may surprise the chairman, but I was actually called out just a little bit in the financial services committee by one of our colleagues on the other side accusing -- well, saying that I was like raising my voice I believe or something because it was Office of Management and Budget director there and I was actually pressing this whole point about our fiscal situation.

And I share the views that have been expressed here particularly around our side here that I don't believe that administration has fully grasped the threat of our fiscal -- the risk that we have and he is not fighting for it. I didn't see him fight for it in the State of the Union, for example. I walked out just really stunned with the lack of attention to this matter and I acknowledged easily and quickly that both sides have contributed to it. But I'm one 435th of one-half of -- one half of this part of the government that actually works on all of this. He is one half.

And I'm just going to take this opportunity to share with you as I did with Director Donovan that I don't think we're grasping the severity of our fiscal situation. I want my president in his remaining term of office here -- I'm not expecting much actually -- but to really bring a clear end call to this and to do what is needed to set our country on a better fiscal path for a host of reasons.

And I want to respect the time, and Madam Secretary, I appreciate your service and I share the respect that all of us here have for you. Thank you.

BURWELL:

Thank you.

COLE:

Thank you. Next, we'll go to my other friend, the gentlelady from California, Ms. Roybal-Allard.

ROYBAL-ALLARD:

Thank you, Mr. Chairman, and welcome, Madam Secretary. Let me begin first of all by expressing my concern also as Ms. Lee did with the $21 million cut to the REACH Program. And I can't help but question that even though there have been 150 journal articles documenting the achievements of REACH in reducing health disparities that there is a need for another study. So I just wanted to put on to the record, but I do -- I have another question regarding adult immunization.

As you know, this country is falling woefully behind in our progress toward reaching the Healthy People 2020 goals for adult immunization. And the recently released 2014 National Health Information survey data confirms very little change in adult immunization rates over the last four years, with fewer than 45 percent of adults receiving recommended influenza vaccine and barely 20 percent of adults aged 18 to 64 being immunized against pneumonia.

Especially concerning the fact that immunization coverage among minority populations is even lower. The 2014 data revealed that racial and ethnic disparities persisted or all seven recommended adult vaccine and worsen for both herpes zoster and Tdap. For these reasons, I was pleased to see that your National Vaccine Program Office recently finalized the National Adult Immunization Plan with four goals centered on improving infrastructure, access and demand for immunizations as well as fostering innovation in vaccine development.

Could you please describe the short- and long-term steps that your department will take to move the NAIP implementation forward, specifically how does the plan address immunization disparities in minority communities and how will HHS measure progress in bringing adult immunization rates closer to the Healthy People 2020 goals over the next four years?

BURWELL:

So I think the those four steps that you outline in terms of especially the access, the infrastructure, and demand and in terms of when one is thinking about all three of those steps, making sure that we are going to the population that is most underserved in those spaces in terms of minority populations, and that will guide our communications strategy as well as how we reached people.

And I think you know some of the tools that we have used in the marketplace in terms of understanding how to reach consumers where they are our tools that we will transfer and are learning from throughout the entire department to make sure we are communicating because one of the things that we have found is often our communications don't reach people, one, and often they are not done by people who are trusted.

And so, these are two very important lessons that I think from the marketplace that we are going to try and apply. It is why this year in terms of the places I went for open enrollment I went to barbershops. I went to beauty shops. We went to churches. Those are the places where people get the information that they trust and use.

And so, I think we need to shift some of our approaches to how we do this. We welcome your thoughts specifically on how we can reach the community in the ways that we are reaching them that you think are working in the ways that we tried that aren't so that we can quickly -- because I think that consumer feedback, which I hope you're hearing can help us get to a place where we can be much more effective because it is the larger part of the population with regard to these adult vaccinations that people don't do.

The other thing that I would ask for your help and assistance, in Medicare, one of the things the Affordable Care Act did was it created new preventative services for free. These are included. We've seen some increase in uptake but enough. And so, this idea of our targeting needs to be across all age groups and especially adults in that band (ph) because some of these adult vaccines are especially important as you get older.

ROYBAL-ALLARD:

Before he went into politics, my father was the public health educator responsible for educating Latino communities in California about the spread prevention of TB. And because of that experience, I grew up with a healthy respect for the dangers of this disease and have been closely following the case of the 35-year-old man in Los Angeles who has been battling extremely drug-resistant TB for three years and I was pleased to see the December 2015 White House release of the national action plan for comp -- commend you for this thoughtful and very comprehensive five-year plan to develop new tools for diagnosis and treatment of the new research investments for an effective TB vaccine.

But I am skeptical that the plan will be successful in reducing MDR-TB infection in the United States and abroad without any designated funding for its implementation in your FY 17 budget proposal. Why was there no funding requests for the national action plan...

COLE:

I would ask the gentlelady to wrap her question up and quick response.

(CROSSTALK)

ROYBAL-ALLARD:

... on the implementation and the cost.

BURWELL:

Yes. We'll provide information on that as well as the combatting antibiotic resistance funding too, which will be a part of it as well.

ROYBAL-ALLARD:

OK. Thank you.

COLE:

Thank you very much. I now recognize my good friend, the gentlelady from Alabama, Ms. Roby.

ROBY:

Thank you, Mr. Chairman, and thank you, Madam Secretary, and I'm sorry that we were unable to connect prior to today. On Tuesday, the chief of the U.S. Border Patrol testified Senate that border agents are seeing a dramatic surge in the number of unaccompanied minor illegal immigrants arriving at our southern border. In fact, the border agents have apprehended over 20,000 children from October 2015 to January 2016. That's double the number from the same period last year.

And let me just be clear to my colleagues here today and to the people that I represent. I feel nothing but compassion towards these children and I think the most compassionate thing that we can do is return these children to their families in their country of origin.

Unfortunately, that is just not happening. Only 4 percent of these children according to the statement made my colleague, Senator Jeff Sessions, actually returned to their families in Central America. And as a mother of an 11-year-old girl and hearing the stories about what is happening to these children in this treacherous journey to United States is horrifying quite frankly. It's worst of human trafficking.

And so, you know, I don't feel as though there is discouragement taking place from the Obama administration. I don't feel like we're sending a very clear message. And I have a real concern about the fact that there is consideration -- continued consideration to house these children on active military bases.

We received a letter between Christmas and New Year's, a week where most people aren't paying attention, but we were that in fact Maxwell Gunner Air Force Base in Montgomery Alabama was under consideration to house these children. On that, with your Office of Refugee Resettlement, recently, we went over all the criteria about why and how and should this be dying with the military liaison that was there as well. And I am deeply concerned that any of our military bases remain on the list to house these children. I can share with you -- I have a map that shows the building where these children are going to potentially be housed at Gunner.

And for those who don't know, what happened is the space on this military installations where these children are to be housed are fenced (ph) off an outside contractor then comes in, most of the tie armed on to a military base and these children are fenced in an area, a small area mind you, right next to a neighborhood -- and this is on a military base, Gunner, where everything they do is top secret clearance. This is a lot of cyber warfare going on, new buildings are just adjacent to the very buildings where our active military personnel are doing very important missions on behalf of United States military.

So, I share all of these with you. I know we might do a second round, I hope. In the last remaining 1 minute 45, I would like for you to first engage on this and maybe we can followup in the next

round. But I just want you to know that I have a very strong opposition. We need to get this children home. And in the, meantime, we certainly don't need to have them housed at a military base.

BURWELL:

So I think you know our job is to -- once the child is in the United States to make sure that they have appropriate care and are placed in an appropriate and safe setting and that's the role of HHS. With regard to the discouragement issue that you raised, which I think is an important one, what we've seen is you were right about the numbers. Of that 20, we received 17,000 -- the 20 that they saw, 3,000 never came to us which mostly usually means they go back immediately through DHS. But those that came to us, we now have seen a drop off in January, which is a good thing, but we do not know that that will stay.

And so, my job is to make sure we have enough facilities that the children do not back up at the border, as we had in that one situation. And this gets to the issue of do we have a plan. Yes, we have a plan. But in order to have a plan, we have to have an ability to open facilities quickly as we need them because it is a balance of the taxpayers' money with regard to empty beds.

And when you can bring beds on in terms of paying for them with regard to it, we would review and appreciate your engagement in helping us review the bases. The bases are an important part of this because of the process, and we are looking at other private sites across the country. But as you said, finding sites that can meet the conditions that will work with in city the community and the children both the children safety, the community safety, we weigh all of those considerations.

ROBY:

Would you agree with me -- and we'll continue discussing this -- but would you agree with me that a military base is the last place that we want to house these children?

BURWELL:

The issue with military bases is that they actually have housing and facilities that are used to. So when I go and get GSA buildings, the millions and millions of dollars that it will take me to reset, you know, most of the GSA buildings that I would go and try and get in terms of accessing. The other issue, to be honest, is when I access a non-government facility it has to do a process in every state for approval.

COLE:

Question right at the end, I would just ask -- quite all right. I understand the passion around these issues. We have had the good fortune to be joined by what we affectionately call the big chair. And so, I'm going to move directly to him for whatever statement he cares to make and whatever questions he would care to ask, the big chair.

ROGERS:

Well, thank you, Mr. Chairman. Madam Secretary, it's good to see you. Welcome...

BURWELL:

Good to see you.

ROGERS:

... to the subcommittee. I apologize for being late, but we got 21 hearings this week across our 12 subcommittees and I had to attend to one across the hall with the secretary of defense for a period of time. But I wanted to be here to hear your testimony and (inaudible).

As you know, Congress and the administrations set discretionary budget caps for fiscal 2016 and 2017 and the Bipartisan Budget Act, and I'm proud to say that the 2016 omnibus stayed within that agreed upon cap. The budget proposal put forth by the administration for HHS is also touted as adhering to those spending caps, but it's really just an illusion to be frank with you.

This year, HHS requested $75.68 billion. But that number does not include an estimated $3.8 billion that you proposed in mandatory funds to support what are traditionally discretionary programs. While I very much enjoy our collaboration in the immediate past on a host of issues, I am disappointed that the important goals that we share for your department are undermined frankly by what I consider a partisan nature of that request.

We both know that these figures and budget gimmicks are unrealistic. Frankly, it makes the already very difficult job that we have even more challenging. We all know that the mandatory side of the budget -- and that's three-fourths of federal spending as mandatory entitlements -- growing out of control. We only appropriate a little less than a third of all federal spending and we cut that -- we cut that for the last five years back of almost $200 billion of discretionary. But mandatory just grows willy-nilly. And so, you're proposing switching some money over to mandatory, and outside the jurisdiction of this committee to oversee. That's why it's a difficult thing for us to have to contain with.

There are two areas in particular that see astronomical growth in mandatory spending under your request. First, NIH, National Institute of Health, plays an important role in groundbreaking medical research. NIH projects often result in life-saving medical treatments that impact people all over the world.

This committee understands the importance of NIH. We're all personally committed to NIH and demonstrated that support through an increase of $2 billion over fiscal 2015 that we put in the omnibus, thanks to the great work of your chairman, Chairman Cole. It was a bipartisan achievement.

And for the administration to propose its well-publicized $1 billion Cancer Moonshot through mandatory spending outside the terms of the BVA, outside the scope of this committee's jurisdiction, that's simply disingenuous. We're all committed to cancer research, all forms of medical research. But we still are governed by the laws of nature. We got to make tough choices

about how and where to spend taxpayer dollars and when you thrust this money into mandatory it puts extra burden on us for trying to find money on discretionary to fund the things that you're displacing (ph).

The same can be said for the billion-dollar proposal to address our nation's raging opioid epidemic. Madam Secretary, I sincerely appreciate your efforts to keep the national spotlight on prescription drug and heroin abuse, and you and I have talked about this time and again, month after month, year after year, and you're a soldier in that cost.

I know your roots in neighboring (ph) West Virginia. My district and your area are next door neighbors. And the battle has been waged there for a decade or longer. It's been a source of personal motivation, but you have dedicated to that cause and you've taken, indeed, strong decisive action to eradicate abusive prescription practices, educate our communities about the dangers of these drugs, and treat those suffering from the grips of addiction. We undoubtedly share those same goals and I believe we've made some real progress together.

But I also believe this request exposes our diverging plans to the promise land. We got to continue to provide states the support they need to defeat the epidemic, what we also got to do so within the reasonable confines of our budget. Supplementing existing funding with mandatory dollars to fight substance abuse only hurts admittedly (ph) to address the problem in near and distant future.

Finally, the ideas and this budget request merit consideration. The president's request is simply not feasible as written. So I hope we can work together to address my concerns and because the stakes here are far too high for response (ph).

Before I close, let me -- I would be remised if I didn't mention that rural hospitals across the country are struggling financially and it's across the board. Many of them are on the brink of having to shut their doors. I have several in my district that are at that stage leaving the small communities without a dependable source of emergency in hospital care. Instead of working with these hospitals to make sure rural Americans have affordable and reliable care close to home, some of the proposals of the president's budget will compound their financial troubles.

These harmful proposals ranged from adding a user fee for hospitals that utilize the 340B drug pricing program to cutting the reimbursement levels for clinical hospitals that oftentimes serve the chronically ill and elderly. While the most of them may seem like a few dollars here and a few dollars there, each proposal chips away the sustainability of these rural hospitals. So I hope we (inaudible) to solve a problem that is really crippling rural American (OFF-MIKE).

I thank you for your work and thanks for being here.

BURWELL:

Thank you.

COLE:

With that, I want to go to Mr. Dent. But before I do, after Mr. Dent enjoy a full five minutes, with unanimous consent, I'm going to move us to two minutes. The secretary has to get out of here. I know she has an engagement. We want to try and help here. But also there's a lot of questions here and I want to give everybody a chance. So please again, after Mr. Dent, we'll try and hold it to two minutes. So, thank you very much. And with that, my good friend from Pennsylvania is recognized.

DENT:

Thank you, Mr. Chairman, and good morning, Madam Secretary. I regret (inaudible) hookup. I appreciate your phone call though.

As you know, for several years, I've been working on legislation that waives co-insurance with colorectal cancer screening, test for Medicare beneficiaries one of the screening results, and removal of tissue or polyp. I'm encouraged this year that the budget includes a recommendation to do just that. How can we, on the subcommittee, continue to work with you and CMS to implement this commonsense policy that we can further encourage more people to be screened for...

BURWELL:

I think we are...

DENT:

... colon cancer and what was the impedes for including this in this year's budget?

BURWELL:

Thank you for your leadership and effort in this space. And what I think we're hopeful is that this is something that is a change that people could agree on as part of the budget process and we -- when we put in the budget it's because we believe we need help to get it done.

DENT:

Well, I'm pleased to see it in there and something we need to correct.

BURWELL:

We look forward to working with you on it.

DENT:

And my second question deals with the NIH issue and I like to discuss this discretionary funding cut the NIH faces in the proposed 2017 budget request. We provide NIH with a $2 billion discretionary increase in 2016 and I was more than a little surprised at the 2017 NIH request reverses this with the billion-dollar decrease from NIH discretionary funds. The request presumes

to backfill these dollars or mandatory funds which are outside the jurisdiction of this committee. We believe that's totally unacceptable budget gimmick.

Further, only -- it only assumes mandatory funding for one year. In other words, it creates an out year mandatory funding cliff of $1 billion in fiscal year 2018 that our committee would have to address. Mandatory funding cliffs are reason we appropriate and do not support switching discretionary programs in the mandatory funding. The bill always comes back to rest at the doorstep for this committee to fix. And I certainly urge all NIH supporters, like myself, to avoid efforts to swap discretionary funding for mandatory funding streams.

On top of this gimmick, the budget presumes to add another $825 million mandatory fund for NIH to support the Cancer Moonshot, precision medical initiative, and BRAIN Initiative, all the programs. Please discuss the impact on NIH if authorizers don't act to provide mandatory funding. And specifically, how will this impact extramural investigator grants success rates and NIH's ability to sustain research supported with a $2 billion increase provided this year?

BURWELL:

So we're appreciative of the increase that we received and I think this is about putting the overall budget together in terms of how and why we took these steps. And I think in a world where -- and this gets to Dr. Harris and some of the comments -- in a world where we have -- you know, in 2019 will have one of the lowest discretionary as a percentage of GDP, which when one things about your spending, thinking about the your size of your economy seems like an important way to measure.

And as we think about that, the question is, if that's the path we want to choose in terms of our discretionary levels and that's -- part of that is in terms of what deal we did on the sequestration and the replacement of it and do we think with the right discretionary level. We think we're at the right discretionary level. I think we wanted to stick with the agreement that we believe and have paid for. And one of the things that happens even when we do the agreements to raise the discretionary caps often the pay force that we have in our budget are those that end up getting used.

And so, I think the real question -- and I understand. I'm very appreciative as my former role in OMB -- of the issue with the discretionary and mandatory. So I'm very appreciative of the concern and the questions that you're raising. I respect those. But I think the larger question for all of us is do we believe that as a nation that we are supporting the things that we need to support.

And I think you know I came back to OMB with regular order and I am so appreciative to Mr. Rogers and Ms. Rogers and Ms. Mikulski for getting the first omnibus since 1987 in terms of regular order. And so, I prefer regular order in a world where that may not be people's first choice because they have concerns with discretionary levels. That's part of why were doing it.

So I think what I am hopeful is that we, together, can have a real conversation and that part of the conversation I think we can have because I think everybody is hopeful. I am so glad to hear all the hearings are going on. To me, that means regular order. And so, that means that hopefully we will

get this done in the June, July timeframe and this can be a part of that broader conversation in terms of -- and it relates -- NIH is one of piece of the issues that Mr. Rogers raised.

DENT:

Right now, just to say that this is -- this one area where we've seen mandatory programs where funding being diverted to mandatory programs. I have the same problem with the Veterans Choice Act. That funding is going to expire. It's going to fall on the Appropriations Committee to makeup it up the discretionary funds next year, but that's a subject for another day.

Thank you. I yield back.

BURWELL:

But I think it does get to the broader issue and why I think we should have the broader conversation.

COLE:

Thank you very much. As my chief clerk jointly (ph) reminded me, the chairman did not have five minutes. So Chairman, whatever time you care to consume, you are welcome to consume. Everybody else will be confined to the two minutes when their turn comes.

ROGERS:

I'll try to be very, very brief. The critical access hospitals, the hospitals face a unique set of challenges. And that rural district, we had seven critical access hospitals, many of them already struggling to keep their doors open. What do you believe will be the impact of these reimbursement cuts that you're proposing will have on these hospitals?

BURWELL:

So with regard to the issue of rural and rural hospitals, I think you know because of where I come from this is an important issue overall. And so, there are number of places in the budget in terms of regulations where the issue of what it does to rural communities and we can go into some of those places.

But with regard to this specific question, I think it is our thought that because these hospitals actually are receiving more in terms of Medicare payments than non-critical access hospitals (AUDIO GAO) is not something that over burdensome too much, and that's why the proposal is as it is. But I think the broader question of how we support our rural hospitals is one that I think is an extremely important one.

And throughout our budget, whether that's how we're thinking of providers in terms of some of our support for people that will tend to go to rural hospitals in terms of the public health funds that we do to provide -- due providers, whether it is how we're thinking about doing telemedicine and having Medicare Advantage. One of our proposals is that Medicare Advantage would be

reimbursed in terms of telemedicine so that we can use those facilities and those rural hospitals can benefit from that. And so, we're trying to think about the issue of rural hospitals overall.

And the other thing, while it is not an issue in your state, in other states, we have seen a larger closure of rural hospitals in those that have an expanded Medicaid. That's not, you know, an issue your state.

ROGERS:

Yes. Thank you. Your opioid proposal is sweeping...

BURWELL:

Yes.

ROGERS:

... to say the least. And I am pleased that the request clearly recognizes and acknowledges the importance of fight against drug abuse. But I'm interested to hear your views on how these new pieces of the puzzle fit together, specifically the degree to which the request relies on new mandatory spending, that part troubles me. For example, budget outage $1 billion in new mandatory funding to SAMSHA and HRSA for treatment programs.

Fifteen to twenty years ago, OxyContin was just rearing its heard in appellation. Certainly, my district was the headquarters of that. Ten years ago, heroin was just a blip on the radar. But to date, opioid abuse has spread to every corner of the country. Cheap heroin is being laced with fentanyl, so strong that unsuspecting users die everyday from overdose.

With the fight against drugs changing at the speed of light, it seems irresponsible to tie our hands within flexible mandatory funding. We need to be agile and move with the times, adapting to the needs as they arise. And the only vehicle that makes that possible really is discretionary spending so that we can help you adjust to whatever takes place as we march down this path.

Now, what's your take on that idea?

BURWELL:

First, thank you for your partnership and leadership. As you mentioned, we have worked on these issues together for a long time. And with regard to it, this specific issue because we put most of the money in treatment -- medication-assisted treatment. I think you and I discussed the strategy. I think it is a bipartisan agreement. That's important. Those moneys will all go to states and communities mostly in terms of getting their ability and getting their infrastructure and ability. Some of that is to train providers that would be -- you know, you want to continue, but that may be more one- time money.

I think the question fundamentally with regard to medication- assisted treatment and the behavioral health issues is historically in our country we actually have had a situation where those are funded at the local level, and that's one of our biggest challenges right now, 85 percent of rural counties don't have behavioral health and that's because often it is funded at the state and local level.

And so, I think as we think though this question about discretionary, mandatory, short term, long term, we actually need to answer whose responsibility do we believe that is. And I think we're going to face these questions. We face these questions in Flint as Ms. DeLauro mentioned. We face these questions in behavioral health and whether that's, you know, the money we put in for the 223 waivers that are part of that proposal or this. And so, that I think is a part of the conversation we're going to have.

Do we believe? It should be the federal government's responsibility over the long term. And if we do, let's think about how we can find space on the discretionary side or lift those camps.

ROGERS:

We can continue to talk.

BURWELL:

Thank you.

ROGERS:

Thank you, Mr. Chairman.

COLE:

Thank you, Mr. Chairman. Madam Chairman, I'm next, and I'm going to be very brief on my questions, almost code to give you as much time of my two minutes I can to respond. I will warn you these are matters I'll be bringing up with you multiple times probably in the months ahead.

The first one, as you know, recently CMS flagged three Indian Health Service hospitals as, quote, "posing an immediate jeopardy to the health and safety of their patients." Those hospitals are under the jurisdiction of your department. I take this very, very seriously. I've raised it with the director of Indian Health this morning in an earlier hearing. I want to know that you're focused on this and you have a plan to deal with it.

The second question is the Weldon amendment. I have for a year and a half asked about -- we get constant complaints the state of California is not forcing institutions against their own conscience and creeds to perform procedures, abortions, if they do not believe in it. We've been told there's an ongoing investigation. It shouldn't take that long, neither are or they aren't. But I'd like you to respond to that and tell me where we are in the investigation.

With that, I yield the balance of my time to you, Madam Secretary.

BURWELL:

With regard to the second issue, when you and a number of your other colleagues contacted me and ask for an investigation to be open, we open that investigation. As you indicated, we are still in the middle of the investigation. And as I stated in the hearing yesterday, it has taken longer than I would like. Because the investigation is still open, has not come to closure, I'm not able to comment in terms of that. And in terms of setting a timeline, I'm not able at this point to do that.

With regard to the Indian Health Service issues, it is a priority and I look for your support as we work through it. Right now, we've changed the regional leadership. We have added the deputy for quality and a deputy for management, both at IHS. And I have asked the acting deputy secretary, Dr. Mary Wakefield, who ran HRSA, to have a cross department efforts so that we're bringing the best experiences of CMS, HRSA, SAMSHA, and any of the other best practices we have to increase the quality of the services being delivered at IHS because it is...

(CROSSTALK)

Cole: I appreciate that very much for -- this is an area where we actually increased funding since 2008 by 54 percent. It's been a really good bipartisan effort to try and get the problems in Indian country. And frankly, I wanted the administration to be very proud of its role. So I look forward to working with you on that.

And with that, I want to recognized my good friend, distinguished ranking member from Connecticut.

DELAURO:

Thank you, Mr. Chairman. Just a couple of points before very quick questions. Labor HHS is 32 percent of nondiscretionary spending. With that and our allocation last year, it should have been $10.5 billion. If we were to get the additional $5.2 billion this time we could avoid getting with mandatory funds very quickly.

Secondly, the prevention fund, the secretary has no flexibility over that prevention fund because for the last three years the Congress had (inaudible) medication-assisted treatment. We're talking about your opioid initiative. I would like to have you talk about that. I had the opportunity to witness it firsthand at the New Haven Correctional Center a week ago.

Secondly, let me ask you to see if got some proposals on prescription drug costs -- bringing that cost under control. I'd like to have you just expand on that for a moment.

BURWELL:

I'll do this. The prescription drug -- rising cost of prescription drugs in his budget proposal what you will see is we'd like to move to close the doughnut hole faster, which will mean benefits. Right

now, we've seen $20 billion in benefits to 10 million seniors. We'd like to speed that up as one of the things to help with the cost for individuals.

With regard to the overall cost, we have asked for authorities for specialty and high cost drugs that we would happy authorities to negotiate. With regard to our opioid-heroin strategy, three main parts, and that's where the funding goes towards, these evidence-based strategies.

The first is prescribing. We need to reduce the prescribing. You'll be seeing CDC guidelines that will come out about prescribing. That is one of the things. There are some funding in to help support the implementation of those. The second is medication-assisted treatment. That's where the vast majority of the funding goes because we know it's evidence based. That is the place. There are supplemental proposals in our budget that include things like who can percent -- describe buprenorphine. We hope you do those budget proposals as well. And the third element is naloxone or Narcan. And sadly, when people get to the place where overdose we must have tools for people to help them not die.

DELAURO:

Mr. Chairman, I would hope we could have a hearing on the high cost of prescription drugs in this committee during the period of time. Thank you.

COLE:

Thank you. Let's go to my good friend from Tennessee, Mr. Fleischmann.

FLEISCHMANN:

Thank you, Mr. Chairman. Madam Secretary, I'm very concerned about the recent accounts of American hospitals and doctors offices being the victim of Ransomware and other cyber security attacks to have the potential to compromise or delete patient's personal health information and other critical and sensitive data that our healthcare delivery system relies on.

I have two questions. What is the department doing in conjunction with other federal agencies to address cyber threats to our healthcare system? And as a follow-up to that is, in your opinion, how serious is the Ransomware threat and what resources are you devoting to protect Medicare data critical security breaches?

And with that, I will yield the balance of my time to you Madam Secretary so you can address that.

BURWELL:

So an extremely important issue and actually HHS is one of the -- I think you stated even this week has been recorded as one of the lead departments on cyber security. We need to do it across the whole department, but I think your focus specifically on CMS. Some of the funds in our budget this time are very important funds to continuing our effort in cyber security.

To answer your question about how important and how concerned are we about these issues. When I was confirmed on -- for this job and had my first meeting with the issuer's, everyone -- it was June 9th and so everyone thought I was going to talk about technology and the marketplace, which of course was a topic I should touch on making sure we get that right. But actually, the topic I also want to talk was cyber security and that was in June 2014.

I think this is an extremely important issue that we need to all work together on. I think we need the best practices from the private sector and learn from them, but I also think making sure we have a close tie and connection because when this happens there are questions of breaches of information that could be -- if a violation for individuals depending on what those are. And so, making sure it we're working in a form that we're doing our part as we can, learning from the private sector, and making sure we're sharing as well.

And that's not just at HHS, to your point, we coordinate with the FBI and others because when there is information that is important through DHS, we need to make sure that industry has information as appropriate around these issues.

FLEISCHMANN:

Thank you, Madam Secretary. I appreciate your testimony today. Mr. Chairman, I yield back.

COLE:

Thank you very much. And I'll go to my good friend from Philadelphia, Mr. Fattah.

FATTAH:

Madam Secretary, if we could turn our attention now to another part of your testimony today. It was around the Head Start and early education. So in Philadelphia, over $300 million in federal -- mostly federal funds are used to provide Head Start and Early Child Education, but we're still on the reach in something slightly less than 40 percent of the children and there's more to be done. I appreciate the fact and we'll support the administration's request for $9.6 billion in Head Start funds.

I also noted that you want to create $350 million fund to work with states in terms of preschool development grant. Can you talk a little bit about how that -- those dollars would be used and distributed?

BURWELL:

So as we think about this continuum in early education home visiting, thank you for the support in MACRA in terms of home visiting, but we think about home visiting early education, preschool and childcare and Head Start. They are together. Head Start serves a particular population, but we want to make sure certainly childcare proposal we're serving more. In that early education money, those are moneys that are generally targeted to more low income communities through the states.

And so, some of those for broader communities like childcare and Head start and others are targeted more towards the low income communities.

FATTAH:

Talk a little bit about where you think they -- as you know, the Pew Foundation, which is based in (inaudible), not a lot of work with states. In fact, many of our state governments have been at the very forefront of this work and I know that administration has taken a leadership around these first thousand days of a child life. It is critically important in terms of the networking for the BRAIN and for all of the health-related issues that are very, very important.

Can you talk about how you see the departments work now in conjunction -- in working alongside of some of your colleagues like the Department of Education?

BURWELL:

We share...

COLE:

Madam Secretary, you can talk about it but be...

FATTAH:

Oh, I'm sorry.

(CROSSTALK)

FATTAH:

I withdraw the question.

BURWELL:

OK. Thank you.

COLE:

OK. Thank you very much. I appreciate that. Dr. Harris?

HARRIS:

I don't know if you were here, but we're at two minutes.

COLE:

OK.

HARRIS:

All right. Three very brief things. One, I am concerned -- I won't ask you to address it now -- you know, we're almost one year out from the NCI director, you know, announcing his retirement and we still don't have an NCI director. That's a little -- that's of concern for me, you know, when we're talking about Cancer Moonshots, that the leading cancer person, you know, hasn't -- his replacement hasn't been appointed.

Let me just mention one other thing. You know, the rosy assumption on the president's budget, of course, is 4 percent GDP growth. We haven't had 4 percent GDP growth in (inaudible) 11 percent GDP growth. So that's a really rosy assumption. And one of my concerns is that part of the Medicare savings -- correct me if I'm wrong -- that's project in your budget that, you know, you comes in under all of, you know, ounces, whatever you want to call it, is the change in the target rate of growth from GDP plus 1 to GDP plus 0.5. Is that right? That does achieve some of the savings?

BURWELL:

With regard to -- I have to go back.

HARRIS:

The Medicare...

BURWELL:

I have to go back and check. Some of these questions in terms of those are...

(CROSSTALK)

HARRIS:

Well, I'm assuming since it triggers the IPAB, the Independent Payment Advisory Board, at a lower rate you must be making that to achieve savings. I would imagine. My concern again is with the Independent Payment Advisory Board no one has been appointed to it. It is going to be a rationing device and I just hope Medicare beneficiaries realize what the -- what your budget does to Medicare over the next few years.

Finally, with regard to the Zika request, is it my understanding the administration said they actually want to use some of the Ebola leftover money for malaria?

BURWELL:

With regard to that, that's a question that would go to the state department or USAID. Those are funds that are in their areas.

HARRIS:

So if that's true, the administration has already made a decision to use some of the Ebola money for other diseases and I would suggest that that's the state department things ought to do, that's what you ought to do for the Zika and not come in with a budget busting $1.8 billion request.

And I yield back my time.

COLE:

Thank you. The gentlelady from California is recognized for two minutes.

LEE:

Madam Secretary, in your response to a question that was asked by my colleague, Ms. Roby, you said that it was your job to have unaccompanied children make sure that they were safe. So I was really shocked to read about the release of unaccompanied from ORRN (ph) care into the hands of human traffickers as was documented by the permanent subcommittee on investigations in the U.S.

Can you tell me how much money is ORR requesting for home studies which investigates the backgrounds sponsors before children are released to them and post-release services in which HHS can continue to check in on a child and is the amount requested sufficient to take care of the anticipated number of unaccompanied children? And if you have the time, if you could comment on the department's plan to continue and expand the pilot program for home studies are now required for all unaccompanied children 12 and under placed in category 3?

BURWELL:

The issue in Ohio is a tragic one of people breaking the law and we will work with the justice department to do everything we can to the full extent of the law in terms of that tragic circumstance. With regard to the overarching question of how we do this, there have been a number of improvements that we've made over time with regard to the safety of the children and whether that is background checks on all adults who might be in the home, whether that's followup calls within 2800 number. There are series of steps, I'm happy to get those to you.

With regard to the funding issue, the funding issue because of the unpredictability of the flows, as we discussed with Congresswoman Roby, our ability to do certain parts of this is dependent on the funding flows. Our ability to answer the question you asked would be enhanced greatly by having $400 million, the contingency fund that we put in because that way we could actually focus on it. If there is a flex, we would know where we get that money and we wouldn't use it unless we needed to flex. And then we could have surety of our money for the other services we provide.

COLE:

Thank you very much. The gentlelady from Alabama is recognized.

ROBY:

Madam Secretary, I would appreciate based on the last line of questioning the opportunity to discuss that further. We can use (inaudible) in the short two minutes, the GAO issued a report of the ORR and it's quite concerning. They uncovered a myriad of problems and hint regarding the handling of the detained minors, abused, lack of oversight, lack of control over the whereabouts and livelihoods of these minors. So what I read in the Washington Post certainly -- and I am sure you saw that article as well -- doesn't give me any confidence about what is actually happening within the department, particularly if we have another influx as is being predicted.

So what are your comments on GAO's findings and how is your agency addressing the concerns that were outlined in the GAO report?

BURWELL:

With regard to the specifics, as I said, we have made a number of improvements, but I have to see which report at this point, in terms of the GAO report, the IG report, and I want make sure I am referencing the right report and so we can come back on that. But a number of improvements are made with regard to the children. What I would say that so important is our ability to focus on those issues is extremely important. We want that.

And I think you know I came to the committee and asked for additional funding for this year -- the year we're currently in, the fiscal year-end, not the conversation we're having. I asked. I sent letters. I talked to all four corners, all of those, because this ability to have standardized funding that we know we can depend on is a part of our ability to manage these problems well. And so, that's the one thing as we're having this conversation, especially around the budget that I think is extremely important. We want to hear if people have suggestions for things we can do more.

I think you've heard we've made a number of changes to make sure that we are checking the children. Things are checked before. Many of these children go to their parents here and that's one of the, you know, issues that I think is an important one to recognize that their children they make the journey and they actually are placed with their parents. We still do checks in terms of that as well.

ROBY:

I yield back.

COLE:

Thank you very much. And for the last questions of the morning, I recognize the gentleman from Pennsylvania, Mr. Dent for two minutes.

DENT:

I'll be real quick. Thank you again, Dr. Burwell. Just on the issue of BARDA. I just want to make I guess a quick comment. It's my understanding that a vaccine platform -- these technologies or these platform technologies could now be called upon to quickly develop a Zika vaccine and in general respond more expeditiously to the next outbreak or threat.

What's BARDA or HHS doing to support and facilitate platform- based technologies against known and emerging threats? And I mentioned Zika, but you know there are other threats out there obviously, you know, from SARS, Ebola, H1N1 and H5N1, et cetera. So could you talk on that?

BURWELL:

Right now, BARDA is in the conversation that we're having with the private sector and it is not just in the vaccine spaces, in the diagnostics space as well, certainly for Zika but for many other things as well. And so -- and in the treatment place...

DENT:

Is CDC doing the diagnostics?

BURWELL:

Yes. CDC is doing the diagnostics, but we're looking for private companies to actually take over manufacture of it because right now it's all happening through CDC. We also would like to see the private sector improve the technology. We have a technology. This is one of the difficult things about Zika. The diagnostic that is for you have the full blown disease it works pretty well. We know that you have Zika if you are symptomatic and we test you. If you (inaudible) people don't have symptoms and we want to test you for that, that's a problem because we could show a positive, but you actually could have had chikungunya or dengue instead. And so, our ability on that -- so we're looking to the private sector. As we advanced, we'll move as quickly as we can, but we're happy if the private sector can. So BARDA is playing an important role. In the supplemental, you'll see funding as support for that.

DENT:

Thank you. I yield back my last 18 seconds.

COLE:

I thank the gentleman for his generosity. Madam Secretary, I want to -- this is probably your last appearance before this subcommittee, although we'll certainly have the opportunity to continue to work together for the balance of the year, which I look forward to a great deal.

And again, I want to echo and reinforce the sentiments of everybody on this committee on both sides of the aisle about how much we appreciate your service, what you have done, what I know you will do in the next year. What a delight it is to work with you, frankly, how thorough and professional you are in, and frankly, how much we will miss you in front of this committee, although I suspect you will not miss us very much. You have hardly been able to wipe the smile off your face as the minutes have ticked down. So I recognize that, but you will be missed by both sides of the aisle, and thank you very, very much for your distinguished service to our country variety of capacities under two different ministrations. That's something that you can take a great deal of personal pride and it's something that again every member on this dais certainly respects.

BURWELL:

Thank you, Mr. Chairman. Thank you.