Hearing Transcript

House Education and the Workforce Committee Hearing on Policies and Priorities of the Department of Health and Human Services

March 15, 2016

KLINE:

A quorum being present, the Committee on Education and Workforce will come to order.

Good morning, everyone, and welcome. Secretary Burwell, we appreciate you joining us to discuss the policies and priorities of the Department of Health and Human Services.

From welfare and health care to early childhood development and support services for older Americans, the policies your department oversees affect the lives of millions of Americans. Conversations like this one are vitally important as we work to ensure the Department is acting in the best interests of taxpayers and those in need. As we examine what programs and policies are working, and which ones are in need of improvement, I hope there are a number of areas where we can find common ground.

Of course, there are also areas where we will ultimately agree to disagree, and perhaps the most prominent example is the President's health care law. As has been the case for nearly six years, this flawed law continues to hurt working families, students, and small businesses. It's still depressing hours and wages for low-income workers, still making it harder for individuals to receive the care they need, and still driving up health care costs.

One Emory University professor recently wrote that his family's health-insurance premium is now their biggest expense -- even greater than their mortgage. Before the health care law went into effect, this man was able to cover his entire family of four for less than $13,000. Now, the cost of insuring just him and his wife is nearly $28,000, twice the cost to cover half as many people. In fact, paying more for less is becoming a hallmark of the health care law.

Over the years, Republicans have put forward a number of health care reform ideas, ones that would expand access to affordable care and lead to a more patient-centered health care system. We will continue to do so, because we firmly believe the president's health care law is fatally flawed and unsustainable, and more importantly, because we believe the American people deserve better.

Again, I suspect we will have to agree to disagree, but as I mentioned, there are areas where I am hopeful we can find common ground.

Head Start, for example, currently supports nearly one million children at a cost of more than $9 billion annually. It's an important program for many low-income families. However, concerns persist that it's not providing children with long-term results.

We both agree, I'm sure, changes need to be made, but so far, we have different ideas on what reform should look like. The Department is in the process of fundamentally transforming Head Start through regulations that will have serious consequences for the vulnerable families this important program serves. We, on the other hand, have outlined a number of key principles that we believe will strengthen the program based on feedback we collected from parents and providers. I look forward to discussing where we might be able to find middle ground and work together so that these children can have the solid foundation they need to succeed in school and in life.

I'm also hopeful that we can work together to ensure changes to the Preschool Development Grants Program are implemented as Congress intended. The Every Student Succeeds Act reformed the program to help states streamline and strengthen early learning efforts. To accomplish this goal, Congress moved the program from the Department of Education to HHS, which already oversees the bulk of early learning programs.

As you take on this responsibility, Madam Secretary, please know we intend to stay engaged with the Department to ensure a successful transition.

Finally, the department is also responsible for helping states to prevent and respond to child abuse and neglect, specifically those outlined in the Child Abuse Prevention and Treatment Act or CAPTA. As I'm sure you're aware, this law provides states with resources to improve their child protective services systems -- if they make a number of assurances concerning their child welfare policies. It's come to our attention that some states are making these assurances without putting the necessary policies in place. Yet, not a single state is being denied federal funds.

A Reuters' investigation recently revealed the shocking and deadly consequences of this neglect and cast serious doubts as to whether basic requirements of the law are being met and enforced. In light of this tragic report, we wrote to you to better understand the Department's process in reviewing and approving state plans under CAPTA, and I'd like to continue that discussion today. It's clear that the current system is failing some of our country's most vulnerable children and families, and something has to change.

As you can see, we have quite a bit to cover today. These and other issues are vitally important to the men and women we serve, and we have a responsibility to ensure they are serving those individuals in the best way possible.

With that, I will now recognize the Ranking Member, Mr. Scott, for his opening remarks.

SCOTT:

Thank you, Chairman Kline, and welcome Secretary Burwell. I look forward -- thank you for being with us, and we look forward to your testimony.

Today we will hear from -- about the President's Fiscal Year 2017 Health and Human Services Budget Proposal and the Department's policy priorities. Once again, I commend the Secretary for our work to ensure that the budget reflects the priorities of this Committee -- protecting access to

health care for all Americans, giving all children the chance to succeed and making sure that we meet the needs of families and children affected by public health threats when they occur.

In many areas, I believe we've made great progress on these priorities. In the not so distant past, many families were left without affordable health care options and many more did not have access to basic consumer protections in their insurance. Double-digit increases in prices were routine every year. Women routinely charge more for insurance than men.

You lost your job and wanted to start a new business, and you had a pre-existing condition, you're essentially out of luck. If you're a senior and fell into the Part D donut hole, you didn't get any help. And when we considered the Affordable Care Act, thousands of people every day were losing their insurance.

Passage of the Affordable Care Act has given millions of Americans access to health care coverage, many for the first time in their lives. The ACA has helped slow the growth in health care costs, disclosing the donut hole for seniors, and has encouraged and improved access to mental health services on preventive care. A set of thousands losing their insurance, millions more have gained insurance.

So I thank Secretary Burwell for her efforts and her Department's hard work in implementing the Affordable Care Act. I recognize the challenge your Department faces in implementing this law with limited resources and unlimited attacks. Despite these challenges, the ACA has expanded its coverage to millions and given millions more -- more robust consumer protections in their health coverage.

The ACA has provided a historic foundation on which we can accomplish -- which we can accomplish our ultimate goal, making sure that all Americans have the opportunity to succeed. And I do not believe that we have reached this finish line yet, but I look forward to working with the Department and congressional colleagues to make meaningful improvements as we strengthen the law.

I'm also pleased that the President's budget has placed a priority on giving all children a chance to succeed by ensuring robust funding to increase both access to and quality of early learning and child care programs. We must invest in the early quality -- high- quality early learning programs because all children deserve to enter kindergarten with the building blocks to success. Decades of research has shown that properly nurturing children in the first five years of life is essential to supporting enhanced brain development, cognitive functioning, and emotional and physical health. But all too often, low-income working families lack access to high-quality affordable child care and early childhood education, and these children tend to fall behind.

Beyond their achievement gap, children who don't participate in high-quality early learning programs are more likely to have weaker educational outcomes, lower earnings, increased involvement and criminal justice system, and affordable high-quality child care is, therefore, not just critical for children, it's also critical for working parents.

Child care is a two-generation program. Parents of young children need child care to work or go to school, and the lack of stable of child care is associated with job interruptions and job loss for working parents. Child care ought to be a national priority for America's children and working families.

Just two programs provide the bulk of the federal role in early -- early education -- the Head Start program and the Child Care and Development Block Grant. Unfortunately, because of limited federal funding, too few children have appropriate access. This unmet need continues to grow. Only four of 10 eligible children have access to Head Start program and a fewer than one out of six federally eligible children who received federal child care assistance.

We have decades of evidence in investing in programs like Head Start and Child Care and Development Block Grant works. And this is time to invest in these programs, ensure that we're giving all children the chance to succeed.

I also want to commend the Secretary and her Department for -- for their efforts and respond to some of the most troubling health crises of our time. The Ebola outbreak, the Zika and opioid crises, the Department has been in the forefront of responding and keeping Americans safe and healthy.

Particularly when you talk about budgeting, some don't always see the value of investing in prevention or readiness activities so that we're equipped to deal with the public health crisis. Like any -- like many federal programs, in fact, like health care insurance itself, you often don't miss it until it's gone. So it's important now more than ever that we invest in our nation's current and future health and well-being. The President's proposal does this with the Cancer Moonshot and other long-term investments.

Lastly, I'd like to thank the Department and the Secretary for their efforts to respond to the catastrophic situation in Flint, Michigan. Research is clear that the impact of exposure to lead and young -- the research is clear on the impact of exposure to lead on young children. The adverse effects of lead exposure range from decreased academic attainment to increased need for special education and a higher likelihood of behavioral challenges. These impacts can result in a significant decline in earnings, loss in tax revenue, additional burdens to the criminal justice system, and increased stress on our hospital systems.

The opportunity for a strong start is -- to a successful life will be stunted for Flint's children if they are not given necessary resources, including early intervention and the access to high-quality early learning programs such as Head Start to help them overcome the life-long effects of exposure to lead. We need to come up with the money to make that possible and make no mistake.

We should not expect to fix this crisis easy or on the CHIP (ph). In fact, they will cost approximately $1.2 billion to provide long- term comprehensive services to all Flint children exposed to lead just in the areas that cover the programs under this Committee's jurisdiction. Furthermore, it is a moral and (inaudible) imperative to this Committee and the Department continue to examine how federal programs can be responsive to ensure that every Flint youth is receiving the necessary services to mitigate the effects of lead exposure.

The Department's response so far has been commendable. Additional funding for health centers in Flint, Medicaid expansion they'll provide vital health coverage and important health screenings, $3.6 million one-time emergency funding to help Head Start grantees expand early childhood education, health care, and nutritional services. These are examples of targeted federal solutions, but this Committee and this Congress has to do more.

The impact of lead exposure on young children is long-lasting and our response must have a long-term approach. We must use all of the tools available to us starting with prenatal care screening, prenatal care and screenings of pregnant moms, early literacy resources, early interventions to identify special education needs, Title I and Title II funding from the Elementary and Secondary Education Act, afterschool programs, (inaudible) youth prevention programs, even investments in college access efforts.

And know that with all the Department's leadership we can continue to respond to this crisis, and I'm hopeful that together we can put forward real solutions that will help mitigate the damage from the water crisis in Flint, and make sure that young children there get back on track to a prosperous fulfilling life.

So, thank you, Mr. Chairman.

And thank you, Secretary Burwell. I look forward to your testimony.

KLINE:

I thank the gentleman.

Pursuant to Committee Rule 7(c), all members will be permitted to submitted written statements to be included in the permanent hearing record. Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

It's now my pleasure to introduce our distinguished witness. Welcome back to our new environs (ph) here.

The Honorable Sylvia Mathews Burwell serves as Secretary of the U.S. Department of Health and Human Services. Prior to joining HHS, she served as director of the Office of Management and Budget under President Obama and then a whole bunch of other positions in the Clinton Administration. This will be the Secretary's second appearance before the Committee during her tenure at HHS.

Secretary Burwell, I'll now ask you to please stand and raise your right hand.

Do you solemnly swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

BURWELL:

I do.

KLINE:

Let the record reflect she answered in the affirmative.

Before I recognize you to provide your testimony, let me remind you of our lighting system. It's pretty straightforward. It's a green, yellow, red system. The lights are right in front of you.

As in the past, I have no intention of ever dropping the gavel while you are speaking. But I would ask that you try not to go on too long so that members have a chance to engage in the discussion. Members will each have five minutes to ask questions. And as my colleagues know, I am not quite as reluctant to drop the gavel if they are exceeding the five minutes.

And I would ask my colleagues, please don't use the talk for 4- 1/2 minutes and then ask a question that will take her five minutes to respond to. We don't have time for that today because I would advise all of you that the Secretary has a hard stop time at noon. We're going to try to give everybody the five minutes, but we may have to curtail that time if we start running short. So I would appreciate your cooperation.

Madam Secretary, you're recognized.

BURWELL:

Chairman Kline, Ranking Member Scott, and Members of the Committee, thank you for the opportunity to discuss the President's Budget for the Department of Health and Human Services today.

As many of you know, I believe all of us share common interests and that we can find common ground.

In recent legislative sessions, this Committee took important steps to strengthen our workforce and open the doors to new early learning opportunities. Thank you for your leadership in passing the Workforce Innovation and Opportunity Act and the Child Care and Development Block Grant Act of 2014. We look forward to working on both of these in the year ahead.

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

For HHS, the budget proposal is $82.8 billion in discretionary budget authority. Our request recognizes the constraints in our budget environment and includes targeted reforms to Medicare,

Medicaid, and other programs. Over the 10 years these reforms to Medicare would result in net savings of $419 billion.

Let me start with an issue 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 the Department of Health and Human Services. We appreciate Congress' consideration of this important request. This funding will help us implement the essential strategies to prevent, detect, and respond to this virus with a focus on reducing the risks to pregnant women.

I know the rise of opioid misuse, and abuse, and overdose has affected many of our -- of your constituents. Every day in America, 78 people die of opioid-related deaths. And that's why this budget proposes significant funding over $1 billion to combat the opioid epidemic.

Research shows that early learning programs, as the Chairman mentioned, can set a course for a child's success throughout their life. And that's why over the course of this Administration, together with congressional support, we've more than doubled the access to early Head Start services for infants and toddlers.

Our budget proposes a total of $9.6 billion to the Head Start program and an investment in child care services that would allow us to serve over $2.6 million children. And beyond this budget for the children in Flint, Michigan, we have already announced $3.6 million as Mr. Scott mentioned in one-time emergency for Head Start money. With these funds, they can expand early childhood education, behavioral health services, and other vital nutrition services.

Today, too many of our nation's children and adults with diagnosable mental health disorders don't receive the treatment that they need. So this budget proposes $780 million in new mandatory and discretionary resources over the next two years to close that gap.

While we have invested in the safety and health of Americans today, we must also relentlessly push forward on the frontiers of science and medicine. And this budget invested in the Vice President's cancer initiative, today we're entering a new era in medical science. We have proposed increases of $107 million for the Precision Medicine initiative, and $45 million for the Administration's BRAIN initiative. We can continue this progress.

In order for Americans to benefit from our recent breakthroughs in medical science, we need to ensure that all Americans have access to quality affordable health care. The Affordable Care Act has helped us make historic progress.

Today, more than 90 percent of Americans have health coverage, the first time in our nation's history that that's been true. The budget seeks to build on that progress by improving the quality of care that patients receive and spending dollars more wisely.

It proposes investments to improve the access to care for underserved groups across the United States, including many and rural communities with $5.1 billion in health center funding and nearly $14 billion over the next decade for our proposed for our nation's health care workforce. By

advancing and improving the way we pay doctors, coordinate care, and use health date and information, we build a better, smarter system.

Finally, I want to thank the employees of HHS. In the past year they fought Ebola in West Africa, helped millions gain health coverage, and have done a quiet day-to-day work that makes our nation healthier and stronger. I'm honored to be a part of the team. And as members of this Committee know, I'm personally committed to working closely with you and your staff to find common ground to deliver for the American people.

Thank you.

KLINE:

Thank you, Madam Secretary.

It's close to a record of seven seconds over five minutes. Well -- well done. Thank you. Thank you very much.

I mentioned in -- in my opening remarks that we are concerned about the recent Reuters investigation into the abuse and neglect of children or in the families battling drug addiction. And there's a law, CAPTA, that falls under your Department's jurisdiction.

We sent a letter to you asking for information. The Department responded and we thank you for that. But currently we still have a problem out there, it seems to me.

Congress has taken steps to streamline the application process, but the application still goes through the Children's Bureau at the Department of HHS where they review states' applications and sign off that it's adequate before federal funds are dispersed.

So I -- I know you've looked at this. Do you feel like that within the law the Department is doing everything it can to ensure the states are upholding the law or these are more that should or could be done?

BURWELL:

So, when these issues were raised, some of the issues raised in the Reuters articles, we've gone and followed up on the examples that were raised. And right now the state of South Carolina is being put on a performance improvement plan, so specific actions are being taken where we have found that there is wrongdoing. And that's in terms of when things are brought to our attention.

As part of this process of review, we've also put in place a different process to review what the states are saying. When they say they have a plan in this next year's round, we will be asking for more details of those plans so that we can understand that the states actually have something that is a workable plan so we have taken steps in terms of where we understand there is something wrong and trying to get in front of it by making sure we do a different process with regard to review of the plan.

The other thing I would just say is it will be an important part of the administration for children and families as we review their budget.

KLINE:

OK. That -- that is a change to the practice...

BURWELL:

It is a change.

KLINE:

... that's going on.

BURWELL:

It is a change.

KLINE:

We will be watching with interest. It does seem to us that -- that there need to be a way for the Department to be able to confirm that the states are doing -- supposed to be doing without waiting for somebody to come and complain.

BURWELL:

Which is why we've taken that step to do it in a more proactive fashion with the proposal, so we look forward to the Committee's support for the administration for children and families as a part of the budget process that we're able to enforce and do, I think, what the Committee rightfully is raising.

KLINE:

Thank you.

We just passed and the President signed into law the Every Student Succeeds Act. Took six or seven, or eight, or 12 years or something to get to it and through it, but it is done and it's the law. And under the Act, as I mentioned in my opening remarks, the Act now authorizes a preexisting program known as the Preschool Development Grants program.

Your Department now has the lead in that under -- under the law with respect to funding authority and responsibilities. And as I mentioned, it seemed to us that was clear because you already have billions of dollars in preschool funding for $9 billion in Head Start alone.

We believe that Congress specifically limited federal interference and state early childhood systems to maximize state and local control over the improvement or development of the Early Childhood Systems. So, given the language of the law and what I think are clear protections in the law, what -- what are you doing, where are you in the process in affecting that transition from the appropriated but not authorized program that was in education and is now authorized and will be appropriated, I'm sure, program that's in your jurisdiction?

BURWELL:

So, the transition I statute will occur in 2017 not in this fiscal year. Right now we are working with our colleagues at the Department of Education to actually formalize the relationship between us. We're going to do an MOU, a memorandum of understanding to formalize the way that we incorporate the best practices from education and their input as we integrate this program into the continuum.

I think you know, at the Department, we have home visiting. We have early childhood. We have early Head Start. We have this program. And so we will integrate across the continuum, having the Department of Education be a contributor, and we've decided to formalize the relationship.

KLINE:

I'm -- I'm very pleased to hear that, and it is because you're involved in all of those programs, and you have that continuum that it made sense to many of us to put this program there so it can be managed all together.

I'm going to try to set the example for my colleagues and yield back the balance of my time. Pay attention please all.

And, Mr. Scott, you're recognized.

SCOTT:

Nice try.

(LAUGHTER)

Thank you, Madam Secretary. Much has been made about the increasing cost of health care. Can you tell us briefly how the increases in health care costs now compared to what they were before the Affordable Care Act?

BURWELL:

So we have some of the lowest levels of Medicare growth on record that we've had since the passage of the ACA and the implementation. And so that's been a very important part. We've seen four of the five lowest years of growth in Medicare spending, and that's important for the taxpayer and for the federal budget.

With regard to employer-based care, and that's the care that the vast majority of Americans have in this country. Last year, the increase in employer-based care was around 4.2 percent in terms of the premiums. When we look at the period from 2000 to 2010, that number was 7.6. So what we see is a decrease in the premium growth cost for those in the employer system.

With regard to the marketplace itself and the individual market, last year in the marketplace, the premium increases averaged in about the seven percent range. And what we know is before the Affordable Care Act, in the individual market, premium increases were regularly in the double-digit space.

So whether one is looking at employer-based care, Medicare, which I know we are all concerned about from a taxpayer perspective or looking at the marketplace itself, what you see is slowing in the growth of health care cost. It brings us to slowing, but still increasing, and that's why I believe we need to spend a lot of time on delivery system reform and reforming the way we provide quality care at more affordable prices. And I hope we'll be able to talk about that some today.

SCOTT:

And how much more do people with preexisting conditions have to pay?

BURWELL:

With regard to the pre-existing, and I think this gets to the quality portion of what I was just talking about. In the system today, and I think everyone in this room knows someone who has had cancer or has asthma or some other condition, for all of those individuals, they no longer need to worry that they will either be cut-off from their care or not be able to access the care.

And I've had the opportunity to travel around the country and meet those people who previously did not have that opportunity. And so making sure that those with preexisting conditions can no longer be discriminated is a very important part of the progress on quality of care that we've seen.

SCOTT:

Do the people with preexisting conditions have to pay any extra?

BURWELL:

No, they are neither kept out nor do they pay extra in terms of what they would pay in their premiums.

SCOTT:

And can you say briefly how the failure to expand Medicaid in some states affects those who have insurance?

BURWELL:

With regard to how that impacts those who have -- have insurance, it comes in the form of uncompensated costs, so the work that we have done and we have seen about a $7.8 billion reduction in uncompensated costs since the passage of the implementation of the Affordable Care Act.

The vast majority of those benefits are going to the states that have expanded Medicaid. And what that means is that reduction in uncompensated care gets translated through the system and it gets translated to the system to individuals and to hospitals and communities.

We know that now in terms of rural hospital closures, which are something many are concerned about, we see more of those rural hospital closures in states that have not expanded, and this is because of the uncompensated care issue. So it flows into individuals, it flows to communities, and it flows to hospitals.

SCOTT:

Thank you. Disasters can happen anywhere, and if one -- if a disaster would happen in one of our districts, we could look at how you respond to Flint, Michigan to see how you would respond in our areas. Can you say what you're doing in Flint, Michigan for that disaster particularly in Head Start?

BURWELL:

So the President asked the Department of Health and Human Services lead the federal response, which we are doing. And so we are coordinating the responsive team on delivering water, SBA making sure that loans can get through, HUD helping housing get different pipes into public housing, and then the work we are doing.

You mentioned our Medicaid expansion as well as our Head Start work. The Head Start work we have done, a $3.6 million addition to expand both coverage and services, and that is because a lot of what you do to mitigate lead has to do with education and nutrition.

Our colleagues at USDA are working very closely with us as well on the nutrition component and put in place an ability for mothers to use WIC money to do formula that was not water-based because obviously that was a problem for those children focused on the zero to six.

SCOTT:

Does the Zika request include research?

BURWELL:

Yes, it does and I hope we will have more time to discuss Zika. I just got the report today and four U.S. citizens were over 450 million cases, and I hope we'll have an opportunity to discuss that more.

KLINE:

The gentleman's time has expired.

Dr. Roe?

ROE:

Thank you, Mr. Chairman.

Thank you, Madam Secretary, for your pushing the rule for the end of life counseling. That's a huge thing. I've heard a lot of positives about that. I want to thank you for that.

Just a couple of quick questions. Stop-loss insurance regulation, as you know in the private sector, fully a majority of those plans are basically self-insured plans like we had the city of Johnson City where I was a mayor. We used stop-loss insurance to protect our losses if they went above what we calculated they might be.

Would you commit to the Committee not regulate stop-loss insurance as health insurance because it's clearly not in the future as the secretary of HHS?

BURWELL:

I want to understand exactly what the regulations and what the laws are. I apologize this is one I'm not familiar with, want to look into it, and we will get back to you in terms of how we think about that issue.

ROE:

OK. Thank you. And just for the record, our -- our increase in the -- in the marketplace in Tennessee was over 30 percent this year.

A couple of things on meaningful use and electronic health records, as you know, physicians are struggling to meet the meaningful use. On full disclosure, the primary care group I was in have over 100 physicians. And we have met one of the 12 percent in the country. They have met that and about 40 percent of hospitals in stage two.

Why would you go to the penalty phase of stage three this year, which -- which I think you're going to do when 80 -- 80 plus percent haven't met stage two yet. So you know that the doctors and the providers' hospitals and the physicians are going to be cut. Why don't you just put it on pause for a year until they can get the systems up to help them trying? I mean, they're out there trying to do this day and night, so why don't you do that?

BURWELL:

I think what we...

ROE:

(inaudible) pause for a year.

BURWELL:

... I think what we've tried to do is hear the concerns that have been expressed. And I think you know in the rulemaking that we recently put out, we want -- we are working to also include the legislation you all recently gave us on MACRA, and that -- transferring to that system that we have been given legislatively to work through that.

And so working to make sure that we can get to the place where we are listening to providers continuing to (inaudible).

ROE:

That's what I'm hearing out in the real world is that you're not listening, and that's a concern because they're going to get the penalty phase this year. So, I -- I appreciate you working on that. But what I think I'm hearing out there in the real world is we're trying the best we can to comply with these things, but there are so many things with electronic health records and so forth. And I say this jokingly about the electronic health record, I think, made me a congressman not a doctor anymore.

So, a couple of other things I want to go through very quickly is -- and I wrote you a letter about the breast cancer screening guidelines. I appreciate you putting that on hold for two years.

One of my partners in practice, if he had followed the guidelines, 20 -- one doctor in one practice, 24 patients would have fallen to the cracks and not been picked up early -- 24 breast cancer, one doctor.

The other I want to mention is the PSA screening. We have now the United States Preventive Task Force Services, which had no urologist and had no oncologist on it, made a recommendation that that was absolutely should not be done. And you, as a Secretary, are going to penalize a primary care doctor if they order a PSA regardless of the patient's family history, regardless of their race, and regardless of their symptoms essentially. So, I want to know.

And -- and last night I got a call from someone who had a PSA of two, 59-year-old man, had a just -- got out of the bathroom one time at night, went to his doctor. His primary care doctor ordered -- previously ordered another one ignoring these guidelines. It was three. He said, "We better check it again in 90 days." It was 5 point something then; sent to urologist. This man has prostate cancer at 59. He would have been missed by these guidelines and might have died.

I think -- I think these guidelines are going to cost people their lives, and I think we need to seriously step back and take a look at them at least let the science get worked out before you penalize a primary care doctor for not -- for ordering a PSA, a test that is not perfect, but it is an adjunct to clinical history and other things.

I would strongly encourage you to do that. This was last night. I don't know how you would answer that patient's family when that -- that patient would very likely have died had they followed these guidelines.

Another issue I want to just bring up briefly, an affordability of health insurance. I'm in a billion dollar health care system at home where I practice. Sixty percent of the uncollectable debt in that hospital are people with insurance. And the reason to make these plans affordable we've increased the out-of-pockets and copay so high that people can't pay those, just average normal people in rural America where I live.

And the last comment I want to do, we mentioned this last year in rural America where I live, what's killing our hospitals and Medicare is the Medicare wage index, which is very unfair to rural areas. We get 0.74 cents to what another place might get $1.5. And I'd like to hear you on that. I want to work with you.

With that, Mr. Chairman, I yield back.

KLINE:

I thank the gentleman.

Mr. Hinojosa?

HINOJOSA:

Thank you, Chairman Kline and Ranking Member Scott.

I support President Obama's fiscal year 2017 budget for the Department of Health and Human Services because the Administration's priorities, or HHS, support the well-being of all Americans and are closely aligned with the needs of my congressional district.

Madam Secretary, it's a pleasure to have you testify before this Committee. And I want to ask the Chairman that as a member of this Subcommittee, I ask unanimous consent that the three pages of my opening remarks be included in today's report.

KLINE:

No objection. I'm sorry.

(LAUGHTER)

I'm blaming it all on the Ranking Member here.

(LAUGHTER)

HINOJOSA:

Thank you, Mr. Chairman.

Madam Secretary, as you know, the state of Texas did not expand Medicaid and that has hurt us a great deal. I'm pleased to hear of your efforts to incentivize these vital programs. In your view, why is it important for states to expand Medicaid?

BURWELL:

So, the Medicaid expansion issue, I think, has two different elements to it. It has the element of the individual and it is about providing financial and health security for the individual.

In the state of Texas, over 40 percent of those who would be eligible are working folks. And so for many working people, making sure that they can have both that financial and health security is a very important thing to their individual well-being. Separately, there is the issue of what it means economically to hospitals and to the states.

We know that in the state of Kentucky, what we've seen in terms of an analysis by Deloitte as well as the University of Louisville, that until 2021, 40,000 new jobs would be created in Kentucky and $30 billion would flow into the state of Kentucky. And so it is an economic issue in a broader sense, but it's also about the individuals on how their lives can be changed. And...

HINOJOSA:

Thank you.

BURWELL:

... certainly as you reflect, we have a budget proposal to try and keep encouraging states to come in.

HINOJOSA:

Thank you. (inaudible) engagement and involvement has been one of the most critical, if not the most critical part of the Head Start program over the last 50 years. This holistic approach ensures that children are ready for school. How does this proposed rule for Head Start strengthen parental involvement?

BURWELL:

So, Head Start, and I think you know I am a Head Start kid. It has been a successful program for many, many years. And certainly not just my professional opinion, but my personal opinion.

But the issue of the inter-generational part of this, and Mr. Scott referenced it in his opening testimony, is an essential part and it's essential both to get the full benefit of the program. And as we work forward, that is what some of the changes that are in the proposed rule. And it's everything from making it easier.

In the current rule that's there, one-third of some of the requirements are cut-out in trying to get to simplification, to make things easier for parents and easier for providers so that they can engage and participate.

As a parent of a six, seven, and eight-year-old, I am very clear about the engagement and what it means in terms of children's well- being and also having quality places for your children to be in terms of your ability to focus on your work, so it's about (inaudible).

HINOJOSA:

Thank you for that clarification. Thank you.

Madam Secretary, helping children and young people will qualify for help through DACA, Deferred Action for Children (sic) Arrival is very important to my region because I have such a large number of students K-12 who qualify. What does your proposal -- the priorities in your proposal? How does that help them?

BURWELL:

With regard to the DACA issues, I'm afraid I will most likely need to defer to my colleagues at Justice who -- and DHS who are much more engaged in those issues.

With regard to the programs that are available, I think you know that the health centers throughout the Department are important part of health care for people who do not have coverage or coverage access any other way.

HINOJOSA:

Thank you.

Secretary, the ACA has been instrumental in increasing access to health care for residents in my district and across the nation. What can communities such as mine do to increase participation in ACA's health insurers, marketplaces? And what are some of the best practices that you can share?

BURWELL:

So, open enrollment, I would just remind everyone November 1st through the end of January next year. And preparing for that open enrollment is a very important thing because it is about the communities' engagement.

Having visited communities all over the country, what I see are stakeholder groups and groups that have come together -- the hospitals, the insurers, all kinds of local community groups come together and make sure that the information is there, and that people have a place to go.

I visited -- in the state of Texas, there are some great United Way 211. You just dial 211 and you're able to get that kind of access of great care. HINOJOSA: Madam Secretary, in my district, uninsured was 40 percent before ACA. Today it is only 18 percent, so we've made great progress. Thank you.

BURWELL:

Thank you.

KLINE:

The gentleman's time has expired.

Mr. Byrne?

BYRNE:

Thank you, Madam Secretary. I want to talk to you about the transitional reinsurance program and some current concerns that I and others have about the legality of the way these funds have been used.

We're going to put up on the screen the actual text of the law that you see there now. And I also have here the same legal memorandum that my colleague, Chairman Pitts showed you two weeks ago when you testified before the Energy and Commerce Committee.

The non-partisan Congressional Research Service, which put out this memo, analyzed this issue and stated -- I'm going to quote them -- "Insofar as CMS interpretation allows the entire contribution of an issue on any given year to be used only for reinsurance payments such that no part of it is allocated for the U.S. Treasury contribution, and that would appear to be in conflict with a plain reading of Section 1341(b)(4) -- that's the language up there -- because the statute unambiguously states that each issuer's contribution contain an amount that reflects, quote, "its proportionate share," close quote, of the U.S. Treasury contribution.

And that this amount should be deposited in the general fund of the U.S. Treasury a contrary (inaudible) interpretation would not be entitled to deference under the chevron decision. We have that second piece of language up there now.

So, you've had two weeks. That's -- Chairman Pitts brought this to your attention. You have the legal memorandum. I assume you've had a chance to go over this with your staff and your counsel. You would agree that you didn't put $5 billion in the Treasury if you require to. My question now is do you now not agree that you violated the law and not putting the $5 billion with Treasury.

BURWELL:

We believe that our reading of the law is accurate and correct. And as we put out...

BYRNE:

Would you give me the...

BURWELL:

... may I -- may -- yes?

BYRNE:

... would you give me some authorization for that?

BURWELL:

Yes. What we did was we actually put out our reading of the law in a notice of proposed rulemaking or public comment. We put out our logic. We put out our reasoning to the public to review our proposal not in an interim final rule, but in a notice of proposed rulemaking so that we could have comments.

A wide range of groups commented on our rule as is regular practice. No one raised any concerns about (inaudible).

BYRNE:

Madam Secretary, let me take my time back on that. Whether they commented or not, the law is plain on its face. It doesn't matter what you think or somebody outside of your department thinks. If the law is plain, you don't get to interpret it any other way. And the non-partisan Congressional Research Service says that you directly contradicted the law in your -- the way you actually carried it out. So you're saying now that because you put it out in comment that you get to interpret it anyway you want to despite the plain wording of the statute?

BURWELL:

What I am suggesting is that we believe our reading is accurate. The public had an opportunity to point out if they thought it was inaccurate. That was not done. And we believe that our reading of the law is accurate.

BYRNE:

Well, Madam Secretary, let me just say this. The non- partisan Congressional Research Service directly contradicts you. They say that you read it completely wrong and that you clearly, clearly violated the law.

Now, there's a lot of concern in America right now about the anger among the electorate. I just came through a (inaudible) a few weeks ago. The electorate is angry. They're angry because people of position's responsibility like you violate the law. You violated the law that non-partisan Congressional Research Service has said that you violated the law. And here we are today with some excuse that you put it out for comment.

The fact is you put it out for comment does not relieve you of the responsibility to enforce the law as it is plainly written. It is plainly written. There is no wiggle room around this.

The fact that you have had two weeks to look at this and you can't offer me any legal authority for what you did tells me that you just decided or your staff decided, "We're not going to put the $5 billion in the Treasury as we are required to do by law."

BURWELL:

Congressman...

BYRNE:

And I can tell you my constituents and the people around the United States of America are sick and tired of that. So if you want to provide to this Committee at a later date, whatever your legal staff wants to provide as whatever legal basis for the -- for their interpretation that's fine, but tell I made that you put it out for a notice in comment does not answer the question as to how you get around the clear, clear requirements of this law. And it's not just my interpretation that -- that I'm going on here.

I'm going on the interpretation of the non-partisan Congressional Research Service. I appreciate you're telling us what you told us here today, but it is not an answer. And I hope you and your legal staff, after this is over, we'll put something together and send it back to us. And I yield back.

BURWELL:

Congressman, I would like to reflect that what I said was we have put out our legal argument. I understand and respect that there is a disagreement in the interpretation of the law.

What I was saying is we have articulated why we believe our reading of the law is correct. Not only have we articulated that through communication, we did it in a very public way. We believe our reading of the law is correct.

And I would also reflect that with regard to this and this particular issue, there have been 71 I.G. and GAO investigations in terms of the question that you're raising about we are working hard to implement the law. There are three open. There have been other -- 100 examinations.

And with regard to what I am hopeful that we can get to the place where we can have the conversations about how to control costs and improve quality in this country and our health care system. That's what we're working to do...

KLINE:

Madam Secretary, the gentleman's time really has expired, and we won't get to any of that if we don't try to stay within the five minutes.

Ms. Davis?

DAVIS:

Thank you, Mr. Chairman. And good to have you with us...

BURWELL:

Thank you.

DAVIS:

... Madam Secretary.

I wanted to -- to really go to one of the areas where, as you said, we're trying to create a smarter system. And in that regard, I think there has been some early success of the diabetes prevention program. We've seen evidence that really is common sense. I think that if you speak to the need for providing better nutrition, exercise training that you're going to see a reduce on the onset of diabetes. And we've seen that particularly in seniors.

So I just wanted to mention that there is bipartisan legislation to expand the diabetes prevention program to Medicare. There have been numerous pilots to demonstrate that that really can have a demonstrable effect on saving lives as well as cutting costs. So, I am hoping that you can take a look at that as well, how can we work to expand that.

I'd love to see all my colleagues come together on that legislation, but there may be some other tools that we have as well. And so I hope that you'll take a -- take a look at that.

I wanted to -- to shift quickly to early childhood because that's an area that you're going to be working heavily in as -- as we go forward and certainly reflected in the legislation. The transition is in 2017. But I know that within that legislation there is a call to expand the length of the school day among other requirements.

And I'm wondering what you're doing, what the staff is looking at now, how are we going to move forward with that while at the same time, being certain that we're taking the quality the same or at least better, maintaining quality, and -- and certainly finding ways that, you know, we hit the bar of lengthening, but we're not losing some of the other ingredients that make up such a successful program.

BURWELL:

So as part of our Head Start rulemaking right now, it is an open rulemaking. So with regard to what the conclusion will be, not something that I can comment, at this point in time we're reviewing a number of comments in -- in different places.

It does get, I think, though to a little bit of the of the Chairman's comment at the beginning about making sure we're continuing to make strides so that the benefits of these programs are known for the children in the short-term as well as the long-term in terms of that third grade level in some of the research that we've seen.

One of the suggestions of that research that had some questions was the question of lengthening of time, the time there makes a difference to the child's ability to gain and retain what they need in order to build the building block, especially that critical point in the third grade where we really need them reading in a way that it will take off the (inaudible) using the reading for learning when they get to the third grade.

So, the time issue is related to the quality issue that the Chairman had raised earlier.

DAVIS:

Well, I appreciate that. I know that what we don't want to see is enrollment have to drop as a result of that, so that's a big concern.

The other one is regarding homeless children. And in San Diego we -- we certainly have a number of children who come in and out of the school year. How will then -- and again as you're working on the rulemaking -- can we provide for spaces for children who may be in and out of the program and be sure that we guarantee that they have a spot when, in fact, they present and that they need to be part of that program?

BURWELL:

I think it has two elements to it as we continue to think about the issue of making there's flexibility for those children, but also working deeply on the issue of homelessness as well so that you're addressing the problem for those that are taking on that issue.

And I have -- at the beginning of this year, I became the chair of the United States government's Interagency Council on Homelessness. And because of the work that we actually share, this Committee and the Department, we will be focusing on homelessness as one of the main priorities. We'll continue the work on veterans homelessness because great progress has been made, but we

want to take that next step. So working on flexibility within the programs, but also trying to get to the root of the issue we will engage in.

DAVIS:

Yeah, thank you so much because I know that in terms of visibility of young children's lives, it's key that they're in a program and they can count on that when their family is moving and not as -- not stable and that's -- that's important to them.

And very, very quickly, just on one other issue, in the Administration for Children and Families, the plans to provide about $9.5 million in demonstration grants to help prevent USEC's trafficking. And I'm wondering if you could just speak briefly to how you expect states to utilize these funds.

BURWELL:

You know, I think this is a place where different states are going to use different tools based on their problems and their approach to those problems. This is also a place where our regional offices are engaging directly with the communities.

DAVIS:

Thank you.

KLINE:

The gentlelady's time has expired.

Mr. Curbello?

CURBELLO:

Thank you, Mr. Chairman.

Madam Secretary, more than 4,000 foreign children and adolescents have resettled in Miami Dade County in fiscal year 2015, and 937 more in the first quarter of fiscal year 2016. Foreign-born students at an average of $2,720 in extraordinary cost to local school districts above and beyond the per people state reimbursements.

The numbers of refugees especially Cuban refugees has increased substantially in our community. The estimated number was over 4,000 last year and it's expected to be on a similar pace in the current year. However, this can be an understated number because many parents are emigrating without their children and their children joined them later once they have adjusted their status.

This presents a problem because the late-arriving children of refugee parents do not count under refugee data, but they still represent a major cost to local communities.

Since school districts are barred from inquiring into immigration status, is there a proxy measure for school-wide services that can be used to determine the actual impact of the significant influx on affected school districts?

BURWELL:

You know, I apologize, but I'm going to need to defer to my colleague at the Department of Education with regard to how those measures would be done in schools. I apologize. Our role, I think, you know is with the parent says they come in in terms of the Office of Refugee Resettlement, so I apologize. But we can get that to my colleague.

CURBELLO:

OK. Well, let me ask you, what is HHS doing, if anything, to address the recent increase in foreign-born students that are challenging communities like ours? How can we help school districts like Miami Dade County serve these students?

BURWELL:

You know, with regard to our role, I think one of the things that we can do is make sure that those transitions of the individuals, the Office of Refugee Resettlement, which is a part of HHS, the thing that I think we can do is make those resettlements as successful as possible. And part of that success, I think, is making sure that they become employed members of communities because at that point then, you know, our contribution can be making sure that they are engaged, employed, and contributing members of the community in terms of employment in Texas so that that then is a part of the regular system.

With regard to other issues, again I will defer to my colleague at Education.

CURBELLO:

So let me ask you also because this is a critical issue for our community. And as you know, in the platform as a service year we've seen over 50,000 or close to 50,000 Cubans resettle in the United States. And the Miami Dade County School District and Monroe County schools, for that matter, obviously carries a heavy burden.

Does -- do you know of funding from the Cuban-Haitian Social Services set aside? Can the school districts draw from those funds to mitigate some of the impacts on the -- these school districts?

BURWELL:

I'm not familiar with that, I can. But why don't we go back and check? I'm happy to get back to you on that issue.

CURBELLO:

OK. Well, this is just a critical issue for our community, Madam Secretary. And I hope to work with you and with your Department to find ways, to find more support from Miami Dade County. This is another case where a local community faces the results or the consequences of what I believe is a flawed federal immigration policy, a flawed federal refugee policy in this case.

And I think it's incumbent on the federal government to help communities, like ours, solve these problems because it's unfair for all of these costs, for all of the burden to fall on local school districts and on local municipalities.

Thank you, Mr. Chairman. I yield back.

KLINE:

I thank the gentleman.

Mr. Courtney?

COURTNEY:

Thank you, Mr. Chairman.

And thank you, Madam Secretary, for your outstanding service. Your portfolio is about as complex and broad as -- as any in government. And your -- I think you're doing an outstanding job, so thank you.

BURWELL:

Thank you, thank you.

COURTNEY:

In your testimony, in page 11, you talked about the heroin opioid component in the President's budget, $1.1 billion. And again it's allocated to help law enforcement treatment, prevention, and education, which is what I'm hearing back home in my district 28,000 people lost their lives to accidental overdoses, as you pointed out in 2014. That's a 14 percent increase from the year before.

2015's numbers aren't going to be any better, and I know that because in Connecticut we saw a 20 percent increase in 2015's numbers by the Office of Medical Examiner just a few weeks ago.

Director Botticelli was up in Eastern Connecticut talking to folks who are in the front lines on this. And, you know, what's -- what's striking is that, you know, police and law enforcement are totally engaged in doing their job, but they are the first to say you can't arrest your way out of this problem.

Emergency room providers who are saving lives with Narcan are frustrated because there's not enough detox beds and treatment beds, so there's a revolving door for a lot of these folks who are addicted and have no place to go after they have been revived. And -- and the medical provider

community is ready, I think, to talk about reforming the prescription -- overprescribing of pain killers.

What I think is of concern is that again you -- you just released new funding to -- through HRSA to community health centers, which is much appreciated. But there's no request for emergency funding this year. And when you look at Zika and you look at, you know, OCO, I mean, what Mr. Kline and I are going to be voting on billions in emergency funding for our overseas military operations and the Armed Services Committee.

But, you know, when we look at a problem, we're -- we're losing 28,000 people a year. You know, Senator Shaheen and myself have a bill to -- to sort of, you know, move that push to get resources into -- into this year, which is so obviously needed.

I just wonder if you just sort of talk about your perspective on that and -- and, you know, the Administration's willingness to work with us who -- who really want to get folks who are on standby, ready to -- to help be a solution.

BURWELL:

So, the issue of the treatment and treatment opportunities is why we -- that's the biggest part of the money, the billion dollars that we've asked for. It's about treatment and I think all of you know in your communities as you visit.

Behavioral health is something that was paid for at the community level, and so it's never been built-up. And now we have a very acute problem with people dying, but know as your law enforcement reflect -- every law enforcement I talked to, they tell you I am not a social worker or a health worker. And so that is why it is so important, critically important that we get funds to move because those funds move to the states and the communities...

COURTNEY:

Right.

BURWELL:

... to get that treatment.

The other parts are very important. But without the treatment we now have a bolus of people who are addicted sadly. You know, I -- I wish that that weren't the case. We need to prevent anymore, but we got to take care of that, which we have.

And right now, Narcan or preventing an overdosed death is not the only solution. If people are in medication-assisted treatment, we can make progress. So that's why we're pushing hard. We appreciate your leadership and others in terms of trying to make sure we get that funding for the treatment.

The funding will also go to other issues as naloxone getting an access to people because not all -- I'm sure you hear this in your communities, not everybody in terms of first responders have access.

We have also worked at FDA. They have approved the nasal approach, which will be easier for others to use that don't have to be a trained first responder to do that. So we'll work across, but the money for treatment, which I think is what you're focused on right now is an essential part of getting to another place in this crisis.

COURTNEY:

So the Senate -- again, you know, sort of went partway there last week in terms of the...

BURWELL:

Yes.

COURTNEY:

... Comprehensive Addiction and Recovery Act, but again it's authorizing legislation without resources. And as -- I remember Congressman Kildee used to say, "An unfunded authorization is kind of like a get well card to somebody who is sick." It doesn't really, you know, fix the problem.

And -- and again, that's where I -- I think the HRSA funding that was out last week is getting, you know, to the House on fire that's -- that's happening out there. But again I -- I -- the budget priorities are totally on target as you said. The question is timing right now because this -- this issue is accelerating and intensifying. And -- and I hope all of us are going to work together because it affects every district -- you know, rural, suburban, urban. It's hitting veterans who, you know, again are -- because of service-connected injuries, you know...

BURWELL:

(inaudible).

COURTNEY:

... this -- this should be an easy one for us to work together on.

BURWELL:

Yes. And, you know, they fire alarm. We've sent -- you know, this is seven-alarm fire and we sent, you know, one department. We need seven or eight others to -- to get to the real issues and the problem.

COURTNEY:

Thank you. I yield back.

KLINE:

The gentleman yields back without mentioning basketball.

Ms. Stefanik?

STEFANIK:

Thank you, Mr. Chairman.

First, I want to echo my friend and colleague, Mr. Courtney's statements that heroin and opioid epidemic is an issue that I've been focused on in my district. And I look forward to working with you on that issue.

Thank you, Madam Secretary, for being here today. Just shifting gears, I think we can all agree here that we need to make sure that our seniors receive the best care possible. And in order to do that, we must accept that there are differing needs across this country.

The Older Americans Act is an important law that helps seniors remain in their homes and out of expensive institutional care. And as you know, what -- what may work for seniors receiving meals or care in urban areas is likely to be inadequate to the unique challenge facing rural areas such as the district I represent in New York's north country where we have one of the highest concentrations of seniors in New York State.

One of the hallmarks of the Older Americans Act is the state and local control provided through the structure of the Aging Network. And this is a great example of legislation that understands one-size- fits-all does not always work.

Can you speak to how this structure is important to meeting the needs of this nation's elderly and what we will do to continue the successful model?

BURWELL:

Yes. And thank you for your leadership in terms of the reauthorization we think is important to continue.

I think what you're reflecting is we need to make sure we maintain the flexibility for states because it is in very wide variance in terms of what it means to serve that community and serve that community well. And so we want to continue.

We think the reauthorization doesn't need major changes but some small changes, but some small changes that can help us with making sure that we're using the best data and evidence that we have, which is based on some of our learnings that different things are working in different places, and keep that flexibility in place.

I think you know in this budget that's before us, even without the reauthorization, we have some funding increases in particularized area. And whether that is protecting against elder abuse and how that's done in rural areas versus urban areas protecting in that space as well as some of the food programs that you mentioned, but we want to work across the spectrum of needs and work with those communities on what their priorities are.

STEFANIK:

Great. Thank you for that, and I yield back.

KLINE:

The gentlelady yields back.

Mr. Polis?

POLIS:

Thank you, Mr. -- thank you, Mr. Chairman.

I want to thank the Secretary for joining the Committee today, and I want to thank her and the administration for putting forward a budget that reduces our deficit, make some important investments in health and education that our country needs.

I applaud the work of Department of Health and Human Services for working to implement the Affordable Care Act. Congratulate you on the especially successful 2016 third quarter enrollment period and 4.9 million new customers in the federal exchange.

Madam Secretary, you've seen firsthand, of course, the positive effects of the Affordable Care Act. I know at my home state of Colorado, 16.5 percent of people lacked health care insurance before the Affordable Care Act. And last year the number upheld is 6.7 percent, a historic low.

I am concerned, however, about how the geographic rating areas for each state can skew the cost of health care. My constituents in Grand County, for example, face among the very highest premium increases in the country. Their premiums went up 20 -- at least 25 percent this year. How can the department -- how -- and they pay, by the way, nearly twice as much as other Coloradans for insurance. How is the Department helping the states to guarantee that families and individuals who live in the rural mountain communities are able to access high-quality care at a reasonable cost the way the Affordable Care Act intended?

BURWELL:

So, one of the things that's important in both the employer-based market as well as the individual market is the fact that the Affordable Care Act actually put out-of-pocket caps in terms of what people will spend. And that's another important benefit getting to quality and affordability that we haven't touched on. And I think that's important. With regard to the other issues in terms of the

Affordable Care Act and the steps its taking to work on places where, I think, it's fair to say that in our country there are pockets such as that what you have described and, in some cases, states such as the state of Alaska where a market isn't working in terms of creating the amount of competition either in providers or insurance companies to put downward pressure on price.

And I think a part of that is why some of the changes that came in the Affordable Care Act that help us with delivery system reform and some of the work we're doing in the innovation centers to create models that people can use to have that downward pressure. So there are two parts to it. It's focusing on specific markets themselves where the problems exist, but then overall as a nation figuring out the steps we need to take to put that downward pressure.

And our accountable care organizations we've already seen hundreds of millions of dollars of savings. And while the statutory level that you all gave us is very high to meet success before one can replicate. We have met that and believe and are now in a phase two of that. So it's about regional and retail strategy, and then a strategy across the nation.

POLIS:

And has some states rolled out single geographic rating areas for their entire state?

BURWELL:

I'll have to go and check. I think...

POLIS:

Because that's something we might be able to...

BURWELL:

I will check. I...

POLIS:

Thank you.

BURWELL:

... (inaudible) answer that, but I don't want to give you an incorrect answer.

POLIS:

Sure.

BURWELL:

So we'll come back on that.

POLIS:

The transition to Head Start, of course, I'm a firm believer in the benefits of Head Start for kids and communities. And in my district, in my state, we also have many high-quality charter schools that serve at-risk kids.

Public charter schools have the autonomy to offer a unique curriculum. Many students and parents used to take advantage of that, and Denver public schools about a quarter of the kids attend public charter schools.

And you know Head Start grants are giving the nonprofits, community centers, sometimes traditional public schools. But to my knowledge, no charter school has received Head Start grants and a few have applied. Can you talk about what your agency is doing to clarify guidance and do outreach so that high-quality charter schools know that they are eligible for Head Start grants and understand how to meet the Head Start requirements so they can offer those services for families?

BURWELL:

Out of conversation last year this is something that we have followed up on and are issuing, hopefully, clear guidance. I think we believe it's possible and people can do it, but clearly I think you reflect that people don't understand that charters can do it. So we are issuing guidance to make that clearer and then we'll work to implement that so people can know what process they need to do to do it because we think it is quite possible and people can do it.

POLIS:

Thank you. I also wanted to briefly address transgender health. I've worked closely with my colleagues in the Equality Caucus, Representative Takano, Representative Pocan, also on this Committee. HHS proposed a rule to implement the non-discrimination provisions of the Affordable Care Act that would prohibit discrimination on the basis of gender identity.

When can we expect a final rule? And are there improvements from the proposed forum to the -- to the final rule, which is so important to the LGBT community?

BURWELL:

Because it's an open rulemaking process, I won't be able to talk about the specifics of the final rule. But a rule that is very important, I think, you probably know that 1557 we were implementing before, but it had been five years.

POLIS:

(inaudible) time to complete that rule, correct?

BURWELL:

Yes.

POLIS:

OK, thank you. And I -- I'll have some other questions for the record, and I'll yield back.

KLINE:

The gentleman yields back. I need to advise my colleagues that we're going to restrict the time now to four minutes and hope that we don't have to go to three minutes, but the math shows that we have so many people have not enough time.

Mr. Russell, you're recognized for four minutes.

RUSSELL:

Thank you, Mr. Chairman.

And thank you, Madam Secretary, for being here today. As a returning combat veteran I had some firsthand experience with prescription painkillers, in -- in my case, Percocet. But it left me with a clouded mind. It reduced the pain. I became concerned about that. I didn't like not having my faculties, and so I quit taking them.

However, pain management are not just among our veterans has resulted in perhaps a lot of what is categorized as suicides. It might have been accidental death.

On a broader scale nationally, at least 18 states now have more deaths due to prescription opioids than car fatalities.

BURWELL:

Correct.

RUSSELL:

The fatality rates have increased five folds since 1990. Accidental overdoses are up 360 percent since 1999.

In 2004, prescription and other over-the-counter drugs were responsible for more years of lost potential life than all accidents from falls, firearms, drowning, fires, and non-medication poisonings combined. Opiate painkiller prescription has increased 800 percent from 1997 to 2006, and the data for the next decade will probably exceed even further.

America now has had an increase in these, but I cannot imagine they've had an 800 percent increase in pain. Instead, America now has seen health science environment that allowed lawmakers to pass these laws in the first place, and I think America has been sold faulty health science and a bill of goods.

So my question to you, Madam Secretary, rather than a $1.1 billion spending program to provide treatment to those exposed in suffering this abuse, we've been exposed to prescription heroin nationwide. What actions will you be taking to curtail the science that suggested that these laws be passed in the first place?

BURWELL:

The research on pain and pain treatment, I think, is an important part of the solution. I think when we look at the steps that we need to take to push back on many of the statistics you articulated, number one, we need to change prescribing practices because that's how many folks are getting this prescription. And then that is sometimes a transfer to heroin itself because I think you're -- you were referring to both. We need to work on the medication- assisted treatment. We get -- need to get access to naloxone.

With regard to the research issues, at NIH, there are two parts to this, and one part is making sure that we are researching pain issues as well as the treatment of pain, and this is a space where I actually work with my colleague at the Department of V.A. because they have much of the research. And in doing some of the advances because as you articulated, it is a pool of people sadly who have these issues in terms of pain. So we're working on it there. We're working on it at NIH.

And with regard to FDA, what we're trying to do is speed along the process for those that can find drugs that are not opioid-based in terms of pain as well as those that are tamper-resistant. And those are some of the changes we most recently made at FDA.

RUSSELL:

I would hope rather than chase more money after bad practices that we would take these things off of the market. I think that we existed for a long time as a country. We fought world wars. We did a lot of other things. America has not had an 800 percent increase in pain. And I would hope that you would devote more effort towards the faulty science that's allowed these laws to pass.

We are creating an epidemic that we're not likely to recover from. And I do appreciate your efforts thus far.

Thank you, Mr. Chairman. I yield back my time.

KLINE:

The gentleman yields back.

Mr. Sablan?

SABLAN:

Thank you very much, Mr. Chairman.

And, Madam Secretary, I -- you mentioned that this would be your last budget. I think you should be proud of it. There are so many things in here that are -- are, you know, proposals that are -- would serve America great.

But I'm -- as I'm the only member here who is not from -- representing a state, so I'm going to limit my conversation to one issue.

The President proposed in his fiscal '17 budget that the National Medicaid program be available to the four million Americans who live in the insular areas including my constituents in the Northern Marianas. And thank you, this is a very (inaudible) proposal.

The people of the Marianas are not as well-off as the rest of -- of Americans. Our median household income is about $20,000, and national median income is $50,000. Because we have so many who are poor, we have many who qualify for Medicaid. 15,036 of our total population of 53,000 receive medical care through the Medicaid program.

But as you know, Medicaid in the Marianas and the other insular areas is not the same as Medicaid elsewhere. There's a cap on the total amount of federal Medicaid money that goes to our islands, about -- only about $5 million per year to the Marianas.

And the local cost share of Medicaid is set in law not computed based on overall income as it is in the rest of America. So our commonwealth, the local government has to pay 45 percent of the cost more like one of the richer U.S. states will pay.

We're not rich, however, so we welcome the additional Medicaid money provided by the Affordable Care Act beginning in 2011, about $13 million per year.

That little money kept our only hospital open and the local government have to stop its annual funding for a hospital because of the great recession and loss tax revenues. But that Affordable Care Act money is only available through 2019. What happens then? Does our hospital close? And what about those now on Medicaid? Do they lose coverage?

I'd like to give you the time to please explain to the Committee about the President's proposal. And how are we -- how we are going to make sure that Americans in my district get the same access to health care as Americans elsewhere -- everywhere else in our nation?

BURWELL:

So our proposal is a proposal that we hope will address the issue of a cliff and not create further cliffs. With regard to putting in place a proposal that will transfer a way from a cap and create matches that are more aligned with the matches that other Americans receive.

At the same time, the proposal includes steps to make sure that there are reforms and governance is put in place. And so it would happen over a period of time where steps would have to be met in order for the changes to occur. And so the proposal both about getting out of where we have a cliff in the problems that you've described in terms of the need, but do it in a way that's also encouraging high- quality Medicaid performance and program integrity.

And so the proposal combines those two things. We believe it is a -- a reasonable and a very needed proposal, and that we should get ahead of this issue. And that's why we have it in our budget.

SABLAN:

Well, thank you very much. The word "very needed" is -- is very appropriate at the -- at this instance not just for the Northern Marianas but for Puerto Rico...

BURWELL:

Puerto Rico as well.

SABLAN:

American Samoa, Guam, and the U.S. Virgin Islands. And I yield back my time.

KLINE:

I thank the gentleman. He yields back.

Mr. Barletta?

BARLETTA:

Thank you, Mr. Chairman.

And thank you, Secretary Burwell, for being here today. I -- I was deeply disturbed by a recent Senate report that found the Centers for Medicare and Medicaid Services, which is part of your department had built out roughly $750 million in Obamacare subsidies to half a million people who are unable to prove their citizenship or lawful presence in our country. These tax credits are solely intended to be used to purchase health insurance by United States citizens, and those lawfully residing here. Instead they were improperly distributed, and the federal government will likely never see a sent return.

This report was just one of many reports that have recently come to light detailing the rampant fraud and waste under Obamacare mismanagement that hard working Americans have had the foot to bill for.

Now, I've been working to fight illegal immigration for more than a decade now, and -- and I find it extremely troubling that at a time when our national debt is $19 trillion and counting that the federal government continues to throw money away with no regard for the consequences. I'd have a hard time explaining to families in my district, many of whom are struggling to put food on the table as to why they should be helping to pay for the health expenses of someone who broke the law to get here and has no right to those federal dollars.

Secretary Burwell, who -- who's decision was it to prioritize illegal immigrants over American citizens?

BURWELL:

So with regard to the Senate report, and I take the issues of program integrity and budgets very seriously. You probably know it was during the years that I was at OMB that we actually had balanced budgets for the -- only about the -- closed the only time during my lifetime, so take these issues of program integrity very seriously.

And with regard to the Senate report, I think what the Senate report reflects and says is that they were not able to provide, they did not provide the documentation, not that they -- we don't know whether they did or they didn't.

And I think with regard to the program integrity that you raised, as one looks at what happened in the first year of the Affordable Care Act, and that there were about 250,000 people who were taken off last year in terms of changes, both the immigration and income, 1.6 million people...

BARLETTA:

But -- but...

BURWELL:

... in terms of when we reviewed and we were not able to receive the documentation not knowing whether they could or they couldn't, and that was both for immigration. The immigration number is about 500, and the other number is about (inaudible).

BARLETTA:

(inaudible) correcting that the tax credits are -- are used that somebody cannot produce legal documents at the time that the tax credits are used until they can -- could come back and give them an opportunity to come back and prove their legal status.

BURWELL:

It is a 90-day period, which is given...

BARLETTA:

Right.

BURWELL:

... to (inaudible) statute.

BARLETTA:

So -- so my question is after the 90 days, why then did the federal government not go back? Why did we not go back to those people after we gave them the tax credits? So now, get the money back of the tax credits that could have been used someone else.

And as the head of an agency that knows what it's like to scratch for every penny, please explain to me how the Administration is going to make up to my constituents and ensure that three-quarters of a $1 billion is returned to the American taxpayer.

BURWELL:

With regard to that, that is the regular tax process. And so for any of these individuals, what will happen is they will owe those in taxes in terms of reconciling. And so the IRS and its process is...

BARLETTA:

We can count on that money coming back 700...

BURWELL:

So what will happen is when they go in, this will be reconciled through the IRS process. And that's -- that is the way that the enforcement will occur because it is a tax matter, so it occurs on the IRS side of the House.

BARLETTA:

Thank you, Chairman.

KLINE:

The gentleman yields back.

Ms. Bonamici?

BONAMICI:

Thank you, Mr. Chairman.

Thank you, Secretary Burwell. Your work covers so many areas that affect the daily lives of Oregonians and Americans. I appreciate that.

I want to thank my colleague and friend, Representative Stefanik, for bringing up the Older Americans Act. I want to ask you about the home and community-based support of the services program that fund services like legal assistance, elder abuse prevention, transportation and (inaudible), medical appointments, referral assistance for seniors and their caregivers.

Now, I am supporting the additional $10 million in the President's request as well as -- as many of my colleagues. Why is it important to increase funding for the Older Americans Act programs especially the home and community-based supportive services given that rapidly rising population of older Americans? And I do want to save time for another...

BURWELL:

I'll just quickly say that I think there are two elements. It's about what it means for the individuals in terms of these programs we know are making a difference in terms of supporting people to be able to have care at home if that's what's appropriate for them. And so it's about the individual, but it's also about the economics as well in terms of the success of these programs contributes economically.

BONAMICI:

You think seniors in their home (inaudible).

Thank you. The Oregon Health Science University has been working in collaboration with Intel on genome mapping. That's especially useful in cancer research. The goal is to make personalized genomic analysis faster, less costly, more routine. What are some of the challenges that research institutions face regarding the collection ensuring that information? And what opportunities might the cancer moonshot provide to overcome some of these obstacles in advanced precision medicine?

BURWELL:

Some of the limitations are the fact that the areas of science don't work together, and you actually need an engineer to help deliver through the system. A biologist figures out what it needs, but an engineer actually delivers the delivery mechanism. And we have not broken down those silos as we think about the science. I think it can help with that.

The other thing I can help with is data and information because one of the things -- and this is part of what precision medicine is about -- is making sure that data and information can be widely accessed in safe, secure ways that's both about privacy and cybersecurity. But that information can be used widely and broadly to discover and understand more quickly. It also then will save cost because how one access this information for trials will become easier and less costly, which is a very important cost element to drugs for drug (inaudible).

BONAMICI:

Thank you. I look forward to working with my colleague then. Those are important issues.

And -- and finally, I think my colleagues who brought up the -- the issues with opioid overdose and abuse and all the death -- resulting deaths. We've had an explosion in -- in my state as well as in the country. I applaud your three-pronged evidence-based approach. And can you talk a little bit about the -- the prong of improving prescribing practices particularly important (inaudible).

BURWELL:

An extremely important part, and the Center for Disease Control and Prevention will be issuing new prescriber guidelines in terms of the issue of how we can talk about these issues, and think about these issues, because one of the problems many physicians say, "I don't know. I wasn't trained in this way." So we want to get those out and make sure people are using those because when you think that over 250 million prescriptions a year for opioids, we know we don't need that many as a country, so prescribing is an issue. So we're going to target that as an issue, get out new guidelines. And then we need to probably work with the Congress to make sure those guidelines are used.

BONAMICI:

Thank you. And I -- and I know my state just received about $2.7 million to expand (inaudible) services, particularly focused on treating opioid abuse. I know that's not enough. We still have more work to do.

I had a fourth question, but the Chairman asked already about preschool development grants. And I look forward to watching how that seamless -- I hope -- I hope to transition as seamless as the HHS continues to manage those grants.

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

KLINE:

The gentlelady yields back.

Dr. Foxx?

FOXX:

Thank you, Mr. Chairman.

Secretary Burwell, I want to follow-up somewhat on what my colleague, Mr. Byrne, was talking about in his line of questioning. But first I want to say I've heard from employers who self-insure that this transition of reinsurance fee is particularly burdensome to them, depriving them of resources that could be used instead to create jobs. And you asserted that HHS interpreted the law

accurately and appropriately. You claimed that the comment period for the NPRM resulted in no objections to the Department's interpretation of the law.

However, most of us believe that the NPRM was drafted in such a complicated way that no one could interpret it in the way that your Department did where you used convoluted language to create a loophole to justify your reasoning.

Given your dubious interpretation of the law thus far and you've heard members of this committee and you will hear us say, "We think you've interpreted it wrong." I agree with Mr. Byrne, you've interpreted it wrong. You're hearing directly from members of Congress you've interpreted wrong.

I am now concerned that you're going to find a way to extend the transitional reinsurance program even the law -- even though the law clearly states that it expires this year. So could you expand in greater detail your legal interpretation of implementing the transitional reinsurance program contrary to the letter of the law? And can you commit to this Committee that you will follow the letter of the law, which states the program must cease collections for the program at the end of this year? Do you plan to distribute funds after 2016?

BURWELL:

With regard to the question of reinsurance program I think it's actually important to focus on what the substance of this program is about. And the substance of this is an issue that we've actually talked about a number of places, which is pressure on cost that you were indicating in another space in terms of this is about putting downward pressure on cost by creating an ability for the issuers in a new market. This is one of the transitional programs, and there are no plans to extend it beyond.

FOXX:

OK. So, you consider the transition period time is over.

BURWELL:

We have no plans to change our reinsurance timetable that was set out. Risk adjustment is the only program that will continue beyond right now.

FOXX:

OK. When you say we have no plans, would you be a little more explicit. You will or you will not?

BURWELL:

I am being very clear. We have no plans. We just issued our rulemakings. Our proposed notice of payment notice, there is nothing that indicates anything that we do other than where we are.

FOXX:

All right. Madam Secretary, I have some other questions.

But, Mr. Chairman, in the interest of time and my colleagues, I will yield back the balance of my time.

BURWELL:

I thank the gentlelady.

Mr. Pocan?

POCAN:

Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today. I'm trying to get the three subjects in four minutes, so I'm going to try to go fast.

Is the name Brent Brown (ph) from Wisconsin ring a bell to you? This is the gentleman who wrote a letter to the President, and I'd like to ask unanimous consent. I'd like to enter this letter into the record.

KLINE:

Without objection.

BURWELL:

Oh, yes, then I do know.

POCAN:

Now you know, yeah.

BURWELL:

(inaudible).

POCAN:

So a gentleman who had spent his entire lifesavings...

BURWELL:

Yes.

POCAN:

... on health care.

BURWELL:

Yes.

POCAN:

You know, he was literally a dead man walking, couldn't get at health insurance because he had a pre-existing condition. And because the Affordable Care Act, he's alive today.

What's unique about the letter and I just want to read two of the paragraphs or three of the paragraphs. This is in his letter. "I probably wore pins and planted banners displaying my Republican loyalty. I was vocal in my opposition to you particularly the ACA. Before I briefly explain my story, allow me to say this, 'I am very sorry.' I understand written content cannot convey emotions very well, but my level of conviction has me in tears as I write this. I was so very wrong, so very wrong." And then he goes on to explain about his preexisting condition. And not been (ph) for the Affordable Care Act, he won't be alive today. So I just think that that is a wonderful example and story.

And more importantly, part of his appeal was to try to tell people maybe on the other side of the aisle, they've been trying to repeal this for 63, 64 times. You know, maybe it's time to -- to move on. So I just want to mention that.

One of the issues that came up -- I'm checking the time -- was about the Affordable Care Act. When it first came out that on the employer roles that you're going to reduce employees because the part- time hour commitment, do you very quickly have any updates on that how we're doing?

BURWELL:

We have seen no evidence, and we've continued the recovery in terms of involuntary part-time employment. The involuntary part-time employment increased as part of the recession, but we continue to see progress and a normal recovery. So there are no analytics that show that there has been an impact in terms of part- time work.

POCAN:

Great. Thank you. I know a number of us talked about opioid abuse. I'd like to talk about something different, behavioral health and on mental health issues. You know, I know that while the opioid issue really is getting a lot of attention right now, I think mental health issues especially as someone who is a former legislator, 25 to 30 percent of the people in the prison system in Wisconsin are

there for mental health. They were there because they had cancer. People would be in the streets, but that's not how we are dealing with this issue and the amount of cost that goes into it.

I'm very supportive of the President's budget and the increase that he's trying to do, but I just want to make sure that we're keeping the focus on mental health as we do this because not just, you know, the state government -- that's in Wisconsin -- $250 million to $300 million a year just for the people of mental health and the correction system, but in local jails, at local government, et cetera.

It just, I think, really is sad commentary on how we treat the disease and not have enough efforts there. And anything that we can do would be much appreciated.

BURWELL:

I think the Affordable Care Act together with the Mental Health Parity Act are the two most important steps we can make as a nation to get parity in this space.

POCAN:

Right. And then the final issue I just want to raise in the last minute I have prescription drugs. One of the issues that we have seen is prices are rising again going up. And I recently was at our V.A., and he was telling me about one drug that he needed to do for one of his patients and it's a $125,000 a dose.

We know that recently companies like Pfizer are trying to do tax inversions so they don't have to pay taxes here and go to Ireland by buying a smaller company, yet at the same time they're not going to charge us the prescription prices that they pay in Ireland, which is considerably less than they're paying here.

I would just like to advocate for anything we can do and you can do as the Secretary within your department to help us look at that issue because I think we may need to work with those folks work in inversions because I think it's a real tragedy that we're paying more and more and more for prescription drugs, including 27 percent, I think, of mental health on prescription drugs. We need to do something more.

BURWELL:

High-cost drugs is a priority, and there are a number of elements in the budget, we think, would help address it.

POCAN:

Thank you. I yield back.

KLINE:

The gentleman's time has expired.

Mr. Bishop?

BISHOP:

Thank you, Mr. Chairman.

And thank you, Madam Secretary, for your testimony this morning. On February 19th, as part of the F.Y. 2017 Medicare Advantage rate notice, CMS proposed a cut to Medicare Advantage Employer Group Waiver Plans, otherwise known as Medicare Advantage Retiree Coverage. 3.3 million seniors received their Medicare Advantage coverage through this plan. In fact, in Michigan alone, there are more than 300,000 retirees including labor unions, state and local government, and private employer retirees who rely in Medicare Advantage Retiree Coverage.

These proposed cuts would jeopardize the high-quality care that they depend on for their health and financial security. That's why last week my colleague, Representative Debbie Dingell and I, that a bipartisan Michigan delegation letter that include 11 of our colleagues in Michigan to raise concerns with -- with regard to impact these proposed cuts would have in our constituents. And we also urge the agency to remove the cut to the Medicare Advantage Retiree Coverage from the final rate notice.

Earlier this month, the UAW Retiree Medical Benefits Trust, which provides health coverage to retirees and their dependents of the United Auto Workers Union who formally works for the Michigan's big three -- G.M., Ford, and Chrysler -- submitted comments to CMS expressing concerns with CMS's proposed cut to Medicare Advantage Retiree Coverage that impact these cuts -- and the impact these cuts will have on their retirees.

The trust currently provides coverage to 719,000 people of this population, 534,000, are covered by Medicare. The trust offers their retirees a choice of plans on which they can enroll. At the present time, 161,000 of these retirees have selected and are covered by Medicare Advantage plans.

In comments submitted to CMS, the UAW Retiree Medical Benefits Trust expressed concerns that the proposed cuts to Medicaid -- Medicare Advantage Retiree Coverage might result in diminishing the quality of care available to retirees and a proposed -- the proposal would lead to substantial reduction in payment to employee group waiver plans, thereby resulting in premium increases and/or benefit reductions.

This leads me to my question. I did sent you this letter, and I appreciate the fact that (inaudible) now you just received that letter. Thank you very much for that.

Having said what I just said and the great concerns that they represent to -- in particular, my constituents in the state of Michigan, can you tell me whether or not CMS considered the impact that cuts to Medicare Advantage Retiree Coverage would have on the 3.3 million seniors who depend on this form of coverage when developing the advanced notice.

BURWELL:

So, we did and appreciate that and appreciate the -- the letter that you have sent. And we are in open comment period, so -- so welcome the comments and the concerns. And we did consider this issue.

And we actually looked to our experience when we did this change in Part D. And we did not see the impact that folks are staying could happen. We did not see that impact occur. And so we, like you, want to make sure affordability is an important part of it in our work. What we try and balance is affordability for the individual as well as affordability for the taxpayer with the Medicare dollars and feel that it is a proposal that meets those, but we want to continue to hear the comments and see if there's something that would distinguish it from the experience we previously had.

BISHOP:

And -- and you responded to the UAW's concerns as well.

BURWELL:

Probably because it is a part of the comment and rulemaking process. Most likely we took it in as a formal comment, but I'm not sure how they did it whether it was in the form of a letter or a comment, so I don't know specifically, but it will most likely be a part of the record for the comment period.

BISHOP:

Thank you, Madam Secretary.

And I yield back.

KLINE:

The gentleman yields back.

Mr. Takano?

TAKANO:

Thank you, Mr. Chairman.

Madam Secretary, it's truly a pleasure to hear from you this morning about your Department's priorities. And I'm glad to hear about the Administration's continuing commitment to programs and support, working in families, educate our children, and keep Americans healthy.

First, I'd like to ask you about the Department's work to support LGBT seniors. As you may know, the Congressional LGBT Equality Caucus, of which I am co-chair, has formed an LGBT Aging Issues Task Force.

We sent a letter to Administrator Greenlee asking for ACL to require each state plan to assess whether state units on aging are meeting the needs of LGBT -- of the LGBT community in their area. And as you know, LGBT -- LGBT elders have poor physical health, worse mental health, lower income, and fewer close ties on average than other seniors. Can you speak to whether ACL will be rolling out a guidance focused on LGBT older Americans? And if not, what will they be doing to assist this aging population?

BURWELL:

With regard to this population, which is you articulated, has a higher level of challenges than other parts of our elderly population as a nation. There have been a number of sets that we, as an entire department, have taken in this space. I think you're familiar with our LGBT Coordinating Committee, which is...

TAKANO:

Yeah.

BURWELL:

... a part of what has led to another thing that will be coming to fruition, which I think is a very important part of understanding the problem better is data collection -- a five-year data collection that will be targeted and so we can better understand the specifics of both what's happening in terms of the results, but what's causing many of the things that you talked about in terms of the discrepancies that we see in the elderly.

And then the third piece that I would actually mention is that we have created a national resource center specifically focused on LGBT issues for communities to access so that they can find out information and better serve the community. So we're going to continue to work on these issues, appreciate your leadership, and look forward to continuing with the things that you think we can do more in this space.

TAKANO:

Well, thank you, Madam Secretary. I wonder if you do want to have a meeting with the members of the LGBT Caucus to discuss this other important issues facing the...

BURWELL:

I'm sure that we and our team can figure out how we can do that in the best way to get action taken.

TAKANO:

Wonderful. Madam Secretary, in your testimony, you mentioned the Administration's commitment to growing our health care workforce and they can continue the investments in the National Health Service Corps and graduate medical education.

Ensuring that we have robust health care workforce is one of my top priorities. In Riverside County, which I represent, there are only 34 primary care physicians for every 100,000 people. Half the number of doctors needed to provide adequate access to care. Can you share more about the Administration's efforts to guarantee we have the health care workforce that we are going to need?

BURWELL:

So it has a number of different elements. You mentioned one in terms of the National Health Service Corps and our emphasis on the National Health Service Corps, and that -- building that up and continuing to add members of the corps.

In addition, the funding that we do for HRSA, our Health Resources Services Administration, is another important part of making sure that we're building up a core. I think the other thing is how we do the policies.

Our graduate medical education funding proposal, we actually shifted to the mandatory side because we believe that that funding should be a dependable, continual part of funding so that we're encouraging people to go into these fields and know that they will have an ability to have help with their loans.

The other thing that I would mention is the focus on primary care because we believe that's at the center and core of transitioning our system to where people have primary care homes. So it's both in policy and in funding across the department that we are working on the issue of making sure we have enough health providers.

The other thing is people at the top of their license. Right now, we want to make sure that there's more access for nurses and others to be able to do certain types of functions.

And lastly, telemedicine. There are three proposals on that.

TAKANO:

Mr. Chairman, I almost made it. I'm sorry.

KLINE:

The gentleman's has expired.

BURWELL:

I'm sorry.

KLINE:

Mr. Rokita?

BURWELL:

That was me, sorry.

ROKITA:

I thank the Chairman.

Thank you for coming again. Good to see you. I wanted to first -- on behalf of the governor of the state of Indiana, Mike Pence, and -- and many of us are going to say thanks for working with us on what we call HIP 2.0, consumer-driven health care, that I think will -- will be a model to help the Department and others around the country really get at cost constraints while serving more people. So thank you for your cooperation and leadership in that regard.

BURWELL:

Thank you.

ROKITA:

I wanted to talk to you a little bit about the budget this -- this morning. I thought I heard in -- in your opening statement that you are able to get savings for Medicare and Medicaid or did I misunderstand that?

BURWELL:

There are Medicaid proposals as well as Medicare proposals.

ROKITA:

I heard Medicaid and Medicare reforms was -- was the word you use.

BURWELL:

Yes.

ROKITA:

You didn't mean spending reforms or did you mean spending reforms? What's the effect of the reform?

BURWELL:

Savings.

ROKITA:

Savings.

BURWELL:

The effect is savings, $419 billion for Medicare, Medicare and other areas.

ROKITA:

Over the 10-year window.

BURWELL:

That's right.

ROKITA:

Then in your -- OK, thank you. And in your written statement in page two you say that taken together, there's an estimated savings of $242 billion over 10 years. So what's the difference in those (inaudible)?

BURWELL:

We pay for our child care. We pay for the other mandatory issues.

ROKITA:

OK. So it's (inaudible) that reduction.

BURWELL:

So we pay for -- it is -- that is the savings in that -- that space in the entitlement space.

ROKITA:

OK.

BURWELL:

We use some of that for savings, and we use some of that to do things like fun child care.

ROKITA:

Thank you. How do you save -- in terms of Medicaid particularly, how do you save money when I thought CBO general (ph) report said that Medicare spending will grow by $200 billion in only like 10 years? I mean, what's your...

BURWELL:

Medicare or Medicaid, I'm sorry?

ROKITA:

Medicaid.

BURWELL:

Medicaid spending?

ROKITA:

Yeah.

BURWELL:

With regard to some of the proposals in the Medicaid space, one of the proposals and I'll have to see if this is one of the ones that scores into those numbers. But what we want to do is work with states so that they can do purchasing for drugs together, help states do combined purchasing, which can drive down Medicaid cost for them and for us. That one I had to check and see if it is one of the scored ones, but those are the types of things...

ROKITA:

OK.

BURWELL:

... that we're looking at.

ROKITA:

OK. What do you think about flexibility grants or block grants? They're making finite instead of an open-ending fee-for- service kind of structure. What about, you know, taking a finite amount of money and say, "Look, this is what you have to spend state X. Find out who really is poor, what the poor really need, and how a poor should get it."

BURWELL:

So I think the -- the question of capping Medicaid, what the concerns that we have with it are front and center right now in Puerto Rico where we have almost 250 cases of Zika. We have over 10 cases of pregnant women who have tested for Zika, and you have a situation where you have a population whose needs are not being met before they started and then you have a situation like Zika layered on top.

And so having a program that is about the ability to be flexible with the needs of the people to meet the needs...

ROKITA:

Yeah, but...

BURWELL:

... because what happens...

ROKITA:

... that example is a little extreme. I mean, that's what a supplemental funding measure could be for something like that. I mean, we don't have to...

BURWELL:

I hope that's an expression of support for our Zika sup (ph).

(LAUGHTER)

ROKITA:

Well, it's an expression for the Congress can act in emergencies and you're describing an emergency. You're not describing day-to-day.

BURWELL:

The initial situation...

ROKITA:

In Puerto Rico -- you know, I'm out -- I'm running out of time...

BURWELL:

I'm sorry.

ROKITA:

... so thank you.

This is not meant to be a political batch anyway, but I clearly remember and -- and see evidence with the President in 2008 when he was running for office the first time. He said he would be able to lower insurance premiums with this Affordable Care Act at $2,500 per family on average.

Your testimony describes the fact that we've slowed the growth in health care costs. What happened? What's different?

BURWELL:

I think in terms of that number, that is the projected growth, the amount of the projected the differential and growth...

ROKITA:

You said lower premiums. You said lower premiums.

BURWELL:

With regard to the specifics, I -- I apologize I'm just (inaudible) ...

KLINE:

I'm sorry. The gentleman's time has expired...

ROKITA:

Thank you very much.

KLINE:

... and we're rapidly approaching the 12 -- Ms. Clark?

CLARK:

Thank you, Mr. Chairman.

And thank you, Secretary Burwell, for not only your testimony today, but the incredible work that you were dealing. And I especially want to highlight your commitment to addressing the opioid crisis that coming from a state like Massachusetts where it has just been a devastating effect, we so appreciate your partnership and your commitment.

I specifically want to ask you though about adolescents and young adults. I have spoken with many experts who treat this population. And they have been clear that they -- this population needs special protocols to be able to tailor the treatment to their unique social and biological needs. They are also clear there has not been enough emphasis in programming or research in this area.

Can you discuss any efforts that are underway that target action towards young adults and adolescents? And if you see this as an important area for fighting the opioid crisis?

BURWELL:

So with regard to the fighting in the hearing now a couple of elements and steps, one is you are right because what happens is and I heard a story this past week of a young person at Cornell, an athlete injury, got on the opioids overdose (inaudible).

And so these issues -- so there is special need especially because of these athletic injuries. This gets to the prescribing guidelines and making sure that there are alternative approaches to helping these students and young people through their pain and their athletic injuries. That's one whole category.

There's another category that we know sadly that while I think people think alcohol is an OK alternative for these young people, it is not because I think what we know is that that is a gateway often to be prescribed. So, those that are participating in those activities are more likely as they get older to participate in other activities.

Then that's the hearing now and things we need to focus on. The research that we need to do with regard to the question of opiates across the board is a broad part of the research. We -- the questions that -- does it help for long-term pain and acute pain and that sort of thing, and having -- making sure that we're thinking about young people as we do the research is a more longer-term issue, but one we need to focus on.

CLARK:

And one we would love to work with you on.

I want to quickly get back to Zika. And you spoke about some startling numbers even here, the United States. And we know every day we're seeing more of the connection being verified by research about the connection and danger for pregnant women. We are also seeing countries around the globe that have very restricted access to family planning for women saying, "Don't become pregnant at this time."

Can you elaborate on what's being done both here at home and abroad to make sure that women have access to a full range of health care options?

BURWELL:

So, three fundamental things is part of the strategy.

Number one, deep focus on pregnant women because of the concerns around microcephaly and the very extreme birth defects that can occur with women who have Zika while they're pregnant.

Number two, communication, making sure we are reaching as many people as possible who are either traveling to that region or have a partner that has traveled to the region because we know that sexual transmission is possible. So communicating about the guidelines as much as we know as quickly as we know.

And number three is making sure that we are focused on the research that we need to do to understand more about the disease including how to do better vector control. This is a disease that is spread by a mosquito that can bite four people in one setting. It is an indoor mosquito. It can breed in a capful of water. And it's a very difficult mosquito to control. We're continuing to use best practices, but more research on the disease on the vaccine and the vector need to be done.

CLARK:

Great. Thank you.

KLINE:

The gentlelady's time has expired. We are shrinking the available time even more. I'm telling my colleagues as we're moving towards the hard stop.

Mr. Allen, you're recognized for three minutes.

ALLEN:

Thank you, Mr. Chairman.

And thank you, Madam Secretary, and thanks for your call. By the way, I'm starting to get back to you. But I wanted to just comment on a couple of things. One as you mentioned that the -- you've lowered the taxpayer growth in Medicare. I need some background on that because I'm not -- I'm not seeing as if you can get that to me.

The other number that I'm seeing is total -- totally insured. I'm not seeing that in my district. In fact, a very small percentage of my district is insured. In fact, doctors tell me at the emergency room that people just -- is nothing's changed. There's many people who are showing up without insurances as before.

And then also on your comment about you don't pay more for pre- existing conditions. I met a lady yesterday that tell me about her son and his condition, and she want to know why his premiums had gotten so high and is deductible. It was like -- she said $10,000. And I said, "Well, I'll get an answer for you." So I need you to get that to me.

And then lastly but not least, obviously the President signed into law and voted for the (inaudible), which was an attachment to the appropriations bill. How are you monitoring as far as your funding of these various plannings (ph) that no taxpayer funds are being used for abortions? How do you -- how do you monitor that and -- and what are you doing to oversee that?

BURWELL:

With regard to where that would occur, it would occur in HRSA, the Health Resources Services Administration, which are the clinics that we fund directly. And there are stringent guidelines with regard to that that the clinics both know and are educated on, so it's not just a matter of telling the clinics. It is a matter of HRSA making sure that they know and understand what those guidelines are so we can follow them, the (inaudible) guidelines.

ALLEN:

And you're -- you're auditing -- you're auditing these clinics.

BURWELL:

With regard to the specifics of how that goes, I will come back to you.

ALLEN:

OK, all right. The other thing, we got some states that are opting out of the exchanges. And as far -- I think Oregon and -- and Kentucky is talking about getting out of the state exchanges and going back to the federal exchange, do you want to explain why that's going on? I mean, our -- our governor was criticized because he didn't opt to go in the state exchange because he knew eventually that federal government was not going to fund it anymore.

And, of course, in Georgia we required to balance our budget. He had think the funds would be there. What's -- what your take on this?

BURWELL:

With regard to either approach, I think it's about a state choice and decision in terms of how they want to -- whether or not they want to do the set-up of the piece that will attach their consumer to their ability to access it in Kentucky. It's a system that's a well-integrated system that helps with and create efficiencies for both their CHIP and Medicaid. So I think they do it and decided to do it because it creates that. Other states choose not to, and we use the federal marketplace. Either way can work as a system. We just want to work with states to do what is their preference as a state.

ALLEN:

I yield back, Mr. Chairman.

KLINE:

The gentleman yields back.

Ms. Wilson?

WILSON:

Thank you, Mr. Chair.

Welcome, Madam Secretary.

BURWELL:

Thank you.

WILSON:

Unfortunately, Florida, my state is one of 19 states that has failed to expand Medicaid under the ACA. Can you speak to why Medicaid expansion is so important for communities of color especially in my home state and across the country?

BURWELL:

So, while we've made great progress in terms of communities and of color, three million uninsured reduction in the African-American community, 4 million in the Latino community, we know that the uninsured rates are still disproportionately high. And we know that if a Medicaid expansion occurs that a disproportionate number of folks that are minorities will be covered, and so we're excited to continue pushing and pushing hard because we think it will have a disproportionate benefit to communities of color.

WILSON:

Our governor has repeatedly rejected expansion citing budget restraints. Can you speak to how Florida and other states may actually a budgetary relief on the Medicaid expansion?

BURWELL:

So what we know in the University of Kentucky -- sorry, the University of Louisville together with Deloitte has done a piece of work and a -- piece of research on their work in their expansion. And it was -- it led to the creation -- it would lead to the creation by 2021 of 40,000 jobs as well as $30 billion flowing into the state. And we know that we see reductions in uncompensated care for hospitals and communities across the state when expansion occurs, so it's about the individual, but it's also about the economic impact.

WILSON:

And how do -- how do -- how we chew (ph) at the -- our communities of color getting the information they need to successfully enroll.

BURWELL:

One of the things we do during open enrollment, and I had the opportunity to spend a lot of time in your state...

WILSON:

Yeah.

BURWELL:

... and I have gone to every place -- from beauty salons to barber shops -- because we need to meet people where there are trusted voices in Texas.

We -- actually in all states, we do second Sunday where, on Sundays, we work with the faith communities across the states to help people get information that is important information from trusted voices.

WILSON:

Just keep up the good work. I yield back.

KLINE:

The gentlelady yields back.

Mr. Carter?

CARTER:

Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here. Madam Secretary, as you know, I'm -- I'm a pharmacist so I'm -- I'm very concerned about issues, obviously, dealing with -- with patients and -- and dealing with them getting their medications. And specifically, I wanted to ask you about compounding, compounding for office use only.

And I know that -- I'm very concerned about the FDA interpreting legislative intent. And certainly, this is something that comes into play when we're talking about for office use only. I know that you continue to prevent -- the FDA continue to prevent medications to be compounded for office use only. And what this causes is for the patients to have to go back to the pharmacy, get a specific prescription, compound it for them then go back to the doctor to have it applied.

And -- and I'm wondering where you're at in that process. Many states have already allowed for this to take place. Many states have already had regulations and -- and laws in place that allow for office use only for compounds to be made and for the physician to have them there in the office where the physician has the ability to apply and use that medication instead of the patient having to go get a specific prescription filled for them as opposed to having it for office use only. I just want to know where we're at in that process.

BURWELL:

So, we don't have any guidance how preventing that. So maybe you and I -- I can follow-up with your staff to understand that our team can follow-up to understand because while we are -- and we welcome the input on the guidance on the issue, it doesn't exist. So, right now, compounding should be occurring and occurring...

CARTER:

(inaudible) it is occurring but what...

BURWELL:

... and that there's not a problem in terms of any -- any guidance or any rules about it right now.

CARTER:

No, I -- I beg the difference. The problem is is that you're requiring each specific patient to have a specific prescription for medication for a compound in medication. And what -- what in the past we'd be able to do is just to apply the physician.

BURWELL:

Within the doctor -- in the doctor's office.

CARTER:

Exactly...

BURWELL:

Which...

CARTER:

... with a compound that's for office use only in which they can apply that medication.

BURWELL:

It is my understanding that that is able to be done.

CARTER:

OK. Well, we...

BURWELL:

So if there's something that's happening that isn't, we should -- that's why I'd like to follow-up because what you are articulating is not my understanding, so let's understand because this is something...

CARTER:

Absolutely.

BURWELL:

... that a state issue or something else or maybe we're not communicating clearly.

CARTER:

So we're looking for guidance from the FDA on this, and this is an issue that we're very concerned with because again it has to do with patient care. We want to make sure that the patients are getting the care that they need.

BURWELL:

And we would like your input on any guidance that we would do in this space (inaudible).

CARTER:

OK, that would be very much. We'll -- we'll be together. OK?

Thank you, Mr. Chairman. I yield back.

KLINE:

I thank the gentleman.

Ms. Adams?

ADAMS:

Thank you. Thank you, Mr. Chair.

And thank you, Madam Secretary, for being here. And I'm going to move along quickly. I just want to give a shout out to my Police Department in High Point for the work that they're doing in opioid abuse, and I thank you for your work.

Let me ask you about the health of our nation's most marginalized young people as it relates to sexual health services. Amount of data and research performed by CDC, American Academy of Pediatrics and even your Office of Adolescent Health show that far too many young people in the U.S. face barriers accessing and receiving adequate health care services regarding sexual health education. So, can you please speak to existing efforts at HHS leading to ensure that our nation's youth, especially those most vulnerable have the educational skills in the access to sexual -- sexual education services.

BURWELL:

So, across the board, in terms of our tools, it's our health -- our community clinics that we have talked about. It is the CDC as you mentioned. It is also our funding in terms of access through Title X. So those are three different ways we do that.

Also, some of the most vulnerable that you're talking about are through our minority health issues as well. So, that's the other place I would mention that we work on these issues.

ADAMS:

OK. One follow-up, so what's the Administration doing to address not only the southern states that are disproportionate and affected by HIV disease, but also the rural communities that are seeing a majority of the diagnosis.

BURWELL:

There is $54 million in minority health for HIV specifically proposed in our budget that we hope will be able to continue those efforts and work with those southern states that have a disproportionate number like North Carolina.

ADAMS:

OK. Thank you very much.

BURWELL:

It is one of the places (inaudible).

ADAMS:

Mr. Chair, I'm yielding back.

KLINE:

I thank the gentlelady.

Mr. Thompson?

THOMPSON:

Thank you, Chairman.

Secretary Burwell, thank you so much for the phone call. I very much appreciate your reaching out. I just want to know -- you know, we hear the current crisis with the opioids that, you know, that's obviously impacting from -- from infants to the elderly. I think there should -- we need to approach this for a broader perspective. This is symptomatic. I view as a broader epidemic of substance abuse. It doesn't matter how large or how small the community is. It's present. So, this is kind of an all hands on deck with the executive branch, legislative branch, and all other partners. We need to be working together.

My question though is regarding access at health care. In your testimony, you state that through targeted investments the Administration's budget expands access to health care, particularly for rural -- particularly for rural and underserved areas.

I represent Pennsylvania Fifth Congressional District. It's the States' most rural, largest congressional district, about 24 percent of the land mass. So, I know rural. I know it well.

The -- as a former health care provider for almost 30 years, access requires the presence of providers in our communities first. I don't care how you pay for it or all the other part -- moving parts of it. You have to have that access. There has to be a presence.

Really a tremendous concern considering the fact that more than 45 rural hospitals have closed since 2010 and approximately 300 others are in danger of closing. I struggle to understand how the -- these facts support your conclusion that the Affordable Care Act is having a positive effect on the well-being of employers, employees, providers, health care professionals, and most importantly patients in rural areas.

Can -- can you expand on your statement in regards to those -- those facts? That's a trend line that is -- is not good and it's -- it scares me.

BURWELL:

It's a trend line that started before the passage of the Affordable Care Act, and it is a trend line that has a number of different elements that contributed to it. And I think as you articulated, as you described your district, the issues of population density, the issue of providers being willing to go to places where there isn't a lot of population density in terms of their choices that they make, as well as one of the contributions. I think we do see is uncompensated care in the form of Medicaid expansion. And so we do see a difference in the places where it has expanded and the number of

hospitals that are closing. We see a reduction in that because of the reduction in uncompensated care.

THOMPSON:

Yeah, many of the factors, you know, obviously I key my finger on the pulse of this because that -- that was my life, working to provide access to -- to cost-effective care. And I see rapid expansion monopolies, hospitals are emerging if they're not closing, physician groups, health insurance companies. And that compounds it by raising cost. Monopolies tend to do that. It takes the pressure off for the increased quality. I think there's a lot of issues going. And I would say that they have been compounded since -- since that time.

So, thank you so much. I look forward to continue discussion offline.

KLINE:

The gentleman yields back. We have rapidly run out of time. Let me yield to Mr. Scott for any closing remarks that he might have.

SCOTT:

Thank you, Mr. Chairman.

And, Madam Secretary, I thank you, particularly your comments on the Affordable Care Act where we have changed the situation from thousands of people every day losing their insurance to millions were being covered, and the cost savings, a cost rather than often double- digit increases to the lowest increases in modern history showing a significant savings over what the cost would have been had it not been for the Affordable Care Act and people with pre-existing conditions with no insurance to being able to get -- reliably get insurance at standard rates, and more progress. And you also -- more progress could be made if Medicaid were expanded in those states. And those with insurance are actually picking up a lot of that cost because uncompensated care has cost shifted those with insurance.

I appreciate your response to the opioid situation. Finally, I think we're getting a consensus that the early intervention and prevention is better than hospitalization and jails. You know, you -- we put all the money in the criminal justice system. And when have you ever heard a dealer said -- tell all the customer, "I couldn't get any heroin today because the police have cracked down," or a customer say, "Oh, my God, my dealer got busted. I don't -- I can't get any heroin."

All that money spent on the criminal justice system could have been spent with research-based and evidence-based approaches that will actually reduce the amount of -- of opioids being consumed.

I appreciate your work with Head Start, homeless youth. We didn't get into foster care, but to the -- but I do appreciate your request for additional resources and foster care to achieve permanent -- permanent placements to the extent that we can get young people on the right track and keep them on the right track. We'll have fewer problems in the future.

And finally, I expressed appreciation for your effective response to Zika and the request you've made, I hope we can fund that, and to Flint, Michigan. So thank you for your testimony. I look forward to continuing to work with you.

KLINE:

Madam Secretary, I want to thank you also. I want to thank you for your testimony, for your service, for your engagement with the members here and for allowing us to go three minutes over the closing time.

There being no further business, the Committee stands adjourned.