Hearing on the Department of Health and Human Services (HHS) Fiscal Year 2017 Budget Request

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HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

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C O N T E N T S

WITNESSES

The Honorable Sylvia Burwell

Secretary, United States Department of Helath and Human Services

Witness Statement [PDF]

Hearing on the Department of Health and Human Services (HHS) Fiscal Year 2017 Budget Request

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to notice, at 2:00 p.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady, [chairman of the committee] presiding.

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*Chairman Brady. Thank you for joining us today, Secretary Burwell. We appreciate your time and welcome to the Ways and Means Committee to speak about the President's fiscal year 2017 budget request for the Department of Health and Human Services.

I would like to begin the day by speaking generally about this year's budget. Even though the President knows that he does not have much time left in office to solve real problems, he has decided to put forward in my view a budget that really is not rooted in reality for yet another year's budget proposed trillions of dollars of new tax increases and more wasteful Washington spending.

The President's efforts to secure his liberal legacy does not come cheap. While the United States likes to break records, the American people are not cheering for the most expensive budget in our Nation's history.

The President has chosen to completely ignore the very real fiscal challenges our country faces in the immediate future. This budget is a missed opportunity, especially for the programs at your department that impact the lives of millions of Americans.

For example, last year when you testified at the Energy and Commerce Committee you said the Affordable Care Act was leading to substantial savings for households, businesses, and the Federal Government, but we know that is not the case today.

In fact, the nonpartisan Congressional Budget Office recently found the government spending on health care programs would grow from $1.1 trillion this year to $2 trillion in 2026.

We also know that many Affordable Care Act recipients are watching their premiums increase by double digits every year. And the Medicare Hospital Insurance Trust Fund that our seniors rely on will be exhausted in 2026, four years earlier than projected.

These are serious problems that need real solutions, but these solutions are nowhere to be found in this irresponsible and very expensive budget.

To add insult to injury, the budget also duplicates programs that already exist at your own agency. One proposal calls for a new program to provide short-term financial help to those in need, even though that is already the central purpose of the Temporary Assistance for Needy Families Program.

Another calls for a new Home Visiting Program run by the Ag. Department, despite the current Home Visiting Program run by HHS.

Instead of duplicating programs we already have, Washington needs to effectively reform our welfare program and finally help more American climb the economic ladder through work, and while we will disagree more than we agree today, I do believe there are some important areas of cooperation.

I am glad the White House has finally faced reality in one area and agreed that the so-called Cadillac tax simply is not workable.

We must also work to put Medicare on a sustainable path, and while we do not agree with the specifics in the proposal presented today, we do agree we need to address spending on post-acute care and medical education.

I believe we can also find some common ground in the TANF reauthorization proposal that includes many of the items that were released by this Committee last July in its TANF discussion draft.

And when it comes to child welfare, there is broad agreement about the need to keep kids from entering foster care in the first place. We share the belief that all programs should be evaluated and held accountable for making a positive difference in the lives of children across our country.

So, Secretary, thank you again for joining us today. I now yield to the distinguished ranking member from Michigan, Mr. Levin, for the purposes of an opening statement.

*Mr. Levin. Thank you, Mr. Chairman.

And, Madam Secretary, a warm welcome.

I think this will be your last appearance at least as you plan before us unless there is a special call, and I hope you will not brag about it, but you come with a sense of accomplishment and pride in those accomplishments.

If you just look back a few years, there has been so much positive change. Eighteen million previously uninsured Americans now have health insurance, 18 million. The growth of health care cost has been substantially reduced. One hundred and twenty-nine million Americans now do not have to worry about having their health care coverage denied or their premiums increased because of preexisting conditions.

The tens of millions who now have free preventive care and we do not see the consequences perhaps in this Committee, but they are real.

The re-admissions have gone down also because of ACA, and the last enrollment period, and we hope you will cover on this, 13 million, 13 million signed up.

About ten days ago I met a woman who told us this story. She had breast cancer. She lost her job. She lost her health insurance. Because of ACA, she was able now to be covered, and then her breast cancer reoccurred, and she looked at all of us and essentially said, "I would not be here today if it were not for health care reform and ACA."

There are millions of people like this, some with breast cancer, some with diabetes, some with other chronic ailments who have coverage, and without that coverage would be sicker, without that coverage they may not have survived.

So you will hear a lot of ideology today. We have been through that so many times on the floor of the House, efforts to repeal, but I think the realities are so different than that ideology.

The President's budget also proposes important reforms to Medicare. I hope you will cover on those.

And for Mr. Blumenauer and myself and others, there has been finalized advanced care planning codes, which is important. The Administration is also suggesting that we head on tackle the opioid abuse epidemic, as well as providing some additional money for mental health.

I want to close by touching on a real health crisis. I was in Flint two days this weekend. What has happened there is not only intolerable, inexcusable, but with consequences that we cannot foretell. Dan Kildee has proposed a bill with the support of a lot of us to address the needs there.

This is a national crisis. The Senate is now debating a bill, and there is an effort by two Senators from Michigan to add some funds to help address this crisis, this human crisis, in Flint for families and especially for children.

And so I will be asking you questions about the possible role of HHS. I think you have already begun.

I think it highlights what is really in the end the test for all of us. Behind these statistics, behind all of the data are the lives of individuals in this country, and all of us who supported ACA are proud to have done that, and as we go forth in our district and beyond, we see what it has meant in the lives of the people in our district and this country.

I yield back.

*Chairman Brady. Without objection, all the members' opening statements will be made part of the record.

Our sole witness today is the Honorable Sylvia Matthew Burwell, Secretary of the U.S. Department of Health and Human Services. Sworn in on June 9th, 2014, Secretary Burwell is the 22nd Secretary of Health and Human Services.

Prior to serving at HHS, Secretary Burwell was the Director of the Office of Management and Budget.

Welcome, Secretary Burwell. The committee has received your written statement. It will be made part of the formal hearing record, and you have five minutes to deliver your remarks, and you may begin when you are ready.

Welcome.

STATEMENT OF THE HONORABLE SYLVIA BURWELL, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

*Secretary Burwell. Thank you, Mr. Chairman and Ranking Member Levin, as well as members of the committee. I want to thank you for the opportunity to discuss the President's budget for the Department of Health and Human Services.

As many of you know, I believe that all of us share common interests and that we can find common ground. The last legislative session, this Committee embraced the spirit of bipartisan leadership when it took historic steps to pass the Medicare Access and CHIP Reauthorization Act of 2015, and I want to thank you for your leadership on that issue.

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

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

Over the next ten years, these reforms to Medicare would result in net savings of $419 billion.

This budget invests in the safety and health of all Americans. An issue that we have been working on at home and abroad I want to start with and that is as we work to stop the spread of the Zika virus, the Administration is also requesting more than $1.8 billion in emergency funding, with $1.48 billion for HHS.

We appreciate the Congress' consideration of this important and timely request so that we can implement the essential strategies to combat this virus.

I know the rise in opioid misuse and abuse and overdose has affected many of your constituents. Affected every day in America, 78 people die of opioid related deaths, and that is why this budget proposes significant funding in this space, over $1 billion to combat the opioid epidemic.

Today too many of our Nation's adults and children with diagnosable mental health disorders do not receive the treatment that they need. So this budget proposes $780 million to close that gap.

Research shows that early interventions can set the course of a child's success, and that is why we propose extending and expanding the Home Visiting Program to help even more families in need support their children's growth.

While we invest in the safety and health of Americans today, we must also relentlessly push forward on the frontiers of science and medicine. This budget invests in the Vice President's Cancer Initiative. This is a vital investment for our future. Each one percent drop in cancer death rates saves our economy approximately $500 billion, not to mention the comfort and security that it brings families across the country.

Today we are entering a new era in medical science. With a proposed increase of $107 million for the Precision Medicine Initiative and $45 million for the Administration's Brain Initiative, we can continue that progress.

But for Americans to benefit from these breakthroughs in medical science, we need to ensure that all Americans have quality, affordable and accessible health care. The Affordable Care Act has helped make historic progress. Today more than 90 percent of Americans have health coverage. This is the first time in our Nation's history that this has been true.

This budget seeks to build on that progress by improving the quality of care that patients receive, spending our health dollars more wisely and putting an engaged, empowered, and educated consumer at the center of their care. By advancing and improving the way we pay doctors, coordinate care, and use health data and information, we are building a better, smarter, healthier system.

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

As members of this Committee, I think, know, I am personally committed to working closely with you and your staff to find common ground and deliver impact for the American people.

With that, thank you and I am happy to take your questions.

*Chairman Brady. Thank you for your testimony.

We will now proceed to the question and answer session.

Secretary, exchange enrollment for 2016 will be significantly lower than the nonpartisan Congressional Budget Office projected when the law passed, in fact, about half that level, and it has been lower for every year since the law passed, and despite spending over $1.7 trillion on coverage, poor enrollment results show Americans just are not buying what the President is selling on this law. In fact, millions would rather pay the punitive individual mandate tax penalty than buy Washington designed insurance they do not want and often cannot see their preferred doctors or hospitals.

So it is not surprise the law is not working as advertised, and that is because the theories behind this, the Washington designed products, punitive mandates are just fundamentally flawed.

So do you believe the exchange enrollment projections -- I am not talking Medicaid -- exchange enrollment projections made by CBO at the time of the law's passage and not met each year since are fundamentally flawed?

*Secretary Burwell. So with the --

*Chairman Brady. Is the CBO wrong or is it the enrollment just continues to fail to even come close?

*Secretary Burwell. I think with regard to the most recent CBO numbers, as we look at those numbers, the most important thing to focus on is the number of uninsured, and when we look at CBO's original projection there, in terms of that drop, and what we have achieved as a Nation, we are actually slightly higher in terms of the number of reduction of uninsured.

And I think we all would accept that in terms of how we get to that reduction, it is good when we have a lower unemployment rate, and that often leads to fewer people

being uninsured. It is good when it comes through the marketplace, and it also happens through Medicaid.

With regard to the comparison of the numbers, I think you know that at the end of this open enrollment, CBO's adjusted number is around 13 million. Our number is about 12.7 in terms of the enrollment in the marketplace, and one of the big changes from CBO's original estimates, CBO estimated a couple of things.

One is that there would be great movement from the employer-based market to the marketplace, and that we have not seen, and as part of CBO's changes, I think that is an important part of what they are considering.

We now have the numbers before us, and one of the numbers that CBO expressed, whether it is a concern or not, is that people would move from their employer-based care to the marketplace care, and when we have not seen that, but you see an uninsured number going down, but you do not see as many people in the marketplace as they originally projected.

*Chairman Brady. Two thoughts. One, you focused on what happens in the insured, including Medicaid, when the question is really related to the exchange enrollment area, and the numbers you cite are enrolled, not paying customers within that, which we know it will lower again taking us below the projections.

We just see structural problems, disagree with the approach of this law. This Congress, this Committee will continue to work toward repealing it and replacing it with more patient-centered care.

Final question while you are here. I want to talk to you about my requests for information regarding the Obamacare Cost Sharing Reduction Program. For more than a year, both Energy and Commerce and this Committee have been asking HHS for documents and interviews about how the Administration decided to funds cost sharing reduction payments from an account dedicated to something else, premium tax credits.

The law is very clear. It states payments from the premium tax credit account only may be made for tax refunds and refundable tax credits. Cost sharing reduction payments are neither of these. They are payments made to insurers to reimburse for additional benefits provided to eligible beneficiaries.

Nevertheless, this Administration has paid out more than $5 billion in these payments in clear disregard of the law. This Committee has the constitutional obligation to oversee how the Administration implements the programs paid for by American taxpayers and has waited patiently for the necessary information.

In response to our inquiry on January 19th of this year your assistant secretary wrote that Congress did not have a legitimate oversight need for the information requested. This does not represent a good faith attempt to respond to congressional

oversight. This Committee determines what constitutes legitimate oversight, not a HHS assistant secretary.

So let me be clear. It should not be necessary to subpoena the information this Committee needs to conduct oversight, but if HHS does not respond to this Committee's information request, I will not hesitate to issue subpoenas for these documents.

So my question to you, and you can resolve this today: will you provide this Committee the documents requested and allow requested employees to speak with staff, or will I have to compel your cooperation?

*Secretary Burwell. Mr. Chairman, my understanding of where we are, and we have had letters back and forth, I have had an opportunity to speak with Chairman Upton where this is also in terms of your committee and Chairman Upton's committee that we are having both of these conversations; have spoken directly with him, and my understanding is with regard to that issue that we are at a place in terms of an agreement of what our next steps forward are in that space.

I think with regard to the substance of the issue at hand, which was the question of the authorities, that we believe and have cited we believe that the authority exists in U.S. Code 13-3124, which I think is the exact provision. We have filed our brief as recently as last week.

I think you know this is a matter where the House of Representatives is suing the department and myself with regard to this issue, and so we have filed that brief. I think we are in conversations with your staff to provide in terms of the issues in the conversation that you have asked for.

And so I think that we are taking that next step right now, is my understanding of where we are.

*Chairman Brady. I do not think that is the case, but here is my point. This Committee has oversight interests separate from the House's litigation. We have responsibilities and oversight that extend well beyond this particular program that the Administration's actions have affected.

The law is clear. The dollars will be spent. The Administration spent it in complete disregard to that law. That is why we are investigating this action, and so we are going to continue to seek those documents, and I am hopeful that the agency will be forthcoming both on the documents and making those staff available for interviews because we will not give up in this regard.

So with that I would like to recognize the distinguished Ranking Member from Michigan, but I have been instructed that the House will adhere to the 15 minute rule very tightly. So we are going to recess until after these three votes, Madam Secretary, and then we will be back at that point.

The committee is recessed.

[Recess.]

*Chairman Brady. Secretary, thank you for being patient. We just took a short hearing and made it shorter. So after Mr. Levin questions, we will be going to three-minute questioning, and it will be strictly enforced. We want as many members to be able to visit with you today as possible.

I will now recognize the distinguished ranking member, Mr. Levin.

*Mr. Levin. Thank you.

In order to expedite, Mr. Chairman, everybody's opportunity, I will limit myself to three minutes.

Thank you.

There was discussion here about the cost sharing issue. I just want to mention, Mr. Chairman, the Republicans decided to file a lawsuit, and now they want to take depositions outside of that lawsuit. I am not sure what the motivation might be.

You mentioned in your opening statement about TANF. I think you and I agreed that we would have an effort on a bipartisan basis with the subcommittee leadership on both sides to work out possible changes, and I hope we will proceed on that basis.

Let me just ask you about Flint. There is a panel discussion going on now. The person who first came across, I think, the deep problems there is testifying. I think also the Mayor of Flint is there.

So if you would discuss the HHS role because there are so many health aspects to this in terms of the CDC role, in terms of health care for these kids in their schools, et cetera.

So could you briefly describe what you are undertaking? The State failed in its responsibility. The Federal Government is stepping up to the plate here. Tell us what you contemplate.

*Secretary Burwell. So the President asked HHS to take the lead in terms of the interagency effort, working with EPA, HUD, USDA and FEMA, and we have done that. The Assistant Secretary for Preparedness and Response, Dr. Nicki Lurie, is leading that effort from an HHS perspective with Dr. Karen DeSalvo, the nominee for the office of the Assistant Secretary for Health. So that is our lead team.

Our efforts are focused on two fundamental things in terms of where we are and the go forward, supporting the State, the county and the community in two fundamental things.

The first is clean water and water that is potable, drinkable, and usable for the community. That has some short-term issues, and that has to do with things like FEMA helping get bottled water out, the installation of filters, which HUD is helping with, in terms of making sure people are putting in those filters right.

So there is the short-term solution, and then there is the longer term solution in terms of piped water being clean and usable. Focusing on that part, EPA obviously is leading much of the Federal Government's work in that space.

The second part of our effort in terms of what we are focused on in our plan is to support the local community as well as the State in determining the extent of the problem cost. In other words, how many children are suffering from elevated levels of lead, and then the attendant circumstances from a public health's perspective that come with that?

As we determine that, then determine how we go forward and assist in mitigating those circumstances.

*Mr. Levin. And in terms of health services, in particular, if you would just describe that because in mental health I was deeply troubled to learn there is one social worker, I think, for the entire elementary school system, and you have here a major health crisis for thousands of children who are now threatened through no fault of their families at all. Tell us a bit about that.

*Secretary Burwell. So the mental health and the behavioral health we think is an extremely important thing, and when we activated our efforts and the President asked us to go in, we activated SAMHSA, the Substance Abuse and Mental Health part of HHS so that they are supporting and providing behavioral health for the children, for the parents, for everyone.

We do that in crisis whether that is where other kind of crises occur, natural disasters, shootings or other things. And so SAMHSA is also a part of our extended effort on behavioral health.

With regard to other parts of the health issue, we have worked with USDA, and USDA is making sure that WIC will pay for a formula that does not need to be water mixed.

*Mr. Levin. If it is mixed with water, it makes it worse.

*Secretary Burwell. Right. So USDA is taking those steps. So we are working on the health issues both in a preventative form, in terms of pregnant mothers, as well as making sure that these children are getting tested.

And we are using our HHS facilities and sites to help with that, and whether that is using our health centers that are funded through HHS or using our Head Start facilities to get the information correctly to parents so they know that they need to get tested, and so

we are supporting the State and the local community in that effort to get the children tested and then to do the follow-up services needed.

Testing is also something paid for in Medicaid.

*Mr. Levin. Thank you very much.

Thank you, Mr. Chairman.

*Chairman Brady. Thank you.

Mr. Johnson, you are recognized for three minutes.

*Mr. Johnson. Thank you, sir.

Madam Secretary, I would like to start by asking you about the President's budget for refugee resettlement. Is it not correct that he proposes increasing the number of refugees to at least 100,000?

*Secretary Burwell. That is correct, by 2017. By 2016, 85.

*Mr. Johnson. Now, that is an increase of over 30,000 from 2015, with many of those refugees coming from Syria. It is no secret I oppose the President's plan. We just cannot take the chance of a terrorist slipping through because we cannot vet these folks.

Since Texas receives about ten percent of all refugees, my constituents are very troubled, but you know what else is troubling? These refugees end up on social welfare programs like food stamps and Medicaid, and for more than just a few of them. In fact, in 2013, over 91 percent of Middle East refugees received food stamps while fewer than half worked any point in the last five years.

Madam Secretary, with all of these Syrian refugees coming in, how much is this going to cost the American taxpayer, given their long-term use of social welfare programs?

And what are we looking at? After all, we are over $19 trillion in debt right now.

*Secretary Burwell. So with regard to the issue and our role in the refugees, I think you know our role is at the point at which the refugees have been placed that we do limited support to the local communities and to the refugees for a limited space of time.

I would be interested in making sure we get the numbers that you have with regard to the work numbers because the numbers that I have seen are generally higher than that in terms of the percentage of people that actually through our refugee programs that end up working. So I would love to make sure we can follow up with your staff to understand if there is a difference in the numbers that we are seeing because that is related to this issue of the estimates of the total cost to communities and other services.

*Mr. Johnson. Yes, we would be glad to get those to you.

Where are you on issuing new Medicare cards without Social Security numbers? Are you still on track to reissue all Medicare cards by 2019?

*Secretary Burwell. Congressman, this is one that you and I had both similar interests and similar questions, and in terms of 2019 and that time frame, yes, we are very much on track to meet those deadlines that have been legislated. I have actually pushed the team to see if there is any way that we can beat those deadlines, but we are certainly on track at this point.

*Mr. Johnson. Thank you, ma'am.

Mr. Rangel, you are recognized.

*Mr. Rangel. Thank you, Mr. Chairman.

Welcome. Puerto Rico, I understand that you have had some changes with the DSH formula as well as removing the cap from Medicaid, but since I have been in the Congress, Puerto Rico's health care system has been far below the national in terms of the access to quality health care, and as a result of the recent fiscal crisis, it is my understanding a lot of doctors and health providers have left the island.

This changing in the formula, what does this mean in dollars and cents as relates to $82 billion discretionary funds that you have?

*Secretary Burwell. So with regard to the proposal that we currently have, I think as you said, what we want to do is try and get the Medicaid efforts to a place where they are more similar to those for the rest of Americans in the country.

*Mr. Rangel. They are crippled now, and all I want to know is in terms of fiscal relief, I mean, what you talk about is equity and fairness that we should have had. Now they are crippled for a variety of reasons, and health care is a major reason.

In the three minutes I have, could you tell me out of your budget how much is set aside to try to give assistance to our citizens, most of whom are not Muslim, but to make it easier; how much money is set aside to help them in this fiscal crisis?

*Secretary Burwell. So there are a number of places in the President's budget that --

*Mr. Rangel. Total, if you brought them all together, what would it amount to?

*Secretary Burwell. That I will have to go because I need to work with my colleagues at Treasury and we will get back to you.

*Mr. Rangel. Why do you not give an estimate so I will have some idea of the degree of urgency that HHS has placed on this?

Because a large part of their problem is within the power of HHS.

*Secretary Burwell. I think at this point I will have to get back in terms of the number. The number is a large one.

*Mr. Rangel. Well, whatever formulas you have changed, when we do anything on the committee, we have to put a dollar estimate on what is it going to cost.

*Secretary Burwell. And we do have a dollar estimate in the budget, and I will get back on the number. I am --

*Mr. Rangel. You could not even guess how much of the 82 billion we are changing the formula, bringing equity and fairness, bringing it up to Stateside, providing more money for a disproportionate share, Medicaid caps removed.

*Secretary Burwell. With regard, there are a series of proposals throughout the budget --

*Mr. Rangel. How soon can I brag about how your office has comes to the assistance of our citizens in Puerto Rico?

*Secretary Burwell. You will be able to do it by the end of the day.

*Mr. Rangel. That is fair enough. I pass.

*Chairman Brady. Thank you.

Mr. Tiberi, you are recognized.

*Mr. Tiberi. Thank you, Mr. Chairman.

Secretary Burwell, thank you for being here.

As you know, I think you would agree -- maybe not -- Obamacare's co-ops have been a disaster, and after using American taxpayers' piggybank, more than half have failed. This morning, the Columbus Dispatch, my hometown newspaper, I was greeted with this headline: "Customers mad about late notice. Ohio Health dropped."

So Ohio Health is the largest hospital system in central Ohio, the largest, and these articles, and there is a second one that I am going to submit for the record, Mr. Chairman, both of them, and we will get you a copy of both of these articles.

They indicate that a company called InHealth, which is a co-op, headquartered in Westerville, Ohio, is under enhanced oversight, which means CMS is concerned about its financial stability and it is closely monitoring its operations.

The article that I read this morning says about 9,000 Ohioans are enrolled in InHealth, and they recently got some bad and surprising news. At the last minute, InHealth decided to drop most Ohio Health hospitals and doctors from their network, leaving them with few options now that the enrollment period has passed.

So this article from this morning's paper talks about a couple in Marion, Ohio. Marion County has one hospital. It is an Ohio Health hospital. So this couple now has to drive over 20 miles to go to a hospital outside of the county to get an in-network hospital rather than go to the one just down the road that they have been using for years.

Another article from last week quotes a man from Westerville where InHealth is headquartered in my district, also had a preferred hospital, Ohio Health, that he went to that is now out of network for him.

So these folks in this article have been going to doctors and hospitals that they wanted to until they got onto this co-op that was created under Obamacare. So the article goes on to talk about how this co-op is struggling, and the article now also says that these folks are now going to have a narrower provider network because of the mandates and regulations under Obamacare.

So what I do not understand is how the Administration that has been crowing about consumer and patient protections in the President's health care law allow a co-op that was created under the health care law, can allow this co-op that is supposed to be closely monitored, pull the wool out.

And you will see the article here. Some of these people are just devastated from losing their doctors and hospitals, to allow a provider to pull out of a provider network, provide a major announcement, major changes, after the enrollment period has passed.

[The information follows: The Honorable Patrick Tiberi]

*Secretary Burwell. With regard --

*Chairman Brady. Madam Secretary, I apologize. Time has expired in the three minutes, and hopefully you will get a chance to respond to that a little later.

Dr. McDermott, you are recognized.

*Mr. McDermott. Thank you, Mr. Chairman.

I will respond. The Republicans gutted the risk corridor money, and so these co-ops are going down. That is what happened in Ohio. So there is no mystery to what happened.

The newspaper just did not go to the fact that the Republicans in the Congress had taken away the risk corridor money.

*Mr. Tiberi. Will the gentleman yield?

*Mr. McDermott. No. I have got only three minutes.

I want to ask you a question about drug costs because drug costs are scaring the living daylights out of people, and when we put Part D in the law, the Republicans put it in by caving to the pharmaceutical industry and tied the hands of the Secretary and taped his or her mouth shut so you cannot negotiate any kind of reductions in drug prices; is that correct?

*Secretary Burwell. At this point I do not have negotiating authority. That is one of the things we had asked for in our budget, for specialty and high cost drugs. That is one of the proposals that is in the President's budget right now.

*Mr. McDermott. Does the Veterans Administration have the ability to negotiate reductions?

*Secretary Burwell. Yes, they do.

*Mr. McDermott. Do you know the percentage reductions that they have negotiated there?

*Secretary Burwell. We know that they have been able to achieve cost savings.

*Mr. McDermott. Twenty percent, 30 percent?

*Secretary Burwell. I would have to ask the Secretary of the VA.

*Mr. McDermott. You do not know them?

*Secretary Burwell. Yes.

*Mr. McDermott. How much money do you spend in Medicare on pharmaceuticals?

*Secretary Burwell. The number, the percentage continues to risk, and that is why this is one of the areas of focus for us in terms of we know that in the most recent year for statistics, 2014, we saw a 12 percent increase in just the pharmaceutical costs.

*Mr. McDermott. What is the dollar amount that you spend?

*Secretary Burwell. We can get back on the dollar amount. In percentage terms it is a growing percentage of the overall Medicare budget, which is 52 percent of all of the entitlements at HHS.

*Mr. McDermott. Let's say you spent $100 billion on pharmaceuticals, right? Just for a hypothetical.

*Secretary Burwell. Yes.

*Mr. McDermott. If you reduced that, if you could negotiate a 20 percent reduction, that would be $20 billion saved; is that correct?

*Secretary Burwell. Yes, it is.

*Mr. McDermott. If you could negotiate a 40 percent reduction, it would be 40 billion, right?

That is what the Veterans Administration says, somewhere between 40 and 60 percent reduction, and it seems to me that you have asked for that in this budget. Tell us about what is in the budget as far as negotiating ability.

*Secretary Burwell. So there are number of things that are in the budget with regard to the high cost drug issue. This is one of them in terms of negotiating authority. We have also asked for the authority for us to pool with States and Medicaid to create Medicaid pools so that the States can negotiate in a more effective way in terms of drug costs for the States.

The third thing that I would mention in the area of high cost drugs that is in this budget that I think is important is speeding up the closure of the doughnut hole for our seniors. Right now through the ACA, the closure that originally occurred has saved $20 billion for ten million seniors in the country, and so working through our ability to do that are three of the priorities we have.

*Chairman Brady. Thank you. All time has expired.

Mr. Reichert.

*Mr. Reichert. Thank you, Mr. Chairman.

Thank you, Madam Secretary.

I just want to cover quickly some of my major concerns with the President's budget. Reduces biologics market exclusivity from 12 to seven years, a serious impact on TPP and the biologics industry.

It cuts medical education payments to hospital by ten percent; cuts reimbursement to critical access hospitals, which are the small rural hospitals like Sequim Valley Hospital that you are familiar with coming from Washington State for those many years; cuts payments to long-term care hospitals, skilled nursing facilities, home health agencies; cuts Medicare Hospice payments. Those are some of my major concerns.

But I want to also in my short time thank you for your work with the Bill and Melinda Gates Foundation, for promoting women's health, children's health, and fighting global poverty, and all those things that you have done. You know, I know your heart. It is a caring heart, and so I am going to move away from partisanship messages for a moment and ask for your help, and I'm going to ask for the President's help and the Vice President's help, the Administration's help on this.

I am on a mission, and I want you to be a part of the mission, and the mission is this. The President has said we are taking a moon shot on cancer, $755 million in this effort. But here is a group of people I am going to share with you who are left out.

One of the most common side effects from cancer treatments is lymphedema. It afflicts an estimated 15 percent of all survivors and 40 percent of all breast cancer patients. As beneficiaries live longer, an even greater emphasis must be placed on self-care. These lymphedema patients need these compression garments. I am asking today, Madam Secretary, for your help, the Administration's help in providing the care for 40 percent of breast cancer survivors who need these garments.

The money we save, the health issues that we can avoid, providing these garments, well, they are not measurable. Can you help us with that?

*Secretary Burwell. Congressman, I will look at it and follow up and follow up directly with you.

*Mr. Reichert. Can you help us with that?

*Secretary Burwell. I assume it is a payment issue in terms of what we do and do not pay for? Is that what it is?

*Mr. Reichert. We just need your help. Yes. Would you help us with that?

*Secretary Burwell. I will look into it and work to see what we can do within our authorities. You know, when it is a payment issue --

*Mr. Reichert. It has been years, and the $755 million we are asking for, the President asked for, at least some consideration for the help of these people suffering from this disease should be considered.

I yield back.

*Chairman Brady. Thank you.

Mr. Lewis, you are recognized.

*Mr. Lewis. Thank you very much, Mr. Chairman.

Madam Secretary, welcome.

*Secretary Burwell. Thank you.

*Mr. Lewis. Thank you for your service and for all your great and good work.

Madam Secretary, as you well know, the CDC is headquartered in my congressional district. Can you talk about public health preparedness generally? Are we ready? Are we prepared?

My understanding is that the Zika cases have already been reported in the United States. Do we have an estimate or the potential cost of this virus?

*Secretary Burwell. So the Zika virus, I think, is part of the broader preparedness, and fortunately, the work that we did in Ebola has put us in a place where there are a number of things that help us.

But with regard to the Zika virus specifically, I think it is important to note a number of things that are very important. First of all, the most important concern we have right now is pregnant women, and I think you know we have put out the guidance that indicates that any woman that is pregnant, the CDC recommends you do not travel to any of the regions because microcephaly, the birth defect, that while we have not been able to scientifically put the causal link, we have enough concern that we have made that recommendation.

So focus on pregnant women. Next is we need to make sure that we are focusing on controlling the mosquitos that cause it. This is different, and I think many people will harken back to Ebola, but this is fundamentally different because it is passed by a mosquito biting someone who has the disease and then biting another person.

Eighty percent of the people that have it do not know, and so this is a part of what is a very large problem, and for those that do have it, it is about a week's worth of fever, and sometimes they think that it is the flu or something else.

With regard to our domestic preparedness, we have a plan together with the CDC, the NIH, the Assistant Secretary for Preparedness Response in terms of our homeland preparedness.

What we need to do though, and we have the supplemental that we have proposed, is make sure that we are able as Nation to be prepared as we go into the summer months, especially in the South.

So there are two mosquitos that transmit this. One is a very efficient transmitter, meaning it will bite four individuals in a meal, and so you can imagine how that gets passed. The other mosquito, that mosquito is limited into the Deep South in our country. The other mosquito can cover almost up to 20 or so States. That one bites other things, but I still may be a transmitter.

So we need to get in place the right communications, the right public health, and the right mosquito control before we hit the South.

Right now in the United States no continental cases have been passed by a mosquito to a person. It is travelers coming back, and one sexual transmission in Dallas. In Puerto Rico, we have a situation where already we are seeing mosquito pest cases.

And so those are the elements we need to do. We have a plan. That is why we have asked for the funding.

*Mr. Lewis. Thank you, Madam Secretary.

*Chairman Brady. Thank you.

Dr. Boustany, you are recognized.

*Mr. Boustany. Thank you, Mr. Chairman.

Secretary Burwell, I want to get the Administration's clarification on health reimbursement arrangement or health reimbursement accounts. In 2013, harsh penalties were applied to small business owners who use these health reimbursement accounts for their employees to the tune of $100 per day per employee.

I questioned Secretary Lew about this last year during the budget talks, and subsequently the Administration put this on hold for less than a year.

I heard from Randy Noel in Louisiana, who is a small business owner, he has been advised to pay these penalties because the time in which this was put on hold was less than a year.

There has been so much uncertainty, but this is a very draconian penalty. Is the Administration going to eliminate this penalty or would you work with us? Because Mike Thompson and I have bipartisan legislation; it is bicameral and it is also bipartisan in the Senate, to eliminate these harsh penalties.

*Secretary Burwell. Is this the rulemaking that you spoke with Marilyn Tavenner about? Is it that particular rulemaking?

*Mr. Boustany. I actually had a conversation with Secretary Lew about this. I think I did raise this with Marilyn Tavenner as well.

*Secretary Burwell. I want to follow up because there are two different provision, and I am not sure which one we are talking about here.

*Mr. Boustany. Well, this is specifically about the health reimbursement arrangements which allow for employers to provide dollars' assistance to their employees. It is fine under ACA, but for some reason the Administration going back to 2013 imposed a $100 per day per employee penalty.

It is very draconian on these small businesses, and Secretary Lew admitted it was a problem last year. It was put on hold, but for really less than a year. I think it was like six or seven months, and now we have this penalty re-imposed.

These small business owners do not know what to do. We think it ought to be eliminated. These employers are trying to help their employees and provide for insurance.

*Secretary Burwell. Let me check and follow up. It is on the tax side though. Is that why you went to Secretary Lew?

*Mr. Boustany. Well, I did raise it because it is a tax issue, but it also is a health issue.

*Secretary Burwell. Okay. I will follow up on our end.

*Mr. Boustany. I intend to ask Secretary Lew about it when we have him in front of the committee as well.

*Secretary Burwell. Okay. I will follow up with the Secretary. This one probably sits with them, but as you reflect, it is an important part of the --

*Mr. Boustany. It is a health issue.

*Secretary Burwell. Yes. So I will follow up.

*Mr. Boustany. Thank you.

I yield back.

*Chairman Brady. Thank you.

Mr. Neal, you are recognized.

*Mr. Neal. Thank you, Mr. Chairman.

Thank you, Madam Secretary.

Madam Secretary, the Massachusetts delegation lunched today with Michael Botticelli and the Sheriffs' Association of Massachusetts to talk about the opiate crisis. Governor Baker, to his credit, has suggested that more than 1,200 to 1,300 people died last year in Massachusetts of opiate addiction.

Heroin is being sold on the streets of Springfield and Hartford for $2.50 a bag, and clearly the movie HBO presented called "Heroin on Cape Cod" is riveting. I would recommend it to anybody who might be interested in what has happened.

The President's Drug Czar today, Mr. Michael Botticelli, said that part of the problem clearly is the overuse of prescription drugs, and that it has heralded a new era in how to treat addiction.

Seventy-eight people as you noted lose their lives every day as a result of these drugs, and you have offered several proposals in your budget to deal with this alarming epidemic.

Could you give us greater detail as to how you suggest that we might proceed?

And applause to the President for suggesting $1 billion in new expenditure to address this issue.

*Secretary Burwell. So an issue that is deeply important to me. As many of you know, I am from the State of West Virginia where the problem has been acute for many, many years. So a priority since I came.

When I came to HHS, we put together a three-part strategy in order to make progress on it. The first has to do with prescribing. We know in 2012 there were 250 million prescriptions of opioids. I think you all know how many adults there are in our country, and the idea that in 2012 there were 250 million prescriptions, the overprescribing is a problem. We need to take that on.

As part of that, the CDC will be issuing new regulations. We know pain is important. It is important to be treated, but the overprescribing that has occurred, we need better direction. So that's part one.

Part two is medication assisted treatment, and right now as you reflect in terms of the numbers that are in your State and in many of the States represented here, we need these people to be in medication assisted treatment. There is not access to the treatment, and

that is one of the major parts of the funding that you mentioned. It is to create an ability for States and communities.

So the money would go to SAMHSA and a little bit to HRSA, and that money would then go on to States and communities because we need to build the capacity for the medication assisted treatment for these people because right now they come into law enforcement.

You were just meeting with the sheriffs. I have met with the sheriffs. I met with them in Massachusetts with Governor Baker. What they will tell you is we are not social workers, but we see these people time and time again and have nowhere to send them.

The third element of the strategy, and sadly we have to have this element, is naloxone or some people call it Narcan, which is the drug when people have overdosed because sadly we have so many people that are in a state from either heroin or prescription drugs and they have overdosed, and at that point we are just trying to save lives.

And so some of the money will go to move and fund naloxone at the community level.

Much of the money we are asking for is about moving it to the States and communities that are in need so that they can build their capacity to work against these three strategies.

*Chairman Brady. Thank you.

Mr. Roskam, you are recognized.

*Mr. Roskam. Thank you.

Madam Secretary, two quick issues. I think they are pretty straightforward and pretty simple. The House has inquired about the basic health program, and I was able to receive a briefing from your Assistant Secretary for Financial Management, Elaine Murray, who is here today and came and gave me some good insight into the process.

Out of that discussion, we put forward a request for documents on something that we learned about, and that was a document called "the big ugly table" that she said was critical in putting together the basic health plan.

Now, recognizing that we are not in litigation so that there is no concern there, we have requested this document and other documents, including the memorandum of understanding between CMS and the IRS.

The results have not been forthcoming. We have gotten, you know, redacted information followed up, back-forth, back-forth. The latest was literally a 234-page printout of public information from the CMS Web site that is submitted to Congress.

In the spirit of Congressman Rangel and the dispatch with which you were able to easily answer his inquiry, can you get us this "big ugly table" by the end of the day along with the CMS-IRS memorandum of understanding?

*Secretary Burwell. So, Congressman, my understanding is that we have turned over documents. We --

*Mr. Roskam. They have not been responsive.

*Secretary Burwell. So I would like to follow up with staff to understand. Our staffs need to get together to understand this.

*Mr. Roskam. Great. It is a complete mystery, and time is short. So I want to move to another issue, but it is to the point of absurdity. So if you can intervene and get us the "big ugly table," which according to the briefing was critical to the decision making, along with the memorandum of understanding between CMS and IRS, that would be helpful.

Secondly, we heard testimony at the Oversight Subcommittee about the fraud and erroneous payment rate from CMS. The Deputy Administrator said the number is 12.7 percent. The remedy or part of a solution Mr. Blumenauer and I are working together for a common access card using the same technology that DoD uses and has used in the financial services arena.

We received some technical assistance, but it was like pulling teeth from CMS; had to get the Administrator personally involved to get this done. Okay. Because he is meeting people who do not want to change things.

But this, Madam Secretary, as we both know, is a system that desperately needs to change. Would you be willing to help Mr. Blumenauer and me, as we are trying to move forward, get the technical assistance and put together a common access card pilot program that we can see if it works and if it saves money?

We are persuaded it will do that, but we need your help and we need your personal help substantively because we are meeting a lot of passive-aggressive folks that do not want to be helpful.

Will you help us?

*Secretary Burwell. I will look into seeing what we can do in terms of whether we have -- is it statutory? Is that why we are providing technical assistance?

*Mr. Roskam. Yes.

*Secretary Burwell. Because it is statutory. Okay. Then let us look into it and understand because I think hopefully this is the kind of thing that will move us along the

electronic health benefits end using technology and data to do delivery system reform. So I would like to understand it more fulsome and figure out if we can provide technical assistance if it is statutory.

*Chairman Brady. Thank you. All time has expired.

Mr. Doggett, you are recognized.

*Mr. Doggett. Thank you, Mr. Chairman.

And, Madam Secretary, the President's budget indicates that, quote, "The Administration is deeply concerned about rapidly growing prescription drug prices."

Certainly that is a concern that is so real to many consumers who are basically faced with the choice: your money or your life.

While I am fully supportive of the Biden Cancer Moon Shot Initiative that you referred to to try to convert some of the pain and grief that he and so many families have, unless the Moon Shot addresses accessibility for so many of our neighbors, it will really be just a shot in the dark.

The one thing that we already know without any more research on drug effectiveness is that an unaffordable drug is 100 percent ineffective. I applaud each of the budget's legislative proposals that you outlined to Mr. McDermott. Together they would save taxpayers over $172 billion.

Republicans are always telling us about how entitlements need to be brought under control and Medicare is unsustainable. I think the place to begin is by cutting those who think they are entitled to charge the highest drug prices in the world to Medicare and Medicare consumers.

Clearly legislation is required, but you and I know that lightning could strike the Capitol dome in the same place not twice but ten times, and this Congress would not be willing to stand up to the pharmaceutical lobby. It is essential that the Administration use every tool at its disposal to prevent price gouging.

You are aware that 50 of our colleagues have asked that you and the NIH use existing authority to at least set some standards for prices when taxpayers paid for the research that led to a drug. Can you assure that our request is receiving your thorough consideration?

*Secretary Burwell. It is. It is. Your letter we have received. Thank you, and we are continuing to try and pursue every administrative option.

We have proposed legislative and statutory changes as part of the budget but are looking at a wide array, which we welcome your letter and your suggestion.

*Mr. Doggett. I am pleased with your Dashboard, with your proposal on Part B payment models. I hope you can build on the oncology care model from the Innovation Center.

I believe that when you ask that we mandate pharmaceutical companies to provide certain information that is vital, that is a good idea, but I hope that you will consider requesting that they voluntarily provide that information this year and will continue to look for ways to bundle pharmaceuticals with other services, will implement your bio-similar reimbursement rule, and take every step you can, knowing this Congress will do little, but there are still steps you can take to help American families on pharmaceutical price gouging.

Thank you so much.

*Chairman Brady. Thank you. All time has expired.

Mr. Smith, you are recognized.

*Mr. Smith of Nebraska. Thank you, Mr. Chairman.

And thank you, Secretary, for your presence here today.

I do want to follow up on a characterization made earlier that it is Republicans' fault for removing some funds, therefore causing the co-ops, the Obamacare consumer oriented and operated plans to collapse.

I do want to add though that on April 11th, 2014, from a fact sheet from CMS they stated that, quote, "We anticipate that risk corridors' collections will be sufficient to pay for all risk corridors' payments." I just want the record to reflect that.

But certainly the collapse of CoOpportunity Health for Nebraska and Iowa has been a huge deal in Nebraska. Many Nebraskans are still smarting from it. Actually a constituent named Pam has lost her coverage three times, thanks to the Obamacare, the entire plan that certainly denied her the coverage she was told she could keep, that she could afford, that covered her preexisting condition.

And so I do have a question though. As it relates to the Administrators of CoOpportunity Health for Nebraska and Iowa, it is my understanding that they kind of saw trouble on the horizon. So they requested the opportunity to suspend enrollment, and that request was denied.

Can you speak to that?

*Secretary Burwell. We discussed this, I think, last year when I was before the committee, and I would like to follow up in terms of where they felt the request because

we did not, when I followed up, feel that there was a request at all that came into us and that was denied.

So I would love to follow up because when I followed up on this before, we had not received that request.

*Mr. Smith of Nebraska. Okay.

*Secretary Burwell. And so let us understand because we work with all of the co-ops on this issue. Our number one priority is the consumer, as you are indicating. That is our priority as well. That is why, to be honest, a number of the co-ops came out before this open enrollment as we worked with the States that are their primary regulator. We worked with the States on that issue.

So the consumer is the number one concern. So if we can understand how they felt they did that because if there was a process that is unclear or something there, I think it would serve everyone else if we can learn from this example.

*Mr. Smith of Nebraska. Right. And overall, you know, we heard a couple of months ago I think it was that the co-op program is on sound footing, and yet we have now learned that Maine, I believe, who was the only one at one point turning a profit, is now beginning to lose money.

Where do we stand on that entire issue? Are they on as solid footing as we were told some weeks ago?

*Secretary Burwell. So with regard to that, as you know, at that point as when we came to open enrollment, we worked with all the States to make sure that the State Commissioners of Insurance and we felt they were.

With the facts that we have and had at that time, that is where we are. I think we also have taken steps to help the co-ops in terms of how they can access capital if they need it. That guidance was put out about two weeks ago as well.

We are going to continue to monitor closely with the States.

*Mr. Smith of Nebraska. Thank you.

Thank you.

*Chairman Brady. All time has expired.

Mr. Thompson, you are recognized.

*Mr. Thompson. Thank you, Mr. Chairman.

Madam Secretary, thank you very much for being here and the outstanding work that you and your team do.

I've got a couple of issues I would like to get a response on. The first is the recovery audit contractors, the RACs. I have had dealings with these folks in my district, and I am assuming other folks on the committee have as well.

The idea that a provider would have to wait 800 days for a decision is just wrong, and I am hoping that you are going to be able to tell me that you are working on fixing that.

And I know that the Provider Relations Coordinator Program has done some good in this area. Are there plans to expand that so we can get this number down to let people in some cases stay in business?

And then also I want to talk to you a little bit about TeleHealth. Congressman Black and I have legislation that would expand TeleHealth. It is a way that you can accomplish two I think very important goals. One is to save money, and the other and most important is to save lives.

I know the President's budget has provisions in there to expand the venues whereby TeleHealth can be used, and also to allow it to be used in Medicare Advantage.

And I would be interested in knowing if you have some sort of means by which to collect data on the cost savings because if we can quantify that, I am sure it will help us expand TeleHealth even more.

*Secretary Burwell. With regard to the first issue in the RACs, we have made changes. And so if it goes beyond the 60 days, they don't get the money, in terms of the RACs. We've actually put in place changes with the feedback.

*Mr. Thompson. With the contractors?

*Secretary Burwell. Yes. Yes. And so if it goes beyond that period of time, it doesn't. If at any point the decisions are overturned in the process, they don't get the money either. And so we put in place a number of steps in response to the criticisms that we have heard about RACs. With regard to the telemedicine issue, as you stated, we have several proposals in our budget. We think this is an important place to make a difference, both in terms of quality of care that we can provide, access in rural areas, particularly. It's very important.

And right now, we have, we have those numbers scored. And so we have been able to score the savings that we think can occur by using telemedicine. And so we can get to you all as you all are considering your legislation how we score those numbers. And there are two different provisions, both in terms of our federally qualified and rural health clinics being initiation sites for telemedicine, as well as making sure that in Medicare

Advantage it can be paid for. Which is sometimes one of the prohibitive things with telemedicine.

*Mr. Thompson. Well, we'd like to see those numbers and that methodology, and also would love a commitment from you to work with us to make sure we can further expand telemedicine. Because it does save lives and does safe money.

*Secretary Burwell. Yes. And we'll probably come to it, I think, if we're going to talk about the Indian Health Service as well.

*Mr. Thompson. Thank you.

*Chairman Brady. Thank you. Ms. Jenkins, you're recognized.

*Ms. Jenkins. Thank you, Madam. Or, Mr. Chairman. Thank you, Madam Secretary, for being here. As many of my colleagues on this Committee have already mentioned, the President's health care law has continued to fail so many Americans. Over the past few weeks, I've hosted almost 20 town halls throughout Kansas. And folks back home often tell me how they face increased premiums with fewer options for care. 2016 premiums are expected to increase by 15 to 25 percent in my home state of Kansas. This simply is not right, especially in the face of a failed economic recovery. And I, along with my colleagues here, continue to work to replace Obamacare, repeal it, find proposals that drive competition, lower cost and improve health care quality for all Americans. One particular provision of Obamacare that's especially cumbersome and drives up healthcare costs for the everyday American is the requirement that individuals have a prescription from a physician in order to purchase over the counter medicine with their health savings accounts and flexible savings accounts. And I have worked on a bill, HR1270, the Restoring Access to Medication Act, which would eliminate this unnecessary requirement that's both confusing and frankly, it's just a waste of time for patients and physicians. And we've worked closely on this legislation now for three years, with my colleague, Representative Kind, from Wisconsin. When you testified in front of our committee last June, I asked if you would support us on this type of legislation. At the time you indicated you weren't familiar with the issue. Have you had a chance within the last year to review it now? And if so, would you support the legislation?

*Secretary Burwell. With regard to the issue in terms of driving down the costs on the over the counter prescriptions, I apologize in terms of the specifics of the legislation. We'll need to come back to you on that. In terms of the basic concepts of making things simpler and easier, we're working at that across the board. And whether it's the announcement that occurred yesterday with Walgreens about over the counter and Niloxone and other drugs like that. So the concept of this is something that I think we want to continue to work on. With regard to the specifics, I will need to get back.

*Ms. Jenkins. Okay. Well, I believe this is just a few easy, common sense approach. It's bi-partisan. If the Administration will just take a look at it. It's kind of

frustrating, year after year after year to have you come before us as if you're not interested in looking for some of these common sense solutions to help all Americans, especially when they do have bi-partisan support. So thank you. I yield back.

*Chairman Brady. Thank you. Mr. Paulsen, you're recognized.

*Mr. Paulsen. Thank you, Mr. Chair, and thank you Secretary. Secretary Burwell, Mr. Larson. Thank you, Secretary, Madam Secretary, for being here. Madam Secretary, several states have closed down their exchanges, and many other states are facing some challenging financial situations with self-sustainability. That includes MNsure, which is Minnesota's exchange in the program. And a new audit found out that over a five month period last year, MNsure repeatedly failed to properly determine the eligibility of enrollees, resulting in potentially 271 million dollars in overpayments. That's 271 million dollars of taxpayer money. And this is the headline from the Minneapolis Star Tribune, just a week and a half ago. I'd like to enter this for the record, Mr. Chairman. And these are overpayments that occurred despite the fact that a report a few months earlier had warned MNsure that it was not accurately applying eligibility requirements. Now, the President's health care law, it does require that state-based marketplaces, that they be self-sufficient. It requires that they follow the law. But HHS doesn't really seem to be doing anything to enforcement it on the enforcement side. Instead, they've acknowledged or they've given more money, in terms of no-cost extension requests through the end of this year. And so it seems there's no gatekeeper. There's no enforceable plan.

And this is really not about being against Obamacare. It's about enforcing the law and making sure the taxpayers are protected, and continuing to hold these exchanges accountable is going to ensure that patients ultimately are not going to be hurt when there's a change in health insurance. So my understanding also is that after all these reports, after all these audits, throwing away millions of dollars in taxpayer money, HHS's own inspection, Inspector General, is also going to be coming out potentially with a report in a few weeks that will explore issues with MNsure's internal controls. So your own Inspector General is acknowledging some of these problems. So can you just share anything with us about the upcoming report that might be coming out? And more importantly, just can you give a little bit of plan of action for making sure that MNsure is following the law?

*Secretary Burwell. So with regard to the state based marketplaces, as you reflected, a number of them are in various states and have been able to achieve certain things and not. And when they're not, you know, the Administration has engaged. And HHS has engaged with them. And whether that's in Hawaii or security issues in other state exchanges. And so we do engage on that. The IG's report is something we look forward to, and will be a part of us determining what are the appropriate next steps for us in terms of that engagement.

But across the board, as different state based marketplaces have had different issues, I think you probably know we have engaged and at various points and times needed to switch them to the platform, if they aren't able to meet certain of the conditions that you

articulated. That they are making sure that there are adequate networks. That there are different types of issues. Most have been technology related, but not all.

*Mr. Paulsen. Okay. So we'll see some enforcement mechanisms, some follow ups, some follow through?

*Secretary Burwell. We look forward to the IG's report, when we will receive it. I think you know; we work with the IG as part of program integrity across the Affordable Care Act. It's something we work for. But also we want to let them have their independent view. And then they come back and tell us what they have found.

[The information follows: The Honorable Erik Paulsen]

*Chairman Brady. Thank you. Mr. Larsen, you're recognized.

*Mr. Larson. Thank you, Mr. Chairman. And thank you for holding this hearing. And Secretary Burwell, it's always a pleasure to have you here. And I wanted to thank you sincerely for your continuing outreach. You are a model of how we believe that the relationship between the executive and legislative branches should work. And I want to thank you. I want to commend the President and you for the budget. And especially, as Mr. Neal has addressed already, the more than billion dollars that have been put forward to address this long term epidemic that we're facing with heroin overdoses and opiates. And I also want to commend Senator Shaheen and Congressman Courtney. The New England delegation has come together in looking head on at this epidemic. I think this is something that affects every member in this institution, in all states. There's nothing partisan about it. We are in the throes of an epidemic. And it is my hope that while I think the billion is appropriate, by the time that we get through sorting out and going to regular order, if in fact we do, that too many more people are going to have passed away. And so what we're hoping, in the New England delegation, I hope that members of the committee can join with us in sending a letter to the President. I think we need emergency supplemental funding now, along the lines of Senator Shaheen and Congress Courtney have called for, that would provide the 600 million dollars that could be used immediately by those on the front lines of trying to deal with this, this epidemic. I would note that just since January 28th in New London, Connecticut, 24 deaths occurred. The Zika virus is something certainly that needs our attention, et cetera. But I dare say that this is a far greater epidemic and needs our immediate attention. And for so long, has been swept under the floor. I commend Mr. Neal for bringing this to the attention of the entire New England delegation. It's my sincere hope that the committee can join together to see if we can't get supplemental funding. I hope you can join us in that effort.

*Secretary Burwell. We look forward to working with the Congress across the board in whatever appropriate way to get the funding that we need. We think the funding and moving it to communities is important, and we'll look forward to working with the Congress.

*Mr. Larson. Thank you.

*Chairman Brady. Thank you. Mr. Marchant, you're recognized.

*Mr. Marchant. Thank you, Mr. Chairman. Ms. Burwell, one of the most significant things that's happened in Texas in this last year as far as health care was that at least one of the largest health care providers, it may be our largest, Blue Cross, Blue Shield, completely walked away from and abandoned its PPO program. And anybody that had an individual policy had to convert to basically their HMO plan. That's, that has basically created most of the calls about health care in my office this year.

You're proposing, and you've just given notice of a benefit and payment parameters regimen that's coming up. And my concern is, does this new regimen that you're laying out, force the private insurance companies more into abandoning their PPOs and more into an HMO plan? Or will it provide them sufficient room to where they can actually operate a PPO model?

*Secretary Burwell. Well, with regard to the, the rule making and where that will go, I don't think it is something. I think there are a number of things that these companies are considering when they're making these decisions. And I think they are two different things. There's the marketplace, in terms of those folks who are going to the individual marketplace. And then there's the employer based market. And what we know in both of those marketplaces -- and obviously the employer based market is separate from the marketplace that we see some narrowing of the networks.

One of the things in the marketplace though is that you must have an adequate network. That there's at least a test for that for the marketplace in terms of what we're doing. And so many companies are making these decisions. They're making the decisions. It is a private market. And they're following the consumer. In terms of what we saw statistically, what happened from 13 to 14 and 14 to 15, what we saw is the consumer actually making choices that they were choosing a narrower network and lower price versus a broader network and higher price. And I think we see the insurers responding to that in both the private market as well as the marketplace market, the employer based market. And so we want to do this to make sure that choice is available. And this year in the marketplace, in nine out of ten counties for most of the marketplace participants, there were three or more choices. And that's a part of getting to that space. And this comes back to the other question about the networks. What I think we believe is an important part of this is downward pressure on overall healthcare costs. Because that's what's driving insurer decisions. And that's why this concept of delivery system reform, an engaged, empowered, educated consumer at the center, where we pay for value, not volume, where we use data and information and where we change the way we deliver care, is the important when we think over the long term.

*Mr. Marchant. Mr. Chairman, if I can just ask one final question. Is there a place that I can go --

*Chairman Brady. I'm sorry, Mr. Marchant. All time has expired. Mr. Reed, you're recognized.

*Mr. Reed. Thank you, Mr. Chairman. Welcome, Madam Secretary. Madam Secretary, a limited time, I'm looking for an area where we may be able to advance some legislation this year in regards to reform that we can agree upon. And one of those areas is welfare reform. And I read the budget in particular. And I was very interested in pages 55 through 59 of the summary of the budget, dealing with TANF, and the issue of flexibility and the Upward Mobility Project. Could you touch on what the Administration's looking at in regards to giving greater flexibility to local and state entities that you reference in the summary portion of the budget in regards to things like Upward Mobility and others?

*Secretary Burwell. I think this is something we'd want to work with the Congress on. And think as was indicated that there has been bi-partisan work in the space of what we need to do further. I think we're very focused on the work elements and making sure that the money goes, the TANF money. And our approach is about that. And so this is a place where I think we welcome the opportunity to work with Congress.

*Mr. Reed. And are there any areas in particular you could identify for us in regards to greater flexibility, the Administration would be willing to engage in a conversation giving to local and state entities that are in this space doing this much needed work?

*Secretary Burwell. I think we'd like to come back and have that conversation. Is it all right if we follow up with staff? Because I think the bi-partisan effort that was moving last year had a number of these elements that I think we thought were, were good and positive and would like to support, if we can be specific.

*Mr. Reed. Are there any, any areas in particular you can identify?

*Secretary Burwell. I'd like to come back on the specifics.

*Mr. Reed. Well, we'd appreciate having that conversation and being involved in that conversation, as it's an issue that we're taking up in our office. As we want to reform this area. The other area that I'm looking at is if there is a better way that in your opinion, Madam Secretary, that we could measure the success of these outcomes? Often I find in this area measurement of the success is how much money we spend in this regard. Is there anything in your personal opinion you think we could do better, other than just measuring cash or dollars spent on these programs? That maybe we could have that conversation of changing the metrics. Is there anything you personally would like to work with us on in regards to changing those metrics from a cash basis?

*Secretary Burwell. I think one of the metrics that we all want is knowing how many people actually get into gainfully employed situations for an extended period of time.

*Mr. Reed. Oh, I so appreciate that.

*Secretary Burwell. That's not the only measure, in terms of --

*Mr. Reed. Are there any other measures you have?

*Secretary Burwell. But that is one that I do think is an important one. And why, we believe, the money should be more targeted than it currently is in terms of what it's being for in states.

*Mr. Reed. I so appreciate, commend to that metric change. Because I think it is much needed in this culture, to measure the outcome based on success in regards to people getting into a self-sufficiency mode, standing on their own two feet themselves. Is there any other metric you'd be willing to discuss personally that you think is a better metric, to see how these programs are doing?

*Secretary Burwell. I think when we come back on the specifics of the flexibility, let's have that conversation.

*Mr. Reed. I look forward to that. And I thank you always for your hard work, and appreciate working with your office in regards to the issues that we have addressed with you before. With that, I yield back.

*Secretary Burwell. Thank you.

*Chairman Brady. Thank you. Mr. Becerra, you are recognized.

*Mr. Becerra. Thank you, Mr. Chairman. Madam Secretary, thank you very much. And always a pleasure to have you with us. Ma'am, before I ask my question, can I just say thank you for what I know you had a hand in, in the President's proposed budget, to try to deal with Medicaid reimbursement for citizens on the island of Puerto Rico. And the fact that right now Puerto Rico's going through a very difficult time financially, they're trying to right the ship. And one of the worst things that they can face is a situation where they are having a really difficult time funding the healthcare that their residents need. Which ultimately becomes an even worse crisis if people aren't getting care now, before things get really bad. So thank you for that proposal to try to balance the way we treat the U.S. citizen on the island of Puerto Rico.

I'm interested in, if you can give me comment on the Affordable Care Act's provision that expanded the use of Medicaid so that families that are working but earn very modest incomes can still qualify for healthcare through, if not the exchange, then the Medicaid Expansion Program. I know a number of states have incorporated that Medicaid Expansion Program. Others haven't. Those states that haven't, can you tell us how many states have not yet incorporated Medicaid? How many individuals including children are impacted by not having health insurance, as a result of states refusing to adopt Medicaid Expansion? And can you tell us what the impact has been for those states that have incorporated the Medicare -- Medicaid Expansion Program into their healthcare?

*Secretary Burwell. So right now, 30 states plus the District of Columbia have done the expansion. And if all the rest of the states that aren't expanded did it, we estimate that there would be four million additional people who would no longer be uninsured. 3.1 million directly in terms of the individuals that would become eligible. But in all the states where expansion has occurred, there are portions of the population that were eligible but do not sign up, but as part of the expansion, come to sign up. So the total number becomes four million.

With regard to the proposal in our budget, in the conversations with many governors across the country that are not in, one of their concerns is, "Will the Federal Government stay and be a part?" That's a question that, that I am consistently asked. Our proposal gets to that fundamental of making sure they know for the first three years, they know what their budgeting will be, which is an important consideration for governors. In terms of the benefits we're seeing to the individual, the health and financial security that it means is something that I think everyone can understand. With regard to the economics, in Kentucky, we know that the estimates are 40,000 jobs created by 2021. 30 billion dollars into the state's finances. In addition, when we have analyzed those places where there are hospital closures -- and we know that's happening across the country for a number of reasons. But in the states that have expanded, the hospital closures as a percentage are smaller. And we believe that's attributable to uncompensated care that is no longer occurring.

*Mr. Becerra. Thank you. Thank you, Mr. Chairman.

*Chairman Brady. Thank you. Mr. Young, you're recognized.

*Mr. Young. Thank you, Mr. Chairman. Madam Secretary, I appreciate being here. I, I came here a few years ago. I haven't spent a lifetime doing this. And I came here to solve problems. And I have to say I've been frustrated in the last few years. And frustrated because of what I hear back from my constituents. One of the main things I hear from my constituents is that Obamacare isn't working. That they don't like it. That their costs are going up. They regard their health insurance as all but useless. Deductibles are skyrocketing. Premiums are going up. And there's, there's data to support these things. Premiums for example, CBO expects an increase in seven and a half percent. Cost of bench mark plan, across the 37 states that utilize the federal exchange. But you know, eyes start to glaze over, when I talk to my constituents about all of the specific numbers. They just want us to fix this thing. And you know, meanwhile it's been talked about, that availability of coverage continues to narrow. And you know, I came here to solve these problems. It doesn't seem like we have a functioning system when so many of my constituents decide instead to pay the IRS tax penalty instead of buying insurance. That seems like a real problem. It doesn't seem like we have a functioning system when costs continue to go up. When the American people are told that their premiums would instead go down or be the other direction.

It doesn't seem like we have a functioning system, when in the state of Indiana, one of our largest insurers, Assurant, a national carrier, left the exchange. And so forth. And so

I guess in the interest of trying to solve problems, I've asked this before. It's become a big ideological totemic battle between Republicans and Democrats, conservatives and liberals. But are there mandates that you as Secretary would be willing to work with Congress on repealing, vis-a-vis Obamacare? If not all of them. Which has been the position of the Administration in the past. Are there specific mandates that you would be willing to work with us on repealing? And I'll give you the remaining 40 seconds to offer a response. And you can offer whatever else you might have in writing, please.

*Secretary Burwell. There are many things I think most people in America don't want to go back to a place where pre-existing conditions keep you off your healthcare. Where if your child had cancer at the age of 15, that they've reached annual and lifetime limits. And these are some of the important changes that --

*Mr. Young. Is Obamacare working? I guess I'll just interject here. And you can supplement it with written testimony.

*Secretary Burwell. Yes. So, yes. And I believe in the area of access we've seen strong improvements.

*Mr. Young. Because I'm not hearing that from Hoosiers. I am not hearing consistently that Obamacare is working.

*Secretary Burwell. I think the question is --

*Mr. Young. Do you have surveys that substantiate that?

*Secretary Burwell. Yes, in terms of actually people in the marketplace. We have seen the marketplace satisfaction --

*Mr. Young. I'm talking Americans more generally. Do they like Obamacare?

*Secretary Burwell. Americans more generally? But what Americans like is, that you don't have to worry about pre-existing conditions. Is that the question that's asked?

*Chairman Brady. Thank you. All time has expired.

*Secretary Burwell. That is a different question that he has asked?

*Chairman Young. We can deal with that issue together in a different way. Thank you. And I yield back.

*Chairman Brady. Thank you, Madam Secretary. I'm going to --

*Secretary Burwell. And I think there are places we can.

*Chairman Brady. Thank you. I'm going to recognize Mr. Kelly. And then we're going to back to one. I just wanted to make sure we can get everyone on. Mr. Kelly, you're recognized.

*Mr. Kelly. Thank you, Chairman and Madam Secretary. I appreciate your being here. We talked before, on the side. My concern is, when it comes to the quality incentive payments in the Medicare Advantage Plan -- this is what we were talking about -- I don't expect you to be able to answer this now. I know you're going to get back to me about it. But those plans were set up to incentivize a more efficient operation. And under the rule-making process, Mr. Kind and I have a piece of legislation also with Mr. Doyle and Mr. Guthrie. And so it's bi-partisan. Under the bench mark caps, we're rolling the QIPs into that and saying, "This is the cap." So if you're a four or five star rated plan, there's no incentive for you to go beyond that. I mean, it just isn't reachable. So essentially you're being paid at the same rate. I mean, the cap sets a cap. You can get paid lower amounts but you can't get paid higher amounts. And the result of that -- and I'm asking you -- do you have to have legislation to do that, or can you do it internally? I think it's an interpretation of the benchmark cap.

*Secretary Burwell. And we will come back on whether or not we have the statutory authorities across the board in terms of the work that we're doing in the CMI, the Innovation Center, in terms of making sure you have that ability to have that upward movement for good, strong players. We have changed that. And so this is a particular case I just need to understand what we have. In the most recent proposals on our accountable care organizations, we use the logic that you just articulated and have made fixes. So in this particular area on the four and five stars, do we have those still?

*Mr. Kelly. Yeah. And I appreciate it. Because I think the real issue is, how soon can we get this done? Because if it's an incentive, then it has to truly be an incentive.

*Secretary Burwell. For good behavior.

*Mr. Kelly. It can't be a non-incentive that's described as an incentive.

*Secretary Burwell. Yes.

*Mr. Kelly. So we will get that to you in writing. If you can get back to us quickly, I appreciate that. With that I yield back, Chairman.

*Chairman Brady. Thank you. Mr. Blumenauer, you are recognized.

*Mr. Blumenauer. Thank you, Mr. Chairman. Madam Secretary, I'm going to send you a little note about end of life care. And I appreciate that I'm not talking to you about, "Can we make the change?" It's made. I'm interested in how we can implement it more effectively. And I would really appreciate a chance to visit with you about that at some point. But I want to pick up where Mr. Young left off. Because I feel sometimes like I'm in an alternative universe. I have roundtable discussion in Oregon repeatedly. And yeah,

there are hiccups and problems. But it's an entirely different universe. Providers like what's going on. We've expanded service. We've put millions, hundreds of millions of dollars into the system. Now, my friend from Kansas talked about the problems. That's a state that didn't expand it. And the question I would ask to you is, gee, if Kansas had been one of the 30 states that had actually expanded the program and had hundreds of millions of dollars in their health care system, being able to take care of people who were too poor to qualify for the ACA, would it make a difference?

Or in the case of Indiana, which has sort of expanded it, but not in a clean, straight-forward way, it appears from an untrained eye to be kind of a jerry-rigged system that doesn't really work well in terms of the expansion. Can you talk for a moment about what difference that would make and why I'm getting almost universally positive reactions from hospitals, insurance providers and people on the street? None of the evil things that were rumored happened. Inflation is down. Premiums are not skyrocketing like they used to. I remember the debates we had. And my friends who are concerned have not been working over the five years to refine it. They're trying to blow it up or to chip away at it. What difference would it make if there was actual straight-forward expansion in states like Indiana and Kentucky?

*Secretary Burwell. I think the point you raised about the premium increases, it is one of the things that, as we look at historically what premium increases were before, in the individual market they were in the double digit space. In the employer based market right now, over time, for a family, what that, what we have seen is four out of the five years have been the four lowest on record since these records were kept in 1999. That is, that means things are increasing but they're increasing at a much lower rate, to your point.

I understand that still feels like increases for consumers, which is why we've got to move to delivery system reform. With regard to the issue of Medicaid Expansion, I think we do see in many of the states that have expanded, those benefits in terms of what it means in the community and the money. It's the money and the paid for services. In addition, for individuals, we see many more people being treated for diabetes. That leads to longer term reduction in cost if we can get ahead of diabetes.

*Chairman Brady. Thank you. Mr. Renacci, you're recognized.

*Mr.Renacci. Thank you, Mr. Chairman. Secretary Burwell, thank you for being here and thank you for reaching out to my office before the hearing. I'm sorry we were not able to connect, but I really appreciate you reaching out to all the committee members. I think that's important. You do not have an easy job. We all recognize that. So thank you for what you do. I'm hoping that as this year comes to an end, we can work on some things together. As you know, the ACA included a new program aimed at reducing hospital readmissions, called the Hospital Readmission Reduction Program. The goal of this program is one that I and many of my colleagues support. In fact it's estimated that nearly 18 billion per year is wasted on avoidable readmissions of Medicare patients alone.

*Secretary Burwell. Yes.

*Mr. Renacci. However, the implementation of this program has been problematic, especially for those hospitals serving low income populations. Evidence suggests that economically disadvantaged patients, especially patients eligible for both Medicare and Medicaid, are much more likely to be readmitted within 30 days of discharge, regardless of a physician's efforts to educate them on proper post-discharge care. This has also an effect of disproportionately harming hospitals that take care of those that need it most. I've said all along, this is not a Republican or Democrat issue. This is really an issue of fairness of service to those individuals. Do you believe that readmission program criteria can be improved by adding clear adjustments for dual-eligible status, as well as for other plan readmissions, such as those following trauma?

*Secretary Burwell. We do believe in our studying and we appreciate the money that the Congress gave us to do the actual analytics, which should be completed by October. In the space of dual-eligibles people with chronic conditions and the socio-economic issues that you're talking about, those things come together and they come together in high-cost people. And so we are doing the work to understand analytically. We had put out a proposal for some changes related to other areas where it has a negative impact if you are taking. We got comments back that people didn't like that as a solution.

So we we did not go forward with that as a change. But we do believe this is a space where we need to understand where it makes a difference and how our rules can help support those that are taking care of those that are difficult to take care of. You may also know about the piece we just announced, that the Center for Medicaid and Medicare Innovation, where we're actually funding the efforts to do support. So you connect those people with the right services. As a means by which we're going to test whether that improves quality and lowers cost. So there are a number of steps we're taking. We believe it's an issue that we are looking closely at.

*Mr. Renacci. Thank you. I have a bill that I know has 75 co-sponsors, Republicans and Democrats. So I hope we can work together on fixing this issue. Thank you, and I yield back, Mr. Chairman.

*Chairman Brady. Thank you.

Mr. Kind in the corner you're recognized.

*Mr. Kind. Thank you, Mr. Chairman.

Madam Secretary, thanks for your testimony today and for the job that you're doing. See, I want to direct your attention. Chairman Brady and I have been working on legislation reform in the post-acute care setting for increased efficiency, better outcomes, cost savings. So we'd like to engage your office to make sure we're heading in the right direction so we can get moving on that legislation.

*Secretary Burwell. We look forward to engaging.

*Mr. Kind. Also, as you know, I've been a real stickler when it comes to payment reform in the healthcare system, trying to drive the system to more quality value outcome-based payments. And there's a lot churning right now. I just want to give you some time today to give us an update and what's been going on to get to a value-based reimbursement system and if we're starting to see some cost savings as a result.

*Secretary Burwell. Yes. So the commitment that we made last January for the first time I committed that Medicare payments, 30 percent of them would be in value, not volume. It was the first time we'd made that sort of commitment for Medicare, and I am hopeful and expecting that we will meet our 2016 goal of reaching that. We hope that by 2018 it will be 50 percent. Obviously I will not be here, but we'll be here to make sure that we are on that trajectory. And in terms of what that does in terms of the savings, we believe that those are real.

The other place where we're actually starting to see numbers and dollars in terms of the savings is in the accountable care organizations, and we have done the models and the demonstrations. You statutorily gave us standards that had to be met. Quality could not be decreased and we had to have savings in order for them to scale. The actuaries have scored these, and we are able to meet that test. We've seen several hundred million in just a one- and two-year period of time, and so we are starting to see that.

We have taken the input and have rolled out an additional group of the ACOs, the accountable care organizations, and actually just today you saw the governor of Alabama speak because we're working with him on Medicaid in this space as well, and those are regional accountable care organizations.

*Mr. Kind. We've also been seeing in recent years some remarkable cost savings on a per capita basis in the Medicare program in particular, but without a reduction in benefits for the services that our seniors are receiving. Can you give us an update on that?

*Secretary Burwell. Yes. We are in terms of those per capita costs, and that's what we have to focus on. Because we have a growing population in Medicare, focusing on the per capita is where we're keeping our eye on the ball. And that's everything from reducing those costs to making sure they're going into the prevention and getting those free preventative services that help us save costs over time. We're seeing some increase, we'd like to see more.

*Mr. Kind. I think if we keep setting those financial incentives to value quality, we're going to see a lot of innovation, a lot of reform by our providers themselves. We're going to work very hard to hit the mark. So I encourage you to keep your eye on the ball in that regard. I think it's one of the keys to how successful healthcare reform is ultimately going to be in the future.

Thank you, Mr. Chairman.

*Chairman Brady. Thank you.

Mr. Meehan, you're recognized.

*Mr. Meehan. Thank you.

Secretary, I was appreciative of your commentary regarding the over-prescription of the opioids and the tremendous precursor implications of that with the heroine problem. We have a group of former prosecutors working on a comprehensive approach. I would really enjoy if you would communicate back with us while we're looking at this so we can collaborate on this issue rather than discovering later what the intentions are. Can I switch my comments for a moment?

And I appreciated your opening with the idea of a patient-centered delivery model. You opened with discussions about bringing healthcare to children at home, and the value of the home now in a changing healthcare perspective in creating not only just efficiency, but you know yourself when you can deliver healthcare personnel into that setting, the observations they make with respect to the patient and the environment, support of the family, ability to maintain their drug regimen, things of that nature have so many other benefits.

And yet we're seeing a recommendation by the budget to reduce compensation for copays, introduction of copays for home healthcare that isn't generated after a hospital stay, home-infusion therapy, another thing in which we can take an opportunity for a patient to not have to go to a more expensive setting for that same kind of service. These are examples and ways in which I think we can find that home-centered care as a way to drive down health costs as well as continue to see real quality enhanced.

And I hope you can work on that and give me a sense why would we be looking at copays when Congress actually in the 1970s found that that was counterproductive.

*Secretary Burwell. I think the overall concept is what we're moving towards generally, and so with those specific examples that you've given you need to understand why those specific examples. Because the general premise in terms of the demonstrations, the funding that we're doing is all about that home-based care because we do believe it can both increase quality and reduce price. And so most of the changes are going in that direction. So I don't know if there are exceptions to the --

*Mr. Meehan. I know you've got the data exclusivity from biologics and I know we're looking at that seven-year standard. I have real concerns about what it's going to do for innovation, and I hope that you will be able to characterize what it is going to do. I mean we are all working on the reduction of costs, but there's also going to be an impact. That number of 12 years was reached for a reason, and it wasn't something that was arbitrary.

And so the concern we have with a seven-year standard is what it will mean and particularly as we're looking at new challenges from Zika viruses to great new pathways

to deal with cancer. But that's an issue for another moment, and I thank you, and I yield back.

*Chairman Brady. Thank you.

Mr. Pascrell, you're recognized.

*Mr. Pascrell. Thank you, Mr. Chairman.

Secretary Burwell, thank you for being here today. You've been an outstanding secretary, and you've got a year to go. I don't know who's going to take your place. Maybe Dr. Kevorkian, who knows.

Last year at this very budget hearing, you pledged to work with the Congress to find a solution to incorporate unique device identifiers, UDIs, and to health insurance claims to help improve patient safety and quality of care. I'm reading and hearing day after day from all over the country about a major problem which we are not addressing.

CMS has put forward no solution. CMS has indicated that it would support pilot programs to demonstrate the feasibility of UDI in claims. But to my knowledge, no such pilot has been launched. CMS has not taken any steps to ensure that such a pilot gets off the ground. Even if one were to launch today, results would be back for years, and we would miss our opportunity to implement this important policy that can help save lives.

Quite frankly, the time is up. CMS has failed to come up with a solution to incorporate UDI in its claims databases as recommended by the FDA. Device safety experts have recommended it and even you during your confirmation hearing. As you know, CMS works for you, so what steps do you plan to take to ensure that the agency starts to proactively support UDI in claims using every tool at their disposal. And I would claim before you answer the question that the industry itself, the industry itself, it's looked at very, very carefully at chapter and verse about this industry.

Madam Secretary.

*Secretary Burwell. With regard to UDIs since our last conversation about this, we have made progress in terms of what we've done on the Office of the National Coordinator's side and actually put out guidance that says that the UDIs will be a part of the electronic health records. And when we think about why we want the UDIs in terms of having a place where one can go and find out if someone had something -- if we need to track back, having that be a part of the individual's record we think moves a long way with regard to the questions of ensuring and using this tool as a tool for safety. And so have taken steps in that particular space.

With regard to those who make -- we have external guidance that comes from external boards on when we make differences and changes in the claims and what we do in terms of claims records. At this point they have not come to making a recommendation. We

still continue to engage and have those conversations. But with regard to getting to the safety --

*Chairman Brady. Madam Secretary, I apologize. The time has expired.

Ms. Black, you're recognized.

*Mrs. Black. Thank you, Mr. Chairman.

Secretary, thank you for being here today. These are a lot of topics, and I'd like to say that these are topics that are certainly important to our taxpayers, they're important to our patients as well, and I appreciate you being here to answer these questions.

I want to hold up a report that just came out yesterday, the Senate report that there were illegal benefits benefitted from $750 billion in Obamacare subsidies. And the report goes onto talk about how there is not a coordination between HHS and the IRS on these subsidies. The report says that there were over 500,000 immigrants that got these tax credits, but there wasn't verification and never was there verification sent in to show even after the tax credits went out that these folks were here legally in the country.

And so what we've seen in other programs where the money goes out the door, it's very difficult to get that money back again. So there seems to be a lack of coordination in verifying that these folks are here in the country legally, and this is hard-earned taxpayer money that is going out the door. And so I want to know what your plan is to make sure that before these dollars go out the door that we can verify someone's status because we know that once the IRS has to go back and try to chase the money, very little of that money comes back. So do you have a plan for making sure that this does not occur?

*Secretary Burwell. So with regard to one of the things I think that was important in the report is it did reflect that we don't know whether they were illegal or not. What we know is they didn't provide the documentation. And as we --

*Mrs. Black. And so how long a time period would you have let go by with these tax credits going out before there was a verification.

*Secretary Burwell. With regard to that, we follow he statutory guidelines, and that's about 90 days. And so last year 470,000 folks were cut off within that approximately 90-day timeframe. And the thing that I think is also important to recognize in terms of the connects that you're talking about is those individuals that did not have verification will not be able to get the tax credits. And the other thing is the IRS will follow up in terms of their filing.

*Mrs. Black. But the tax credits already went out the door.

*Secretary Burwell. For the period of time that is --

*Mrs. Black. Yes. For that period of time, so --

*Secretary Burwell. -- we follow the statutory -- we follow the statutory guidelines, and we don't know if there --

*Mrs. Black. $750 million went out the door.

*Secretary Burwell. But we do not know that they weren't supposed to receive them. Many of the people that go through the process of verification actually have the right documentation.

*Mrs. Black. Excuse me. I'm running out of time, but I want to tell you I do have a bill that says no subsidies without verification whether that's in the self-cessation, verification needs to be done before the money goes out the door. We have seen this in so many of the entitlement programs where the money goes out, we can't verify and there are billions -- literally billions of dollars that are going out in these programs, and I just don't understand why someone can't come up with their verification. I mean if I make out an application for something and it's not complete, then I don't get whatever service it is that I'm applying for. I think that's really the direction we have to go.

*Chairman Brady. Thank you. Whole time has expired.

Mr. Davis.

*Mr. Davis. Thank you very much, Mr. Chairman.

There are many things that I really like about this proposed budget, especially the continuous support for federally qualified health centers, home visiting, the addressment of behavior health, issues relative to substance abuse prevention and treatment. But I also have some serious concerns about the proposed funding for graduate medical education.

Madam Secretary, I noticed that your budget once again calls for a 10 percent cut in indirect medical education payments to teaching hospitals. Yet my teaching hospitals tell me that the cost of these programs are significantly greater than the direct and indirect GME payments they receive.

In fact, most of the major teaching hospitals in Chicago are training an excess of 100 doctors over the residency cap and we still face significant access to care problems in my community. I'm concerned that these cuts that are proposed would result in fewer doctors being trained. That will heighten the access to care problem. Wouldn't it make more sense or be better to lift the cap and train more rather than fewer physicians?

*Secretary Burwell. I think the changes that we propose on both sides, on the Medicare side as well as the children's GME side, are about trying to make sure that we do get the right numbers of physicians and types of physicians. And so the proposals that we put forth are both about targeting in terms of higher need, higher-need communities as

well as primary care and the specialties where we don't. And that's what are changes are targeted towards in terms of making sure that we are in the Medicare space paying for those physicians that will do Medicare and Medicare hospitals and making sure that we're targeting the right things. And that's the objective of the proposals.

*Mr. Davis. And I note that you're also seeking authority to kind of move more towards primary care.

*Secretary Burwell. That's correct.

*Mr. Davis. Position training and I'm certainly in agreement with that. But when I look at the aging of our population with 10,000 new seniors every day, don't we also need specialists, cardiologists and neurologists to deal with the needs of this population group?

*Secretary Burwell. Yes, we are targeting both primary care underserved, getting positions to go to underserved as well as the issue of specialties where we are short. And so we are trying to have all of this assistance in the medical education be more targeted to those areas. It is --

*Mr. Davis. Thank you very much. I thank you for doing a great job and I yield back the balance of my time.

*Secretary Burwell. Thank you.

*Chairman Brady. Thank you.

Ms. Noem, you're recognized.

*Mrs. Noem. Thank you, Mr. Chairman.

Secretary Burwell, I wanted to draw attention today to an emergency situation I have in South Dakota with my Native American constituents that aren't getting healthcare. And I certainly know you're aware of the situation, but I want to hear today how you plan to fix it.

The Federal Government has a responsibility to our tribes to provide for their healthcare because of treaty obligations. And frankly they failed to follow through on their promise to do so. In fact, in the Great Plains area, we have reports of inappropriate conduct including nepotism, favoritism in hiring practices, reassignment of employees who are underperforming or have been poorly trained as well all leading to very low quality delivery of healthcare.

In fact, a bombshell 2010 Senate report laid out a lot of these allegations, and these problems have been going on for long before I've been in Congress, for a decade or more. And the fraud, the abuse, the waste is rampant in the Great Plains area.

And since then, even since that 2010 report, little has changed within IHS. And I know you'll speak to funding levels, but, before a Senate committee last week, your acting deputy secretary specifically stated that there has been an increase of 43 percent in funding into IHS in recent years. So we know we can't simply throw more money at the problem, that there has to be a whole culture change at IHS that has to happen.

And what I'm concerned about is that last year CMS inspections of the facilities in Rosebud and Pine Ridge showed that it was a dangerous situation. In fact, what was so ironic was that CMS said that it was going to terminate its provider agreements to IHS and the irony of that is that we have one federal agency saying it won't make federal payments to another federal agency when they're both housed within the same department. And it shows the bureaucratic absurdity of the situation we have going on in South Dakota.

And at this very minute, my Rosebud tribal members are driving over an hour to get emergency healthcare services because the IHS's hospital ER was closed due to dangerous care being provided there. So it's not necessarily just funding; there's other issues as well. The mismanagement, the misconduct in the Great Plains area needs to be dealt with and frankly it goes from one administrator to the next. I know that one has recently been reassigned, but then I also hear that he's come to Washington D.C. to a different position, wasn't necessarily penalized for his lack of doing his job in South Dakota and in the Great Plains area.

I want to hear your strategies for how you're going to implement change in culture in this Great Plains region. But I also believe that buried within your IHS budget justification this year you have a paragraph that says IHS places a high priority on corrective action in the Great Plains area. The problem is that this paragraph appears to be literally copied and pasted from the justifications over the last four years.

So there's nothing that indicates to me that we're going to have a change. It tells me that, yes, you're aware of the problem, but I don't know that you have a plan to fix it. And frankly we're putting people's lives in jeopardy in South Dakota. And we have emergency rooms that are closed down and an agency that will not reimburse another agency because we have people addicted to drugs and alcohol doing procedures on people, sterilization of utensils that's happening by handwashing.

So I need your answers, probably written, because I'm out of time. I hope you know how serious I am about this. But if you'd respond to me in written form, I would be eternally grateful.

*Secretary Burwell. Yes, and I would just say this is a place where I think we may need your help as well.

*Mrs. Noem. I will help.

*Secretary Burwell. Because I am committed but I don't have a year -- I have 11 months and days left.

*Mrs. Noem. Yeah.

*Secretary Burwell. But I believe we need to get a different answer and outcome. And so this is a place where I may come back to you for help and assistance.

*Mrs. Noem. I'm there. Thank you.

*Secretary Burwell. Because changing culture is both the relationships on the ground. You know better than I do being from the region. It's going to take a lot, but Dr. Wakefield and I are committed.

*Chairman Brady. Thank you.

*Mrs. Noem. Thank you.

*Chairman Brady. Madam Secretary, thank you.

Mr. Crowley, you're recognized.

*Mr. Crowley. Thank you, Mr. Chairman.

Madam Secretary, welcome. I, too, think you're doing a great job. I'm pleased to see the Administration's initiative to improve funding for mental and behavioral healthcare issues. One of the often overlooked benefits of the Affordable Care Act is that it's extending insurance coverage to millions of Americans. It also has improved access to previously unavailable or unaffordable mental health treatments.

For example, a recent GAO examined six of the states that adopted the ACA's Medicaid expansion and found improved access to behavioral healthcare. There is more work that needs to be done in this area. Which the fiscal year 2017 budget highlights. Can you talk generally about the changes we face in expanding access to treatment for mental and behavioral healthcare and how the President's budget proposed to address some of those changes?

*Secretary Burwell. It's on a number of fronts, this money will be used, and I think one is about actually supporting the access to care in communities. And that's a big part of what the money is about is making sure that we have the access to care. The other is for providers, and this gets back to the issue we were just discussion. The IHS is an incredible example of this in the tribes in terms of making sure we have the right providers.

Parts of this money actually will be directed towards the IHS and other places to make sure we have enough providers that can provide the care. The final element of the

strategy is about making sure for those who have severe mental illness that we get them into care early. That's about connecting to them and having places for them to go.

*Mr. Crowley. One of the other areas that I'm very excited about that you address in the budget is the issue of child care. It's so critical to a child's development for school and for life and it's also critical to helping working families, minimum -- who are trying to get into the workforce and stay in the workforce, to make sure the child is taken care of in an enriching environment, a loving environment. Can you discuss very quickly or briefly the Administration's proposal to improve access to the quality of child care in this country?

*Secretary Burwell. There are two elements to it. It is, one, the implementation that we have been given in terms of improving childcare and direction. We've been given discretionary funding that will be used to implement what the Congress has given us. But I think you also know we have a large mandatory proposal that would be about expanding childcare so that people could have that access and go to work and do the things that they want to do as a family in terms of young children and having care for them as they go to work. And that is a large proposal that's on the mandatory side that would be quality, but expansion in terms of those served.

*Mr. Crowley. I'm very familiar with it because I'm working with Senator Casey and with Congressman Frankel on this very issue itself and sponsoring it --

*Secretary Burwell. We're excited about that legislation.

*Mr. Crowley. -- here in the House. But thank you for the proposal within the budget and for the great work that you're doing. So with that, Mr. Chairman, I yield back the balance of my time.

*Chairman Brady. Thank you.

Mr. Rice, you're recognized.

*MR. Rice. Thank you, Mr. Chairman.

And thank you, Secretary Burwell, for being here. I appreciate you reaching out to me earlier in the week. Very thoughtful, and I appreciate the information you provided to the Committee. I have a couple of questions, one with respect to the Medicaid expansion and the 20 states that haven't expanded.

I don't know if you heard, but the United States has $18 trillion in debt and both the Office of Management and Budget and the Congressional Budget Office, they don't agree on many things, but they agree we're on an unsustainable path. So let me ask you: If you had a wonderful uncle who loved you so and said, look, if you'll buy a house, maybe a more expensive house that you can afford, I'll make the payments for you. And let's say that uncle was just going into bankruptcy. Would you take him up on his offer?

*Secretary Burwell. The question of the analogy, I would just recognize that we've reduced the deficit in this country by $4 trillion. And the budget that's before us right now has an additional $2.9 trillion over a period in terms of reduction. And so I think in terms of the accuracy of the analogy in terms of where we are as a nation, in the President's budget, we will keep the deficit-to-GDP ratio -- will get down to that 2.7 level which we haven't been in many years.

*Mr. Rice. I served on the Budget Committee for three years, and every official from OMB and CBO that I talked to that entire time said that we are on an unsustainable path.

Let me ask you this: The South Carolina Exchange was the ninth Obamacare exchange to close. It closed in December out of 23 that were formed nationwide. Twenty-two of the twenty-three lost money in 2014. Nineteen of the twenty-three had claims in excess of premiums. Why is that?

*Secretary Burwell. With regard to the issue of the co-ops, when we think about the co-ops entering and we think about business, often stable players that have been in a business enter new spaces. Or sometimes what we have is a situation where you have new players entering an old business. In the case of the marketplace --

*Mr. Rice. Why are they losing money? Is it because our government is inept to run the healthcare system, or is it because we just did really bad projections and we didn't know that we were going to actually pay out more in claims that we collected in premiums? How could we have missed it that bad?

*Secretary Burwell. The co-ops are private businesses. I think you're referring to the co-ops, not --

*Mr. Rice. Yeah, I --

*Secretary Burwell. The co-ops are private companies. And with regard to the decisions of those companies, you're right. Those are business decisions that a company is making that we the government do not have control over.

*Mr. Rice. Weren't they created with government money, taxpayer money?

*Secretary Burwell. They were created with government loans, loans that were cut in terms of --

*Mr. Rice. Let me ask you this.

*Secretary Burwell. -- the support that they were going to get.

*Mr. Rice. I'm running out of time, but let me ask you this: Eight million people in 2014 paid a penalty for not signing up for Obamacare. How many were enrolled?

*Secretary Burwell. In terms of the enrollment?

*Mr. Rice. Yeah.

*Secretary Burwell. Last year at the end of open enrollment it was about 11.6 million folks.

*Mr. Rice. So almost as many chose to pay a penalty rather than sign up. Why is that?

*Secretary Burwell. Many people are making --

*Chairman Brady. Madam Secretary, if you would answer that in writing, I apologize. All the time is expired. I know your hard stop was 4:30. We have two members who have waited patiently. Can we finish these out? And we understand your schedule is --

*Secretary Burwell. Okay. I actually can delay the -- yes, let's stay.

*Chairman Brady. Great.

Mr. Smith, you're recognized.

Thank you, Madam Secretary.

*Mr. Smith of Missouri. Thank you, Mr. Chairman.

Ms. Secretary, 37 percent of Medicare Advantage beneficiaries have annual incomes below $20,000 annually. I represent one of the poorest congressional districts in the country. So protecting the Medicare Advantage program for low income beneficiaries is extremely important to my constituents. The Medicare Advantage program offers extra financial protection such as maximum out-of-pocket limits, extra benefits and care coordination activities.

If plans are focused to restrict some of these benefits as a result of the funding cuts in the President's budget of roughly $77 billion, do you believe that these cuts could result negatively, impact low income beneficiaries who may then face higher cost out of pocket?

*Secretary Burwell. So what we've seen in terms of the changes that we've done to date in Medicare Advantage, the program continues to grow and grow in a healthy pace. We've seen premiums not have great increases and 99 percent of folks have access and coverage. And so in terms of what we've done to date, we have tried to take steps that are in ways that will not have the kind of impact that you've described. We believe what we're proposing won't.

We also know that when we compare -- and this gets to the entitlement issues that we began this hearing with, and it's appropriate to end here, is the issue of in a world where we know that the fee for service Medicare recipients on a per capita basis are paying much less than these Medicare Advantage. And MedPAC and other have analyzed that there are changes that are important to saving the taxpayer money.

And so we're trying to get that balance so we don't have the outcome you described. We don't want that. But also make sure that as the taxpayers' money is being used in Medicare Advantage that it's being used wisely.

*Mr. Smith of Missouri. So, yes or no, do you think the $77 billion cut is going to affect my constituents on Medicare Advantage?

*Secretary Burwell. No, we think that what it will do is create many of the changes we're proposing about competition coming back to the earlier point about markets. And so we believe that what we're proposing will not have those negative impacts.

*Mr. Smith of Missouri. Okay. Thank you.

*Chairman Brady. Thank you.

Mr. Dold for the final question.

*Mr. Dold. Thank you, Mr. Chairman. Madam Secretary, first of all, thank you so much for reaching out to our office. I certainly appreciate that. And I also want to thank you for being willing to work with the Committee. And I think that some of the things that we want to do is we want very much the same things. We want to access to quality care at an affordable rate, and that's certainly what I'm hearing from my constituents. That's what we're looking for.

Unfortunately, as you may know, we had some market disruptions in Illinois in the fall of 2015. One of the most popular PPO plans basically said we're not going to offer the PPO. 173,000 Illinoisans were forced to scramble to find a new plan in a much narrower network. And ultimately we heard -- I heard on a regular basis that moms would have to choose between their oncologist or the pediatrician that they take their kids to or those types of things.

The other interesting part of is that is that since open enrollment has closed, several of those insurance companies have expressed their concerns about remaining in the exchanges for 2017. So the question I have for you is: What are you doing or is the agency doing to try to help prevent market disruptions going forward?

*Secretary Burwell. With regard to that in terms of the marketplace, the two things are, one, is it a product the customer demands, and, two, the issuers in the marketplace. We just ended with 12.7 folks in. The issue of market stability, we saw

nine out of ten folks in the marketplace be in counties where there are three or more issuers, which is about choice and competition.

We know we have more work to do, though, to your point. And we are taking those steps. We announced that there would not be a special enrollment period for tax issues this year, and we did that before December 15th to get people to come in before January 1st. We've eliminated a number of special enrollment periods. I'm sure you've heard this from a number of the issuers. That's one of the things that they think will contribute to stability.

The other thing they asked us for is estimates of their risk adjustment numbers early. So there are a series of steps that we're taking to continue to promote a stable marketplace.

*Mr. Dold. I appreciate that. A couple things with regard to the budget. I want to thank you on the mental health side of things, and there's a lot more work that needs to happen there. But I also want to share my concerns with my good friend from Illinois on the funding for graduate medical education, and I also want to make sure I'm raising a concern on the biologics. Taking it down to seven years I think is an enormous concern with regard to innovation, and I think, again, signals something that we have a 12-year date exclusivity right now. To take it to seven is problematic in my view.

Finally, I wanted to just talk to you about something that I think is important as we talk about waste fraud with in Medicare, and that's the Medicare Common Access Card, something I've worked with Congressman Blumenauer on, Congressman Roskam. We're losing approximately $60 billion in fraud admittedly by CMS. And what the Medicare Common Access Card would do is have a chip in it. Right now we've got identity theft running rampant. This is an issue for seniors. Would CMS be interested or at least open to a pilot program doing a Medicare Common Access Card?

*Secretary Burwell. As I mentioned when Mr. Roskam asked about it, I want to look into figuring out what are our authorities and how this would work.

*Mr. Dold. I certainly appreciate that. Thank you, Madam Secretary.

*Chairman Brady. Thank you all. Time has expired. We had an earlier discussion about the comparisons between Part D and the VA. Without objection, I'll submit for the record a letter from CBO outlining their reasons why it would simply not result in savings. So ordered.

[The information follows: The Honorable Kevin Brady]

*Chairman Brady. Madam Secretary, I want to thank you for appearing for us and extending your time. While we have disagreements, you have been very professional, very responsive and clearly dedicated to your job. So thank you very much for being

here today. Members may submit written questions be answered later in writing. Those questions and your answers will be made part of the formal hearing. With that, to Madam Secretary and others, the Committee stands adjourned.

[Whereupon, at 4:42 p.m., the Committee was adjourned.]

Questions for the Record

Public Submissions for the Record