

NOMINATION OF THOMAS PRICE

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FIFTEENTH CONGRESS
FIRST SESSION
ON THE
NOMINATION OF
THOMAS PRICE, TO BE SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JANUARY 24, 2017



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NOMINATION OF THOMAS PRICE, TO BE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

THURSDAY, JANUARY 24, 2017

**U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, DC.***

The hearing was convened, pursuant to notice, at 10:02 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Roberts, Enzi, Cornyn, Thune, Burr, Isakson, Portman, Toomey, Heller, Scott, Cassidy, Wyden, Stabenow, Cantwell, Nelson, Menendez, Carper, Cardin, Brown, Bennet, Casey, Warner, and McCaskill.

Also present: Republican Staff: Chris Campbell, Staff Director; Nicholas Wyatt, Tax and Nominations Professional Staff Member; Jay Khosla, Chief Health Counsel and Policy Director; Kimberly Brandt, Chief Health-care Investigative Counsel; Brett Baker, Health Policy Advisor; and Erin Dempsey, Health-care Policy Advisor. Democratic Staff: Joshua Sheinkman, Staff Director; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Advisor; David Berick, Chief Investigator; Laura Berntsen, Senior Advisor for Health and Human Services; Beth Vrabel, Senior Health Counsel; Adam Carasso, Senior Tax and Economic Advisor; Matt Kazan, Health Policy Advisor; Anne Dwyer, Health-care Counsel; and Ryan Carey, Press Secretary and Speech Writer.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order. I would like to welcome everyone to this morning's hearing. Today we will consider the nomination of Dr. Tom Price to be the Secretary of the Department of Health and Human Services.

I want to welcome Dr. Price to the Finance Committee. And I appreciate his willingness to serve in a position of this magnitude, especially at this particularly crucial time.

When Obamacare was pushed through on a series of party-line votes, Republicans in Congress warned that the new health-care law basically would harm patients, families, and businesses. Not to put too fine a point on it, but we were right. And the next HHS Secretary will play a pivotal role as we work to repeal Obamacare and replace it with patient-centered reforms that will actually address costs, among other things. This will be an important endeavor.

or, one that will and should get a lot of attention here today, but it should not be the sole focus of the next HHS Secretary.

HHS has an annual budget of well over \$1 trillion. Let me repeat that: one department, \$1 trillion. HHS encompasses the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, and many others. It is no exaggeration to say that HHS touches more of the U.S. economy and affects the daily lives of more Americans than any other part of the U.S. Government.

I firmly believe that Dr. Price has the experience and qualifications necessary to effectively lead this large and diverse set of agencies, and many people share that view. He has had a wealth of experience in the practice of medicine, understands these problems, and has been a great member of the House of Representatives.

For example, past HHS Secretaries Mike Leavitt and Tommy Thompson strongly support his nomination. Physician organizations that know Dr. Price's work, including the American Medical Association and most surgical specialty groups, enthusiastically support him. The American Hospital Association and other health-care stakeholder groups do as well.

Perhaps the Healthcare Leadership Council, representing the broad swath of health-care providers, said it best in stating that, quote, "It is difficult to imagine anyone more capable of serving this Nation as the Secretary of HHS than Congressman Tom Price."

Unfortunately, in the current political environment, qualifications, experience, and endorsements from experts and key stakeholders sometimes do not seem to matter to some of our colleagues. At least that appears to be the case, since none of those who say they oppose Dr. Price's nomination seem to be talking about whether he is qualified. Instead, we have heard grossly exaggerated and distorted attacks on his views and his ethics. On top of that, we have heard complaints and a series of unreasonable demands regarding the confirmation process itself. Of course, these tactics have not been limited to Dr. Price.

My Democratic friends have taken this approach with almost all of President Trump's Cabinet nominees, as Senate Democrats' unprecedented efforts to delay and derail the confirmation process and apply a radically new set of confirmation standards has continued unabated.

To that point, let me say this. I have been in the Senate for 40 years, and I think my record for being willing to reach across the aisle is beyond any reasonable dispute. And I have certainly done it with my fellow Democrats here on this committee. In fact, from time to time I have taken lumps in some conservative circles for working closely with my Democratic colleagues. I have, on some occasions, voted against confirming executive branch nominees, but far more often than not I have opted to defer to the occupants of the White House and allowed them to choose who serves in their administrations. I have taken some lumps for that too.

I am not bringing any of this up to brag or to solicit praise from anyone in the audience. I raise all of this today so that people can

know I am serious when I say that I am worried about what my colleagues on the minority side are doing to the Senate as an institution. While the overriding sense of comity and courtesy among Senators has admittedly been in decline in recent years, I have never seen this level of partisan rancor when it comes to dealing with a President from an opposing party. I have never seen a party in the Senate, from its leaders on down, publicly commit to not only opposing virtually every nomination, but to attacking and maligning virtually every single nominee.

Now, let me be clear. I am not suggesting that the Senate start rubber-stamping nominees, nor am I suggesting that any member of the Senate should vote against their conscience or preferences simply out of respect for tradition or deference. What I am saying is that the same rules, processes, courtesies, and assumptions of good faith that have long been the hallmark of the Senate confirmation process, especially in this committee, should continue to apply regardless of who is President. If what we are seeing now is the new normal for every time control of the White House changes hands, the Senate, quite frankly, will be a much lesser institution.

Unfortunately, our committee has not been entirely immune to the hyper-politicization of the nomination process. We saw that last week with the Mnuchin hearing. And I regret to say that I think we are likely to see more of it today. I hope not.

Case in point: I expect that during today's hearing, we are going to hear quite a bit about process and claims that Dr. Price's nomination is being rushed and that the nominee has not been fully vetted. These allegations are simply untrue.

President Trump announced his intent to nominate Dr. Price just 3 weeks after the election. Dr. Price submitted the required tax returns and completed questionnaire on December 21st. That was 35 days ago. And by any reasonable standard, that is sufficient time for a full and fair examination of the nominee's record and disclosures.

By comparison, the committee held a hearing on the nomination of Secretary Sebelius, the Democrat nominee, 16 days after she submitted her paperwork. For Secretary Burwell, it was 17 days. In other words, the time between the completion of Dr. Price's file and his hearing has been more than that of the last two HHS Secretaries combined. And by the way, both of those nominees received at least a few Republican votes in this committee and on the floor.

Outside of extraordinary process demands, Dr. Price has faced a number of unfair attacks on both his record as a legislator and his finances. On the question surrounding finances, I will defer on any substantive discussion and first allow Dr. Price to defend himself from what are, by and large, specious and distorted attacks. For now I will just say that I hope that my colleagues do not invent new standards for finances, ethics, and disclosure that are different from those that have generally applied in the past. There is a saying involving both stones and glass houses that might be applicable as well.

With regard to Dr. Price's views and voting record, I will simply say that virtually all the attempts I have witnessed to characterize Dr. Price's views as being, quote, "outside of the mainstream" have been patently absurd unless, of course, the only ideas that are in

the, quote, “mainstream” are those that endorse the status quo on health care and our entitlement programs.

In conclusion, I just want to note that the overly partisan treatment of nominees and distortions of their records is a relatively new development on this committee. My hope is that we can begin to set a new standard here that we can all be proud of, and that we will work to reverse recent trends and have a fair and open discussion of the nominee and his qualifications.

So with that, I will turn to our distinguished ranking member, Senator Wyden.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman.

Colleagues, the American public heard many promises about health care from the new administration. No cuts to Medicare or Medicaid. Nobody hurt by ACA repeal. “Insurance for everybody . . . much less expensive and much better.” Congressman Price’s own record undercuts these promises.

I am going to start with ethics and undisclosed assets. Congressman Price owns stock in an Australian biomedical firm called Innate Immunotherapeutics. His first stock purchase came in 2015 after consulting Representative Chris Collins, the company’s top shareholder and a member of its board. In 2016, the Congressman was invited to participate in a special stock sale called a private placement. The company offered the private placement to raise funds for testing on an experimental treatment it intends to put up for FDA approval. Through this private placement, the Congressman increased his stake in the company more than 500 percent. He has said he was unaware he paid a price below market value.

It is hard to see how this claim passes the smell test. Company filings with the Australia Stock Exchange clearly state that this specific private placement would be made at below-market prices. The Treasury Department handbook on private placements states, and I will quote: “They are offered only to sophisticated investors in a nonpublic manner.” The Congressman also said last week he directed this stock purchase himself, departing from what he said was his typical practice.

Then there is the matter of what was omitted from the Congressman’s notarized disclosures. The Congressman’s stake in Innate is more than five times larger than the figure he reported to ethics officials when he became a nominee. He disclosed owning less than \$50,000 of Innate stock. At the time the disclosure was filed, by my calculation, his shares had a value of more than \$250,000. Today his stake is valued at more than a half-million dollars. Based on the math, it appears that the private placement was excluded entirely from the Congressman’s financial disclosure. This company’s fortunes could be affected directly by legislation and treaties that come before Congress.

It also appears the Congressman failed to consult the House Ethics Committee following other trades of health-care stocks. That was required, as they are directly related to two bills he introduced

and promoted. Even if some of those trades were not made at his direction, he would have been made aware of them when he filed his Periodic Transaction Reports with the House of Representatives.

Set aside the legal issues. It is hard to see this as anything but a conflict of interest and an abuse of position.

Another key question on the Finance Committee's biographical questionnaire is whether nominees have been investigated for ethics violations. The Congressman has been the subject of two investigations stemming from fundraising practices. This too was not disclosed. The committee needs to look into these matters before moving the nomination forward.

Now to policy. On the Affordable Care Act specifically, and the scheme known as "repeal and run," the secret replacement plan is still hidden away, but already the administration charges ahead with a broad executive order that endangers Americans' health.

As the Budget chairman, Congressman Price is the architect of repeal and run. If his repeal bill became law, 18 million Americans would lose their health care in less than 2 years. In 1 decade, you would go from 26 million uninsured to 59 million. Repeal and run raises premiums 50 percent in less than 2 years. Costs skyrocket from there. The market for individuals to buy health insurance collapses. No-cost contraceptive coverage for millions of women, gone. By defunding Planned Parenthood, nearly 400,000 women would lose access to care almost immediately, hundreds of thousands more would lose their choice to see the doctors they trust. The Price plan takes America back to the dark days when health care was for the healthy and the wealthy.

His other proposals do not offer much hope that the damage will be undone. There is a big gap between the Trump pledge of "insurance for everybody and great health care" and the Congressman's proposals.

In another bill, the Empowering Patients First Act, the Congressman brings back discrimination against people with pre-existing conditions such as pregnancy or heart disease. He gives insurers the power to deny care and raise costs on those with pre-existing conditions if they did not maintain coverage. In effect, the bill said insurance companies could take patients' money and skip out on paying for the care they need.

The Price bill also gave insurers the okay to reinstate lifetime limits on coverage and charge women higher rates because they are women. It gutted the tax benefits that help working people afford high-quality coverage. It slashed the minimum standards that protect patients by defining exactly what health plans have to cover. All this from a bill called Empowering Patients First. I have seen a lot of bills with ironic titles. This one, colleagues, takes the cake.

Here's the constant. The Congressman's proposals push new costs onto patients. Massive cuts to Medicare were proposed in the Price budget, as another example. In my view, the Congress has a duty to uphold the promise of Medicare. It is a promise of guaranteed benefits.

The Congressman advocated privatizing Medicare, cutting it almost a half-trillion dollars. After his nomination, he said he wanted to turn the program into one with vouchers within the first 6 to

8 months of the administration. He supports “balance billing” so seniors would have to cover extra charges above what Medicare pays when they go to the doctor. More extra costs for seniors on a tight budget. In addition, the Congressman calls for block-granting and capping Medicaid, which would shred a vital safety net for our most vulnerable.

Medicaid insures 74 million people. More Americans rely on Medicaid to pay for nursing home care and home-based care than any other program. The program pays for nearly half of all births and covers millions of children. It is a critical source of mental health coverage and substance abuse treatment, vital at a time when our communities are battling the opioid epidemic.

I will close with just two additional points. If confirmed, the head of HHS, the Health and Human Services Department, is the captain of the Trump health-care team. Now the Congressman says patients should be at the center of care. I agree with that. When I look, however, at the Congressman’s proposals, I do not see the patient at the center of health care. I see money and I see special interests at the center of health care.

Now finally, let me just make a point with respect to the process and the comments of my good friend, Chairman Hatch.

Colleagues, the process here is exactly the same process to a “t” that this committee has used for 20 years. It is the process that applied, for example, to Tom Daschle; it applied to Ron Kirk.

I will enter into the record a specific set of details about how this is the process that is exactly what was done on a bipartisan basis for 20 years. And I will make that a part of the record.

[The information appears in the appendix on p. 278.]

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. I am pleased to hand over my normal witness introduction duties today to our colleague, the distinguished Senator from Georgia, Senator Isakson, who will introduce Dr. Price.

And so, Senator Isakson, please proceed.

**OPENING STATEMENT OF HON. JOHNNY ISAKSON,
A U.S. SENATOR FROM GEORGIA**

Senator ISAKSON. Well, thank you, Chairman Hatch, Ranking Member Wyden, and fellow members of the committee. I am proud to have a seat right up there on this committee and enjoy being a part of it.

And I could not be prouder than to introduce Tom Price to you today. This is the second time I have had the occasion to introduce Tom in the last week. The first time I was called, it was to introduce him at the HELP Committee, which I also serve on, and I was proud to do that. And I gave what I hope was the best introduction I could possibly give for a man whom I have known for 30 years. I have known him as a family man, as a legislator, as a member of our community, as a great physician, and a great friend.

And it was easy to do that one. But since that last week, things have changed. I feel like I have been asked to be a character witness in a felony trial in the sentencing phase of a conviction.

There are things that have been said the last week or so, just to me, that need to be refuted. So I am going to take all the positive things and say them at the end, but try and begin by saying there are a few things out there that need a perspective all the way around.

I am very proud that Tom has submitted his income tax returns. A couple of things that the ranking member mentioned came from those submissions. Some of the things that came out in a memo last night about property taxes, those were de minimis items that came out, one late tax payment in Nashville, TN, one late tax payment in Washington, DC. Late, not unpaid—just late, and I have done that myself a couple of times.

On Innate Immunotherapeutics, that was a disclosure that he made, and the valuation difference on a private placement is a normal thing. It is an eyes-of-the-beholder placement in terms of what you assess it at. And this was merely an assessment as to what you disclose in terms of its worth, not whether you disclose it or not.

Tom is a good man. He is a family man. He is a physician. He is an honorable man. And I am proud to be here today, not to defend him, because he does not need defending, but to praise him for the things that he has done.

You know, I think it is important for all of us to look at a Secretary nomination, whether it is Secretary of Defense, whether it is Health and Human Services, and say, "What am I really looking for in terms of this person?"

Well, first and foremost, I am looking for a person who understands the American family. Tom is a great family man. In fact, his wife Betty is here. Raise your hand, Betty.

Last week I told her to stand up, and she was in a crowd and I could not get her to do it, so I am going to get her to raise her hand this time around. Betty is a great lady and a great wife. Their son Robert, I guess, is still in Nashville, TN singing country music. Is that right? So he could not be here today, but Lamar Alexander appreciates that part very well.

Tom is active in his church, active in his community, understands the needs of families, and understands the relationship of health care to a good family.

Secondly, who would I ask to spend \$1.1 trillion of my money? I do not have that much, of course, but that is how much Tom will oversee at HHS. What would I look for in a person to handle that much money?

I would look for a little bit of experience. And Tom has it in terms of being a legislator. I would look for somebody who understood where that cost was going and what he needed to do to manage it. And Tom is that type of person. I would look for somebody I would trust with that amount of money, even though I do not have it, but if it were mine.

Third, does he understand health care? Let me tell you a little bit about Tom and his medical practice. It is called Resurgens Orthopaedics. Resurgens Orthopaedics is the consolidation of a number of small orthopaedics firms around the State of Georgia into the largest orthopaedic provider in our State.

Tom was one of the leading persons who pulled that together and, in fact, ran the practice for a while himself. They are my doc-

tors. In fact, 26 years ago Resurgens saved my young son Kevin's right leg after a terrible automobile accident. And I have never forgotten what they did for him in a terrible crisis that we had in our family.

But they are a great medical firm. He understands medicine. And he has run a comprehensive medical program.

Fourth, I would want to understand if he knew the legislative process. You know, when the President calls Tom in and says, okay, we are going to go to the Senate and the House, we are going to sell our package, Tom has to have the ability to convince 535 people that the President is right or that the administration is right. You do not want somebody going up there who has not walked into a legislative meeting before, somebody who has not been in the political process before. Tom has been there and done that. And he is the type of guy you could trust to make the sale and represent the administration and the people.

Fifth, I would want somebody who is accountable. Tom is an accountable type of guy. In fact, I joked last week and said he is one of those rare ones of us who actually reads the bills. In fact, when I have a big question, I will usually come talk to Tom late at night and say, "Tom, what do you know about House Resolution 3742?" and he will tell me.

He is not exciting. He is sometimes boring, but he is always right, because he is always prepared. But he understands you need to be accountable in this business. You need to be responsible for what you do and responsible for what you say.

Now, there is a rumor that has been spread around by some people that Tom does not support the saving of Social Security. Let me tell you a little story. A few weeks ago, in fact at the end of the campaign in October, I was called by AARP and Tom was called by AARP. They said, will you two go on the road for us and do presentations around the State in your congressional districts about how you are going to save Social Security?

And I guess Alpharetta, GA was the first place. Tom and I went one night and spent the whole night before a room full of seniors defending saving Social Security. So anybody who is passing that rumor around, hey, go ask AARP who is going to save Social Security, go ask the people who are active in that business who is going to do it. Tom Price understands the value of Social Security and the value of Medicare. And being eligible for both, I would not be up here promoting somebody who is going to take it away from me, I guarantee you that.

Now, let me tell you one other thing. Four years ago, I sat in this committee room and in the HELP Committee and I questioned and I asked all that I could of Sylvia Burwell. And when it came time for a vote, I voted for her because she was the right person at the right time for the administration to put in as head of HHS.

Dr. Tom Price is the right man at the right time for the right job. He is my friend. He is a man I have known for 30 years. He has unquestioned character and unquestioned ability. And he will be a great Secretary of HHS.

I thank all of you for taking my calls earlier when I called before this meeting. I urge you to give him the courtesy of your time to listen to what he has to say, ask your thorough questions, and I

hope you will see fit to nominate an honorable man, an accountable man, and a good man to be the next Secretary of Health and Human Services.

And I yield back, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Isakson.

I tell you, Tom, you could not have a better introducer than Senator Isakson. I mean, he is not only highly respected by all of us in the Senate, Democrats and Republicans, but he is very, very articulate, as you can see. And I think he did a very good job talking about you and your future here in this committee.

Now, I have some obligatory questions for the nominee. First, is there anything that you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Dr. PRICE. I am not.

The CHAIRMAN. Do you know of any reason, personal or otherwise, that would in any way prevent you from fully and honorably fulfilling this responsibility?

Dr. PRICE. I do not.

The CHAIRMAN. Do you agree, without reservation, to respond to any reasonable summons to appear and testify before any duly constituted committee of the Congress, if you are confirmed?

Dr. PRICE. I look forward to that.

The CHAIRMAN. Finally, do you commit to provide a prompt response in writing to any questions that may be submitted to you or addressed to you by any Senator of this committee?

Dr. PRICE. I do.

The CHAIRMAN. Well, thank you. Those are the obligatory questions that we ask of everybody.

Let us turn the time over to you, Dr. Price, Congressman Price, to state whatever you would like to state here for the committee this morning.

**STATEMENT OF HON. THOMAS PRICE, M.D., NOMINATED TO BE
SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Dr. PRICE. Thank you so much, Chairman Hatch and Ranking Member Wyden, and to all the members of this committee, for the opportunity to speak with you today and to engage in a discussion about the road ahead for our great Nation.

I want to thank Senator Johnny Isakson so much for his incredibly gracious introduction. As he mentioned, we have known each other for 30 years or so. I am so grateful for his friendship and his kindness. Our State is so grateful for his leadership and his service. And we are blessed to have had it.

I wish also to especially thank my wife Betty, of 33 years, who joins me here today. Her support and her encouragement and her advice—which I will remind you is always correct—and her love that she has given me over those past 33 years, I am more grateful for that than I could ever say.

Over the past couple of weeks and months, I have met with many of you individually and gained a real appreciation for the passion that you all have for the critical work that is done at the Department of Health and Human Services. Please know that I

share that passion, which is why I am here today and why I am honored to have been nominated to serve as the next Secretary of Health and Human Services.

We all come to public service in our own unique ways that inform who we are and why we serve. My first professional calling was to care for patients. That experience as a physician and later as a legislator has provided me a holistic view of the complex interactions that take place every single day across our communities. And today I hope to share with you how my experience has helped shape my understanding of and appreciation for the Department of Health and Human Services.

From an early age, I had an interest in medicine. My earliest memories, though, were of growing up on a farm in Michigan, where I lived until I was 5 years old when our family moved to suburban Detroit.

I spent most of my formative years being raised by a single mom. Some of my fondest memories as a child were those spent with my grandfather, who was a physician, and I would occasionally spend some weekends with him when he would make rounds, which meant that we got in a car and went to people's homes and made house calls. And I will never forget the warmth and the love with which he was greeted at every single door. Those impressions are seared in my memory.

After graduating from medical school from the University of Michigan, I moved to Atlanta, which I have called home for nearly 40 years. It is where I met my wife Betty. It is where we raised our son. I did my residency at Emory University and Grady Memorial Hospital, where I would later return in my career to serve as the medical director of the orthopaedic clinic.

Throughout my professional career, I cared for and treated patients from all walks of life, including many, many children. And anyone who has ever had the privilege of treating a child knows how fulfilling it is to look into the eyes of a mom or a dad and say how we helped heal their son or their daughter. My memories of Grady are filled with the gracious comments of parents and of patients for the team of health-care specialists with whom I had the privilege of working.

After 25 years of school and training, I started a solo orthopaedic practice. Over the years, this practice grew, as Senator Isakson mentioned, and it eventually became one of the largest non-academic group practices of orthopaedics in the country, for which I eventually served as chairman of the board. During 20 years as a practicing physician, I learned a good bit about not just treating patients, but about the broader health-care system and where it intersects with government.

A couple of vivid memories stand out. One is the number of times when patients were remarkably angry about the individuals figuratively, not literally, standing between themselves and their physician in the clinic room, making it so that what the physician was recommending might or might not be possible, whether it was from insurance or regulators or government or the like.

And then there was the day that I remember vividly when I realized there were more people in the office behind the door where we saw patients in the front clinic area trying to fight with insurance

and regulators and government than there were in front of the door actually caring and treating patients. And it became clear to me that our health-care system was losing focus on its number-one priority, and that is the patient.

As a result, I felt compelled to broaden my role in public service and help solve the issues harming the delivery of medicine, and so I ran for the Georgia State Senate.

I found Georgia's State Senate to oftentimes be a remarkably bipartisan place where collegial relationships were the norm. This is the environment in which I learned to legislate, reaching across the aisle to get work done.

In Congress, I have been fortunate to have been part of a collaboration that broke through party lines as well to solve problems. Just this past Congress, as you will recall, it was a bipartisan effort that succeeded in ridding Medicare of a broken physician payment system and which has now begun the creation of a system that, if implemented properly, will help ensure that seniors have access to higher-quality care.

If confirmed, my obligation will be to carry to the Department of Health and Human Services an appreciation for the bipartisan, team-driven policymaking in what has been a lifetime of commitment to improving the health and well-being of the American people. That commitment extends to what I call the six principles of health care: affordability, accessibility, quality, responsiveness, innovation, and choices.

But Health and Human Services is more than health care. There are real heroes at this department doing incredible work to keep our food safe and to develop drugs and treatment options driven by scientists conducting truly remarkable research. There are heroes among the talented, dedicated men and women working to provide critical social services, helping families and particularly children have a higher quality of living and the opportunity to rise up and achieve their American dream.

The role of the Health and Human Services Department in improving lives means it must carry out its responsibilities with compassion. It also must be efficient and effective and accountable as well as willing to partner with those in our communities already doing remarkable work. Across the spectrum of issues and services this department handles, there endures a promise that has been made to the American people. And we must strengthen our resolve to keep the promises our society has made to senior citizens and to those most in need of care and support.

That means saving and strengthening and securing Medicare for today's beneficiaries and future generations. It means ensuring that our Nation's Medicaid population has access to quality care. It means maintaining and expanding America's leading role in medical innovation and of the treatment and eradication of disease.

So I share your passion for these issues, having spent my life in service to them. And yet, there is no doubt that we do not all share the same point of view when it comes to addressing each and every one of these issues. Our approaches to policies may differ, but surely there exists a common commitment to public service and compassion for those whom we serve.

We all hope to improve the lives of the American people, to help heal individuals and whole communities. So with a healthy dose of humility and an appreciation for the scope of the challenges before us, with your assistance and with God's will, we can make it happen. And I look forward to working with you to do just that.

Mr. Chairman, I thank you for the opportunity to be with you today.

[The prepared statement of Dr. Price appears in the appendix.]

The CHAIRMAN. Well, thank you, Dr. Price. I cannot think of anybody who could give a better analysis of why this position is so important to them.

Let me start with this question. The Department of Health and Human Services is one of the largest departments in government, employing, I think, nearly 80,000 employees and encompassing over 100 programs covering a large range of complex and diverse issues.

Now, you have described to a degree, but if you could elaborate a little bit more, can you describe how you will prioritize and oversee the large array of issues for which you will be responsible? And tell us, what in your history has prepared you to lead the Department of Health and Human Services, such a multifaceted department?

Dr. PRICE. Thank you, Mr. Chairman. As you and members know, the mission of the Department of Health and Human Services is to improve the health and the safety and the well-being of the American people. I am committed to that mission, but in order to do that, you have to put together teams of individuals in each sector of health and human services. And my history, wherever I was—whether it was in my clinical practice or in the State legislature or Congress or the work that I did in communities—was just to bring forward the greatest quality of talent that we could assemble.

Second is to understand the scope and the issues. And clearly, having the experience both in the clinical arena as well as in the legislative arena, I understand the scope and the issues.

And then finally, focusing on results. I think oftentimes it gets kind of muddy up here in Washington, what we do. We name the programs, we make certain that the resources are there to be able to provide money for the programs to be run, but oftentimes I think we drop the ball on whether or not we are actually accomplishing the mission. Are we truly improving the health and the safety and the well-being of the American people?

So one of the major goals that I have is to look at the metrics that we are looking at at the department to make certain that we are accomplishing that mission and that goal.

The CHAIRMAN. Thank you. The Center for Medicare and Medicaid innovation, CMMI, has begun numerous initiatives over the past few years, some of which have generated much controversy. Could you tell us your position on the work in CMMI and how it should or should not be continued in the future?

Dr. PRICE. Thank you, Mr. Chairman. Innovation is so incredibly important to health care and the vibrant quality of health care that we need to be able to provide to our citizens. Innovation, in fact, is what leads quality health care. It is what expands the ability of

health-care professionals to be able to treat patients. So I am a strong supporter of innovation, and I think one of the roles that we as policymakers have is to incentivize innovation.

The Center for Medicare and Medicaid Innovation is a vehicle that might do just that. I think, however, that CMMI has gotten off track a bit. I think that what it has done is defined areas where it is mandatorily dictating to physicians and other providers in this country, in certain areas, how they must practice. So whether it is a geographic area that includes 67 or 68 areas in our country that have to perform a certain procedure in a certain way and use a certain implant in a certain way because the government says they have to mandatorily, without exception, or whether it is 75 percent of the Part B Medicare drug demo, what is called a demonstration project, which dictates to physicians and other providers they must use an in-patient setting, that, to me, is no longer a trial, that is no longer an experiment, that is no longer a pilot project to determine whether or not an innovative solution might work. That is changing the way that American medicine is practiced by folks making decisions here in Washington as opposed to patients and families and doctors making those decisions.

So I am a strong supporter of innovation, but I hope that we can move CMMI in a direction that actually makes sense for patients.

The CHAIRMAN. Well, thank you so much. Medicare has lost more than \$130 billion—that is with a “b”—to improper payments over the past 3 years. The program has also been above the legal billing error rate threshold of 10 percent for the past 4 years.

Given that Medicare trustees have issued grave concerns about looming Medicare insolvency if we stay at the current spending levels, will your administration actively champion our Medicare Integrity Program so that we can recover a much higher percentage of the billions of taxpayer dollars lost each year to billing mistakes and ensure that Medicare will be in place for future American seniors?

And also, as a former practicing physician who has experience with Medicare and Medicaid programs, do you have any insights into steps you think should be taken to address the multi-billion-dollar problem of waste, fraud, and abuse in these programs?

Dr. PRICE. Yes, thanks, Mr. Chairman. Nobody supports care being billed that is not needed or has not been provided. And this is one of those areas that I think we need to be very, very focused on.

I am certain that there are some bad actors out there. I think they are a minority, but there are some bad actors out there. And I am certain that if we were to focus specifically on those bad actors in real time—which is what happens in every other industry in our country where that real-time information is available and acted upon—instead of trying to determine whether every single incident of care is necessary, if we were to focus on those individuals who were the bad actors specifically, then I think we could do a much better job of not just identifying the fraud that exists out there, but ending that fraud.

The CHAIRMAN. Well, thank you.

Senator Wyden, we will turn to you now.

Senator WYDEN. Thank you, Mr. Chairman.

Congressman, I am going to start with the trading in health-care stocks. Your position is that the trading was legal because, in your view, it complied with House rules. I think there are debatable legal questions, but there are other matters.

Innate Immunotherapeutics is an obscure Australian company that develops a treatment for immune system disorders and plans to seek FDA approval. Innate's fortunes are affected by congressional action.

Today, the total value of your shares exceeds a half-million dollars. Yet on the Office of Government Ethics disclosure form you filed as a nominee, you significantly undervalued the stock. You failed to include the value of more than 400,000 shares you bought at a significant discount during a private stock sale made available to specially chosen investors around Labor Day. You also significantly underreported the value of this purchase to the committee. It is worth more than twice what you reported.

You heard about the stock from a House colleague who is a board director of this Australian drug company and the largest shareholder. You got in on private placements not available to the public. In these private placements, you bought over 400,000 shares at discounts that were as much as 40 percent cheaper than the price on the Australian Stock Exchange. And you were sitting at the time on committees that have jurisdiction over major health-care programs and trade policy.

"Yes" or "no," does this not show bad judgment?

Dr. PRICE. Well, if what you said was true it might. But the fact of the matter is, that is not the case.

Senator WYDEN. We have a paper trail, Congressman. We have a paper trail for every comment I have made. "Yes" or "no," does this not show bad judgment?

Dr. PRICE. No.

Senator WYDEN. Well, I just—

The CHAIRMAN. Well, let him answer the question too. I mean, you have kind of indicated he did something wrong. Let him explain why it was not wrong.

Senator WYDEN. It was a "yes" or "no" answer.

The CHAIRMAN. No, I want him to be able to handle that problem.

Dr. PRICE. Maybe it would be helpful if you laid out the accusation, sir.

The CHAIRMAN. Be fair.

Senator WYDEN. Well, you purchased stock in an Australian company through private offerings at discounts not available to the public.

Dr. PRICE. If I may, they were available to every single individual who was an investor at the time.

Senator WYDEN. Well, that is not what we learned from company filings. Company filings with the Australian Stock Exchange state that this specific private placement would be made at below-market rates. The Treasury Department says it is only offered to sophisticated investors in a non-public manner. We have a paper trail for every one of the statements that I have gone into. And trading in stocks while you sit on two committees introducing legislation that directly impacts the value of the stocks—

Dr. PRICE. What legislation would that be, Senator?

Senator WYDEN. We will take you through the various bills. But the reality is, this has been cited on a number of occasions.

Dr. PRICE. The reality is that everything that I did was ethical, above-board, legal, and transparent. The reason that you know about these things is because we have made that information available in real time as required by the House Ethics Committee.

So there is not anything that you have divulged here that has not been public knowledge.

Senator WYDEN. Your stake in Innate is more than five times larger than the figure you reported to ethics officials when you became a nominee.

Dr. PRICE. And if you had listened to your committee staff, I believe you would know that our belief is that that was a clerical error at the time that the 278E was filed. We do not know where it happened, whether it was on our end, whether it was on the end of the individuals of OGE. But there was not any malicious intent at all.

Senator WYDEN. Congressman, you also reported it in the questionnaire to the committee, and you had to revise it yesterday because it was wrong.

Dr. PRICE. And the reason for that is because I, when asked about the value, thought it meant the value at the time that I purchased the stock, not the value at some nebulous time when we supposedly made a specific gain.

Senator WYDEN. I want to get in one other question, if I might. This weekend, the President issued an executive order instructing the Department and other agencies to do everything possible to roll back the Affordable Care Act. If confirmed, you will be the captain of the health team and in charge of implementing the order.

“Yes” or “no,” under the executive order, will you commit that no one will be worse off?

Dr. PRICE. What I commit to, Senator, is working with you and every single member of Congress to make certain that we have the highest-quality health care and that every single American has access to affordable coverage.

Senator WYDEN. That is not what I asked. I asked, will you commit that no one will be worse off under the executive order? You ducked the question. Will you guarantee that no one will lose coverage under the executive order?

Dr. PRICE. I guarantee you that the individuals who lost coverage under the Affordable Care Act, we will commit to making certain that they do not lose coverage under whatever replacement plan comes forward. That is the commitment that I provide to you.

Senator WYDEN. The question again is, will anyone lose coverage, and you answered something I did not ask.

I will wrap up this round by saying, will you commit to not implementing the order until the replacement plan is in place?

Dr. PRICE. As I mentioned, Senator, what I commit to you and what I commit to the American people is to keep patients at the center of health care. And what that means to me is making certain that every single American has access to affordable health coverage that will provide the highest-quality health care that the world can provide.

Senator WYDEN. I am going to close by way of saying that what the Congressman is saying is that the order could go into effect before there is a replacement plan. And independent experts say that this is going to destroy the market on which millions of working families buy health coverage. And on the questions that I asked, will the Congressman commit that nobody will be worse off, nobody will lose coverage, we did not get an answer.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, how can anybody commit to that? [Laughter.]

Let me just say, Dr. Price, you have been accused here of investing in securities that you had a direct effect over in Congress and you disclosed the wrong value of shares you owned in Innate Immunotherapeutics.

Now Dr. Price, let me just say this, has a diversified portfolio with Morgan Stanley in a broker-directed account. Correct me if I am wrong on any of this, Doctor. The portfolio includes both health-care and non-health-care stocks. His financial adviser designed the portfolio and directed all trades in the account. The advisers and not Dr. Price have the discretion to decide which securities to buy and sell.

On March 17, 2016 in a rebalancing of the portfolio, the financial adviser directed the purchase of 26 shares in Zimmer Biomet worth under \$3,000. The adviser notified Dr. Price of the purchase on April 4, 2016, and Dr. Price disclosed them on his House periodic transaction report on April 15th.

Now, Dr. Price began his legislative effort related to the comprehensive joint replacement demonstration project in 2015. With one exception, all of Dr. Price's stocks are held in three broker-directed accounts. Neither he nor his wife direct or provide input regarding investments in these accounts. Innate Immunotherapeutics is the one exception.

Now, Dr. Price decided to invest based on public information regarding his work on multiple sclerosis treatments as a disease. He has been intimately involved in treating for years. He directed the investments based on his own research into the company. He invested \$10,000 in the company in January 2015 and reported the investments to House Ethics in February of that year. He made an additional investment in September 2016 and also disclosed that investment.

He has corrected his filing regarding the value of his shares. He has agreed to divest all shares in the company. Is that a correct set of remarks?

Dr. PRICE. I think your summation is correct, sir. And I just would point out that anybody who knows me well knows that I would never violate their trust. And I know the environment that we are in here—you mentioned it in your opening statement—but I appreciate you correcting the record.

The CHAIRMAN. Well, thank you.

Senator CARPER. Mr. Chairman?

The CHAIRMAN. Yes, sir?

Senator CARPER. Just an inquiry. You just consumed about 2 minutes beyond your opening statement. And in the interest of fair

play, is it appropriate for someone to note that 2 minutes is also owed to Senator Wyden or somebody on our side?

The CHAIRMAN. Well, he already did go over 2 minutes, so it is no problem.

Senator CARPER. Okay. But as we go forward in this process, I would just ask you to keep that in mind.

The CHAIRMAN. Well, I am not going to relinquish my role as chairman—

Senator CARPER. No, I understand.

The CHAIRMAN [continuing]. To correct errors that are promulgated here. But I have always been good about giving time that you need, so I will try to do that.

Senator CARPER. Thank you.

The CHAIRMAN. But I am also not going to allow things that are false to go forward without some sort of comment.

Senator CARPER. All right.

The CHAIRMAN. We just cannot allow this to happen.

Senator WYDEN. Mr. Chairman, just a unanimous consent request.

The CHAIRMAN. Yes.

Senator WYDEN. I have a bipartisan disclosure memo I would like to ask be made a part of the record, because it will document what I have stated.

The CHAIRMAN. Without objection.

[The memorandum appears in the appendix on p. 283.]

The CHAIRMAN. Senator Roberts?

Senator ROBERTS. Did you really wink at me and smile? Bless your heart, thank you. [Laughter.]

Good Doctor, thank you for coming. I think it is important to make clear right off the bat that, even if Congress and the incoming administration were to do nothing, absolutely nothing amending or repealing parts of the Affordable Care Act, the law is not working.

Dr. PRICE. Right.

Senator ROBERTS. It is collapsing. The prices are unaffordable, the market is nearly nonexistent, with few options in several States and counties. This year, one out of every three counties in this country only has one insurer offering coverage on the exchange.

What tools do you have, or will you have when you are confirmed, which could be utilized over the next couple of months to provide stability and improve the individual insurance markets, make them more appealing so that insurance carriers will want to come back and provide more coverage options as we transition away from the Affordable Care Act?

Dr. PRICE. Well, thank you, Senator. I think it is incredibly important for us to admit here what the American people know, and that is that this law is not working. It certainly is not working for folks in the individual and small-group market.

You have premiums that are up significantly; they were supposed to go down by 2,500 bucks; now they are up more than 2,500 bucks on average. You have deductibles that have escalated to \$6,000 to \$12,000. You have, as you mentioned, States where there

is only one insurance provider. You have one-third of the counties in this country where there is only one insurance carrier.

This is maybe working for government, maybe working for insurance companies, but it is not working for patients. And so what we need to do is make an effort to try to reconstitute the individual and small-group market. And that begins, I believe, by providing stability in our conversation and in our tone.

And one of the goals that I have is to lower the temperature in this debate, to say to those providing the insurance products across this country, we understand; we heard the challenges that you have.

They are already exiting the market. What we need to do is to say, there is help on the way to allow us to reconstitute the individual and small-group market and allow for folks to gain the kind of coverage that they want for themselves and for their family—not what the government forces them to buy—that allows them to purchase coverage at a reasonable amount, that makes it so that they do not have deductibles through the roof, where they have the ability to pay the premiums and the deductible as well.

So there are so many things that we ought to be focusing on to make certain, again, that the American people have access to the highest-quality care that is affordable for them.

Senator ROBERTS. Doctor, I have 84 critical access hospitals in my State. They are all part of the rural health-care delivery system, which is under great stress. As we have seen when I visit with hospital administrators all throughout Kansas—there was a time I knew every one of them—they are scratching their heads over regulations coming out of HHS, CMS, and all the other agencies that you will oversee when you are confirmed.

I mention the meaningful use program for electronic health care records. Doctors used to spend, what, 10 to 15 minutes with patients. It is now down to about 2 or 3, and then they have to report immediately on what was going on.

The 96-hour rule for critical access hospitals, numerous other documentation requirements—it seems to me there is a lack of understanding of our provider shortages in our rural areas. We are just hanging on by a thread, and these one-size regulations from Washington simply do not translate to rural Kansas or any other rural area as far as population—

My question is, how will you work to ensure an effective but smarter, less-burdensome rulemaking process?

Dr. PRICE. Well, this is really critical, Senator, because, as you mentioned, in the rural areas—Georgia is the largest State geographically east of the Mississippi, and we have a large rural population, and critical access hospitals are so important to communities around our State and truly around this Nation.

But the regulatory scheme that has been put in place is choking the individuals who are actually trying to provide the care, so much so that you have physicians and other providers who are leaving the practice, who are leaving the caring for patients, not because they have forgotten how to do it or they have grown tired of it, but because of the onerous nature of the regulatory scheme coming out of Washington, DC.

The meaningful use project that you mentioned makes it that much more difficult. We have turned physicians into data-entry clerks. And you just have to ask them what they are doing. And if you talk to patients, what they recognize is that, when they go in to see their doctor, they see the top of his or her head as they are punching the information, the data into a computer, as opposed to that sharing of information that is so vital and necessary between the physician and the patient for quality health care.

So, one, a recognition of the problem is incredibly important, a recognition of the importance of rural health care in our Nation and how it needs to be bolstered up, and then looking at the consequences of what we do as government.

As I mentioned earlier, oftentimes I do not think we look at the consequences. We pass the rule, we pass the regulation, we institute it, we think it is the greatest thing since sliced bread, but in fact what it is doing is harming the very individuals who are trying to provide the care. You do not get that information unless you ask.

Senator ROBERTS. All right, I appreciate that. My time is up.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Congressman, I enjoyed our visit yesterday. We had a discussion, when you were kind enough to come visit me, about the fact that I have in the State of Florida 4 million-plus seniors on Medicare, and they are petrified of the idea of privatized Medicare.

And I talked to you about this. And you talked about the premium support system that you are advocating. And you pointed to a study that was done by CBO. You mentioned that you would send me a copy, and we have not gotten it. So what I did, I went and got the copy myself, and it is from September of 2013. And what it concludes is opposite of what you said with regard to high-cost States like Florida.

Medicare is going to be spending 4 percent less under the proposal that you were talking about in this CBO report, lower than current law, and beneficiary costs will decrease by 6 percent on the average, which is what you said yesterday. But in high-cost regions like Florida, you are going to have a higher beneficiary cost than current law under your premium support proposal.

Annual premiums in Florida would increase 125 percent according to the CBO chart on page 71. CBO says that the annual premium in a high-cost region like Florida would be \$3,600 compared to the current law of \$1,600. That is a 125-percent increase. So please help clarify what you were saying yesterday as it applies to Florida.

Dr. PRICE. Yes, thank you, Senator. And I enjoyed our time together as well.

When we talk about Medicare, it is important for everybody to appreciate, as I know that you and your colleagues do, that the Medicare trustees, not Republicans or Democrats, the Medicare trustees have told all of us that Medicare in a very short period of time, less than 10 years, is going to be out of the kind of resources that will allow us as a society to keep the promise to beneficiaries in the Medicare program.

What that means is—and it is important to appreciate what that means—it means that we will not be able to provide the services to Medicare patients at that time, which is very, very close, if nothing is done.

So my goal is to work with each and every one of you to make certain that we save and strengthen and secure Medicare. I think it is irresponsible of us as policymakers to allow a program to continue, knowing—knowing—that in a few short years it is not going to be able to cover the services that we are providing. So that is the first point, that the current Medicare program, if nothing is done, as some have described it, goes broke.

The second point is that my role, if I am confirmed and have the privilege of serving as the Secretary of Health and Human Services, my role will be one of carrying out the law that you all in Congress pass. It is not the role of a legislator, which I had when I was working to try to formulate ideas to hopefully generate discussion and get to a solution—

Senator NELSON. Okay. Let me be so rude as to stop you, because I am running out of time. Remember that Donald Trump in the campaign said that he was not going to cut Medicare spending.

And I would also point out to you a legislative solution—one of the greatest examples on Medicare is 1983, when we were just about to go bust and it took two old Irishmen, Reagan and O'Neill, to agree to come to an agreement that made, in this case it was not Medicare, it was Social Security, actuarially sound for the next half-century.

Let me ask you, Representative Price: you had made a statement that it was a terrible idea for people who had preexisting conditions to have the protection of insurance against those preexisting conditions.

And what I would like to ask you is, if you please, in light of President Trump expressing his desire to retain this basic protection, do you think his proposal to continue the ban on discriminating against people with preexisting conditions is a terrible idea?

Dr. PRICE. No, and I am not certain where you are getting that quote from. What I have always—

Senator NELSON. It came from a *Politico* talking points memo, May 1, 2012.

Dr. PRICE. Well now, there is a reliable source. [Laughter.]

What I have always said, Senator, is that nobody—nobody—

Senator NELSON. So you did not say it is a terrible idea?

Dr. PRICE. I do not believe I ever made that statement. What I have always said about preexisting conditions is that nobody, in a system that pays attention to patients, nobody ought to be priced out of the market for having a bad diagnosis. Nobody. That is a system, again, that may work for insurance companies, may work for government, but it does not work for patients.

So I believe firmly that what we need is a system that recognizes that preexisting conditions do indeed exist and that we need to accommodate them and make certain that nobody loses their insurance or is unable to gain insurance because of a preexisting condition.

Senator NELSON. Mr. Chairman, as I close, I would like to insert in the record the September 2013 Congressional Budget Office analysis of premium support systems for Medicare.

[The analysis appears in the appendix on p. 92.]

Senator NELSON. And I would invite you, Congressman, to please respond with the CBO report that you said yesterday supports your position, because this one does not.

Dr. PRICE. I look forward to that. Thank you, sir.

The CHAIRMAN. Senator Menendez?

Senator MENENDEZ. Well, thank you, Mr. Chairman.

Congratulations, Congressman Price.

Let me ask you a series of questions. Given your medical training and time spent as a practicing physician, I have a couple of simple "yes" or "no" questions to start off with.

In your medical opinion, does HIV cause AIDS?

Dr. PRICE. I think that the scientific evidence is clear that HIV and AIDS are clinically, directly related.

Senator MENENDEZ. In your medical opinion, have immigrants led to outbreaks of leprosy in the United States?

Dr. PRICE. I do not know what you are referring to, but I suspect that there are instances where individuals have an infectious disease, and they come to the United States and that that—

Senator MENENDEZ. I am not asking about an infectious disease. I am asking specifically about immigrants in the United States causing leprosy in the United States, in your medical opinion and scientific background.

Dr. PRICE. Again, I do not know the incident to which you refer. Are you referring to a specific incident?

Senator MENENDEZ. There are statements that have been made in the public domain that immigrants have led to outbreaks of leprosy in the United States. As the person who is going to be designated as the director of Health and Human Services, that is not only the national, but the world's health epicenter, I want to know, in your medical opinion, is there such a causation?

Dr. PRICE. Any time you get two individuals together in any relationship whatsoever, whether it is an immigrant or a visitor, and one individual has an infectious disease, then it is possible that that individual transmits that infectious disease—

Senator MENENDEZ. Including leprosy?

Dr. PRICE [continuing]. Whether it is the flu or a cold.

Senator MENENDEZ. Including leprosy? Including leprosy?

Dr. PRICE. Any infectious disease whatsoever.

Senator MENENDEZ. In your medical opinion, do abortions cause breast cancer?

Dr. PRICE. I think the science is relatively clear that that is not the case.

Senator MENENDEZ. In your medical opinion, do vaccines cause autism?

Dr. PRICE. Again, I think the science in that instance is that they do not, but there are individuals across our country who are very—

Senator MENENDEZ. I am not asking about individuals; I am talking about science, because you are going to head a department in which science, not alternate universes of people's views, is going

to be central to a trillion-dollar budget and the health of the Nation.

Can you commit to this committee and the American people today that, should you be confirmed, you will swiftly and unequivocally debunk false claims to protect the public health?

Dr. PRICE. What I will commit to doing is doing the due diligence that the Department is known for and must do to make certain that the factual information is conveyed to, obviously, the President and to the American people.

Senator MENENDEZ. And that factual information will be dictated by science, I would hope?

Dr. PRICE. Without a doubt.

Senator MENENDEZ. Okay. So let me ask you about Medicaid specifically. And let me just say I am a little taken back about your answer on the question of immigrants and leprosy. I think the science is pretty well dictated in that regard too.

Let me ask you this. One of the most beneficial components of the Affordable Care Act was the expansion of the Medicaid program that resulted in 11 million people nationwide and over half a million in New Jersey gaining coverage, many for the first time. It is one of the biggest programs on the Republican chopping block with proposals to not only repeal the Affordable Care Act's Medicaid expansion, but going further and gutting billions in Federal funding to the States.

There is no doubt that this would result in catastrophic loss of coverage for tens of millions of low-income families and lead to tens of billions in losses to safety-net and other health-care providers.

Do you recognize Medicaid to be a valuable program and consider the coverage it provides to 74 million Americans to be comprehensive?

Dr. PRICE. Medicaid is a vital program for health care for many individuals in this country, but one that has significant challenges. There is one out of every three physicians who should be seeing Medicaid patients who are not taking any Medicaid patients. There is a reason for that.

If we are honest with ourselves, we would be asking the question, why?

Senator MENENDEZ. Well, if that is the case that one in three does not treat Medicaid patients, you have to ask yourself, is that because Medicaid reimbursements are so low? And since provider reimbursements are set at a State level, will not cutting Federal funding and hitting States with higher costs only lead to lower provider rates? And how many doctors would actually treat former Medicaid beneficiaries when they no longer have any coverage or ability to pay?

So, even if there is only one of three, there are still two of three who are providing the services; imagine if you do not have coverage.

Which goes to my next question. You have advocated to, in essence, block-grant Medicaid. Now, the essence of Medicaid is an entitlement, which under the law means, if I meet these criteria, I have the right to have that coverage under the law. When you move to a block grant, you remove the right and you make it a possibility subject to whatever funding there is going to be.

Do you recognize that in doing so you risk the potential of millions of Americans who presently enjoy health-care coverage through Medicaid no longer having that right?

Dr. PRICE. I think that it is important to appreciate that no system that the President has supported or that I have supported would leave anybody without the opportunity to gain coverage. Nobody.

Senator MENENDEZ. Well, that is not my question, so let me reiterate my question. Medicaid, under the law as it exists today, is a right. Is that not the case, "yes" or "no"?

Dr. PRICE. It is an entitlement program—

Senator MENENDEZ. And as an entitlement, does that not mean, if you meet the criteria, that you are entitled to the services?

Dr. PRICE. If one is eligible, that is correct.

Senator MENENDEZ. One is eligible, meaning you have a right. When you move to a block grant, do you still have the right?

Dr. PRICE. No. I think it would be determined by how that was set up if, in fact, that was what Congress did. Again, the role of the Department of Health and Human Services is to administer the laws that you pass, not to make the law.

Senator MENENDEZ. Yes, but I would just simply say to you, I know in our private conversation—and I appreciate you coming by to visit me—you suggested that your role is that of an administrator of a large department. Well, that is not even what the Vice President said when you were nominated. He said he expected your experience, both medically and legislatively, to help drive policy. And even beyond the expectations of the Vice President in that regard, when we have the ability of the Secretary to dictate regulation, that is policy.

So please do not say to me, I am here just to do what Congress says. I respect that you will follow the law and do whatever Congress says. But you will have an enormous impact. And based upon your previous opinion as it relates to Medicaid, ultimately block-granting means a loss of a right. And then it is just a question of funding, and then we will have a bigger problem with a number of providers' will to provide.

And so I hope we can get to a better understanding of your commitment to Medicaid as it is, as an entitlement, as a right.

Dr. PRICE. Thank you, sir.

The CHAIRMAN. Senator, your time is up.

We will go to Senator Carper now.

Senator CARPER. Congressman Price, welcome to you and to your wife.

There is a verse of scripture—you mentioned earlier that you are active in your church—in the New Testament, in Matthew 25, which speaks to the "least of these." When I was hungry, did you feed me? When I was naked, did you clothe me? When I was thirsty, did you give me to drink? When I was sick and in prison, did you visit me? When I was a stranger in your land, did you take me in? It says nothing about, when my only access to health-care coverage was going into the emergency room of a hospital, did you do anything about it?

What we sought to do with the ACA was to do something about it. And we did not, in this room, invent the Affordable Care Act.

The genesis of the Affordable Care Act goes back to 1993 when Hillary Clinton, first lady, was working on what was called Hillary-care. And a group of Senators, led by Senator John Chafee, a Republican from Rhode Island, developed legislation co-sponsored by, I think, 23 Senators, including, as I recall, Senator Orrin Hatch and Senator Grassley.

And what he did in his legislation, what he proposed in his legislation, was to use really five major concepts. One, to create large purchasing pools for folks who otherwise may not have access to health-care coverage. He called them exchanges or marketplaces.

He also proposed that there be a sliding scale tax credit to buy down the cost of people getting coverage in those exchanges within the different States.

The third thing he proposed was the notion that there should be an individual mandate. He wanted to make sure people got covered, and he realized if they did not mandate coverage or people getting coverage, then you would end up with insurance pools that health insurance companies could not begin to cover; it just would be unworkable.

He proposed, as well, employer mandates. And he proposed, as well, the notion that people should not lose their coverage because of preexisting conditions.

Those are not Democratic ideas. Those were proposed by Republican leadership actually in the Congress at the time. And when Governor Romney developed his own plan in Massachusetts, I do not know, a decade or so later, he borrowed liberally from those ideas.

When they instituted it, as you may recall—they instituted what I call, what others call, Romneycare—they found they were doing a pretty good job on covering people, but not such a good job on affordability. And what took place over time was, they found out they had insurance pools where a lot of the people were not young, they were not very healthy, they were older, and they needed more health care. And as a result, the insurance companies, in order to be able to stay in business, had to raise the premiums.

I do not know if any of this sounds familiar to you, but it sure sounds similar to what we have seen in the last 6 years or so with the Affordable Care Act.

To the ideas of Senator Chafee and the ideas of Governor Romney, we have added some things. We have encouraged States to increase the number of people they cover under Medicaid by raising to about 135 percent of the poverty level the eligibility under which people can receive health care. We have encouraged a focus on prevention and wellness: not just treating people when they are sick, but also trying to make sure that people stay healthy in the first place. We provide funding for contraception. We provide funding for programs that are intended to reduce obesity. We have programs that are intended to reduce smoking, the use of tobacco.

This is not a “yes” or “no” question. What was wrong with that approach? What is wrong with that approach?

And the last thing I will say is this, before you answer. The health insurance companies found it difficult to stay in business in the State group exchanges across the country. One of the reasons why they were unable to is because, I think—really we learned this

from Massachusetts—we did not raise the fine or, if you will, we did not have the incentive high enough to get young, healthy people, like my sons, into the exchanges across the country.

S&P, I am told, has just put out, about a month ago, an update looking at the financial health of the health insurance companies in this country as they have tried to figure out how to price this product. And it seems like, according to S&P, believe it or not, they seem to have sort of figured it out, because the financial health of the health insurance companies has begun to stabilize. Your reaction to this, please?

Dr. PRICE. Well, as I mentioned either in my opening or in response to a question, the principles of health care that all of us hold dear—affordability and accessibility and quality and choices for patients—I think are the things that we all embrace.

The next step, how we get to accomplish and meet those goals and those principles, is where it takes working together to do so.

The program that you outline has much merit, whether it is making sure that individuals with preexisting illness and disease are able to access coverage, whether it is the pooling mechanisms which I have actively and aggressively supported for years, there is a lot of merit there.

So again, what I am hopeful that we are able to do is to, in a collegial, bipartisan way, work together to solve the remarkable challenges that we have.

One of my physician colleagues used to tell me that he never operated on a Democrat patient or a Republican patient, he operated on a patient. And that is the way that I view the system. It is not a Republican system, it is not a Democrat system, it is a system where hopefully we are focusing on the patients to, again, make certain that they have the access to the highest-quality care possible.

Senator CARPER. Thank you for that. Let me just conclude, Mr. Chairman, by saying I will use an analogy. There is a large building, and there are people in the large building. And there is a fire in the large building, but for some reason they cannot use the stairways and they cannot use the elevators. And they look out the windows and there are firefighters down in the street saying, “Go ahead and jump, we will save you,” but they do not have any safety nets.

And my fear is, if we repeal what I have described, the system that I described, that we put in place, the Affordable Care Act, largely founded on Republican ideas which I think were good ideas, and we do not have something at least as good in place to catch those people as they fall from the building, we will have done a disservice to them and to our country.

Thank you.

Dr. PRICE. Thank you.

The CHAIRMAN. Thanks, Senator. Your time is up.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

And a quick reminder that the Affordable Care Act was passed with not one Republican vote in the House or the Senate.

So, Dr. Price, a couple of questions just to cut to the chase. Are all of your assets currently disclosed publicly?

Dr. PRICE. They are now and they always have been.

Senator BURR. Okay. Are you covered by the STOCK Act legislation passed by Congress that requires you and every other member to publicly disclose all sales and purchases of assets within 30 days?

Dr. PRICE. Yes, sir.

Senator BURR. Now, you have been accused of not providing the committee information related to your tax and financial records that were required of you. Are there any records you have been asked to provide that you have refused to provide?

Dr. PRICE. None whatsoever.

Senator BURR. So all of your records are in?

Dr. PRICE. Absolutely.

Senator BURR. Now, I have to ask you, does it trouble you at all that, as a nominee to serve in this administration, some want to hold you to a different standard than you were held to as a member of Congress, and I might say the same standard that they currently buy and sell and trade assets on? Does it burn you that they want to hold you to a different standard now that you are a nominee than they are held to as a member?

Dr. PRICE. Well, we know what is going on here.

Senator BURR. Well, we do. We do.

Dr. PRICE. And I understand. And as my wife tells me, I volunteered for this.

Senator BURR. So let us go to substance. You and I have a lot in common. We both spoke out in opposition to Obamacare early. We predicted massive premium increases. When the President promised, if you like your doctors, you can keep them, if you like your plan, you can keep it, we both said these promises would be broken, and, in fact, they were.

Over the last 7 years, you and I, Senator Hatch, Congressman Upton, and others have actually written our own health-care plans because we were, I think, brave enough to say that, if you are going to be critical of something, then put your ideas on the table.

In your opinion, was it clear to the American people that repeal of Obamacare was a promise that Donald Trump made before he was elected president?

Dr. PRICE. Well, I have no doubt that it played a very prominent role in this past election and that the President is committed to fulfilling that promise.

Senator BURR. And as the nominee and hopefully—and I think you will be—the Secretary of HHS, what are the main goals of an Obamacare replacement plan?

Dr. PRICE. The main goals, as I mentioned, are outlined in those principles. That it is imperative that we have a system that is accessible for every single American, that is affordable for every single American, that incentivizes and provides the highest-quality health care that the world knows, and provides choices to patients so that they are the ones selecting who is treating them, when, where, and the like.

So it is complicated to do, but it is pretty simple stuff.

Senator BURR. I want to thank you for not only testifying here, but testifying in front of the HELP Committee when Johnny and I both had you over there. You are brave to go through this, but

the country will be much better off with your guidance and your knowledge in this slot.

Mr. Chairman, I yield back.

Dr. PRICE. Thank you, sir.

The CHAIRMAN. Thank you.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

Dr. Price, again, thank you for your willingness to serve in this position. And we also thank your family for being willing to put up with your voluntary choices.

I want to talk about a few issues in the time that I have. One, yesterday the President by executive order reinstated the global gag rule, but he also did it in a way that is more comprehensive than the previous. The new policy would prohibit any Federal aid to foreign organizations that provide or promote abortion.

In the past, the policy only applied to organizations that got family planning funding; now it will apply to organizations that get global health funding, potentially including maternal health programs, anti-Zika efforts, and expansion of PEPFAR to stop HIV/AIDS.

My question to you is this: if confirmed, how will you make sure that the U.S. can fully participate in these global health efforts to help with maternal health, to help in stopping of the spread of and ending HIV/AIDS, to make sure that the next Zika virus is contained so it does not cause catastrophic effects, if the global gag rule is enforced in a way that prevents us from participating in international health organizations?

Dr. PRICE. Okay. This is really important, Senator, and I appreciate the question. The Department is full of all sorts of heroes, as you well know, and incredibly talented individuals. And my goal, if I am confirmed and given the privilege of serving as the Secretary of Health and Human Services, is to gather the best minds and the best talent that we have within the Department and without and determine what is the wisest policy for this Nation to have as it relates to, in this instance, infectious disease.

Germs no know geographic boundaries. And we do incredible work, the work that the CDC does and the work that is done by others in our Nation, to try to work to prevent infectious disease, work to detect the spread of infectious disease. And then providing a logical and methodical and aggressive response to the outbreak of any infectious disease is absolutely vital to protect the American people, and we are committed to doing so.

Senator CARDIN. And I agree with that. I just hope that you will look at perhaps unintended consequences from these executive orders that could compromise our ability to be as effective as we need to, using all tools at our disposal.

I want to get to tobacco regulation for one moment, an area that I think is now clear within the medical community, the impact that tobacco has, the fact that the Family Smoking Prevention and Tobacco Control Act of 2009 authorizes the HHS Secretary, through FDA, to regulate tobacco products, including restricting the sale of tobacco products to minors. It also has been expanded to include the selling of e-cigarettes, et cetera.

I know initially you did not support that legislation. If confirmed, can you commit to us that you would rigorously enforce that act to make sure particularly our children are not subjected to the new forms of tobacco products?

Dr. PRICE. If I am confirmed, the responsibility that we will have is to enforce the law of the land, and we will do so.

Senator CARDIN. It also requires keeping up with new technologies that are being used by the industry that may require modifications, as we see with e-cigarettes. Are you prepared to not only enforce the law, but to enforce our intent to make sure our children are protected?

Dr. PRICE. Yes, I look forward to working with you, Senator, on just that.

Senator CARDIN. I was listening to some of the exchanges related to the Affordable Care Act, and we will continue to debate the merits of the Affordable Care Act. I am a strong supporter of it. I think millions of people have coverage who did not have it before, the quality of coverage that Americans now have did not exist before, and the rate of growth of our health-care premiums is far lower than it would have been but for the Act. We will debate that later.

The question is, what is coming along? I mean, we have heard you say several times the principles that the President has articulated as to what would be in place of the Affordable Care Act.

I would like just to drill down a little bit, if I could, on essential health benefits. We have talked about preventive care now being available. We know that we have now mental health and addiction services that are available. We also know we have oral health, pediatric dental, that is now available, which is particularly important in my State because of the tragic loss of Deamonte Driver in 2007.

Can you assure us that, as you look at what will be the health-care system moving forward, you are prepared to make sure that Americans have quality insurance coverage to deal with issues such as preventive care, mental health services, addiction services, and pediatric dental?

Dr. PRICE. What I can commit to you, Senator, is that we will do all that we can within the Department with the incredible knowledge and expertise that is there to define whether or not the program is actually working as intended or not, if coverage equals care. In many instances, I would suggest that many individuals right now have "coverage." They have a card, but they do not have any care, because they cannot afford the deductible that allows them to get the care.

So we are committed to making certain that the program works, not just for government, not just for the insurance companies, but for the patients.

Senator CARDIN. And as you know, we eliminated any copays on preventive care. But we can talk about the specifics going forward. I look forward to those discussions. Thank you, Mr. Chairman.

Dr. PRICE. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman.

Tom, as Secretary-to-be, let me ask you a few “yes” or “no” questions. You have been asked a lot of them with the intent of trying to get you to say “yes” that you are going to cut Medicare when you are not going to cut Medicare; you are going to try to improve it and reform it.

But “yes” or “no” to these questions. Question number one: we have been hearing about the joint replacement program that Secretary Burwell launched in 2015. You and many others have raised concerns about this program saving money, that it could actually harm the quality of patient care. So in other words, was this an administrative action by HHS that actually cut a Medicare benefit?

Dr. PRICE. Potentially, yes.

Senator ISAKSON. Second: last year, HHS proposed a new way of paying for cancer drugs so as to reduce Medicare spending on these drugs. Many of us opposed this from our side of the aisle as well as the other. We were concerned it would cut cancer patients’ benefits and, more often, it would be a cut to the Medicare benefit to seniors. Is that correct?

Dr. PRICE. I believe that is correct. Yes.

Senator ISAKSON. Last one: what about all the recent changes HHS has made to cut Medicare payments to Medicare Advantage? Nearly one-third of all Medicare beneficiaries are on Medicare Advantage. Would these cuts not also break the pledge of not cutting Medicare?

Dr. PRICE. I believe so.

Senator ISAKSON. My point being, any one of us can sit at this dais and say give me “yes” or “no” answers and demonstrate the point we want to make, but that all of us, Republican and Democrat alike, are interested in saving Social Security for our seniors, making Medicare work, and saving the taxpayers’ money in the United States of America. Is that not true?

Dr. PRICE. Absolutely.

Senator ISAKSON. And one other point. Any one of us can take a financial disclosure, using something called disparate impact, where you take two facts, one over here and one over there, to make a wrong. Any one of us could do it to disrupt or misdirect people’s thoughts on somebody. It has been happening to you a lot because people have taken things that you have disclosed and tried to extrapolate some evil that would keep you from being Secretary of HHS when, in fact, it should not be true.

For example, if you go to Senator Wyden’s annual report, he owns an interest in BlackRock Floating Rate Income Fund. The major holding of that fund is Valeant Pharmaceuticals. They are the people we jumped all over for 2,700-percent increases last year in pharmaceutical products. But we are not accusing the ranking member of being for raising pharmaceutical prices, but you could take that extrapolation out of that and then indict somebody and accuse them. Is that not true?

Dr. PRICE. I think that is correct, yes, sir.

Senator ISAKSON. So the point of that is, we ought to in the end be looking for the best person, man or woman, for the job and not trying to trick them into agreeing to something that is wrong, but in fact let them execute the programs that improve Medicare for the American people.

Dr. PRICE. Yes, sir.

Senator ISAKSON. I thank you for your time. And I reserve the rest of my time.

Senator WYDEN. A point of personal privilege, Mr. Chairman.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. I do not trade in health-care stocks.

The CHAIRMAN. Okay. Did you care to—

Senator ISAKSON. My only point to the Senator from Oregon is, you do have mutual funds like most of us have. The mutual funds have holdings in pharmaceuticals, many of them, one of them you own. But nobody should accuse somebody of holding pharmaceutical stocks if they have a mutual fund by pulling—

Senator WYDEN. Mr. Chairman, to continue on this point of personal privilege. Mutual funds in particular, by independent experts, ethics experts, are considered in a completely different category than personal trading in stocks. Even past Republican ethics experts make that same point, and they have never seen anything like what the Congressman has engaged in.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Brown?

Senator BROWN. Thank you, Mr. Chairman.

And welcome, Congressman Price.

Dr. PRICE. Thank you, Senator.

Senator BROWN. I was troubled by your response to Senator Wyden when he asked the question, if you repeal the Affordable Care Act, will you commit that no one will lose insurance? That is 22 million Americans, almost 1 million in my State.

He asked, will you commit that no one will lose their insurance? And you ignored the question and responded that no one who lost their insurance under the Affordable Care Act—and to my knowledge that is 2 million to 4 million people, and almost all of them ended up getting reinsured—you said that no one who lost their insurance under the Affordable Care Act will basically lose it after they have been reinstated.

So you pretty much ignored the 22 million, and that is the problem we all face. But I want to ask you about something else.

If you are confirmed, obviously you will play a role in the repeal of the Affordable Care Act. I would like to ask you “yes” or “no” questions, and they really are “yes” or “no” questions; they are not meant as a trap.

Marguerite is from Lyndhurst, OH. She suffers from a chronic condition. She was turned down by insurance companies for 25 years before the ACA. She will lose her insurance if the ban against discrimination based on existing conditions is weakened.

My question is, if you are confirmed, will you maintain the current scope of the law and continue to vigorously enforce the law’s ban against discriminating against individuals with preexisting conditions, “yes” or “no”?

Dr. PRICE. I commit to you that we will not abandon individuals with preexisting illness or disease.

Senator BROWN. Thank you. Victoria is from Buckeye Lake, OH. As a senior on Medicare, she relies on free preventive services provided by the ACA. Will you commit to ensuring seniors like Vic-

toria, who rely on Medicare, continue to get their preventive care—no copays, no deductibles, no out-of-pocket costs, “yes” or “no”?

Dr. PRICE. Preventive care and wellness care are absolutely vital for so many members of our population.

Senator BROWN. That is part of ACA. You will commit to that?

Dr. PRICE. And I believe it is a part of health care and health coverage, and it ought to be a priority.

Senator BROWN. Yes, and we did that. Okay, I do not mean to be rude. We did that under the ACA.

Grace is from Westlake, OH. She is 24. She was diagnosed with stage four metastatic melanoma in 2015. She is still on her parent’s health insurance, which was purchased through the ACA marketplace, and she benefits from the ACA’s ban on annual lifetime coverage maximums. Her first 3 months of treatment cost \$800,000. As Secretary of HHS, if an insurer asks you for an exception to the current ban on out-of-pocket maximums as provided in Friday’s executive order, will you commit to stand up for patients like Grace and refuse to grant any insurer this exception?

Dr. PRICE. As I mentioned, I think patients ought to be at the center, and our goal is to make certain that every single patient has access to the highest-quality care.

Senator BROWN. I do not want it as your goal, I want you to commit that you will stand firm, as the ACA does, on this provision of canceling care, canceling insurance, because patients are too expensive.

Dr. PRICE. As I said, nobody ought to lose their insurance because they get a bad diagnosis.

Senator BROWN. Okay. Alice is from Bethel, OH. Prior to the ACA, she could not afford her preferred method of birth control. Now thanks to the law, she benefits from covered contraceptive coverage. Are you able to set aside any personal political views and protect the doctor/patient relationship by committing to ensure every woman’s right to access the form of contraception deemed best for her by her doctor at no cost, as currently provided in the ACA?

Dr. PRICE. I think that contraception is absolutely imperative for many, many women. And the system that we ought to have in place is one that allows women to be able to purchase the kind of contraception that they desire, between their doctor and themselves.

Senator BROWN. As the law is now with the ACA. Thank you.

President Trump said he is working with you on a replacement plan for the ACA, which is nearly finished and will be revealed after your confirmation. Is that true?

Dr. PRICE. It is true that he said that, yes. [Laughter.]

Senator BROWN. So not that he has ever done this before, but did the President lie? Did the President lie about this, that he is working with you? He said he is working with you. I know we do not use the word “lie” here because we are polite when Presidents say statements that are not true. But did he lie to the public about working with you?

Dr. PRICE. I have had conversations with the President about health care, yes.

Senator BROWN. Which is not quite an answer, so will you commit, with this President's plan, to maintaining the protections for those Ohioans you just committed to in the replacement plan?

Dr. PRICE. Our commitment is to make certain that every single American has access to the highest-quality coverage and care possible.

Senator BROWN. I am still not sure if the President lied, not to you, but to us, the public, about whether he is actually working with you. It sounds like he did.

Last series of questions briefly, Mr. Chairman.

I want to find out about the Children's Health Insurance Program. You said last week to staff that it has been a remarkably successful program. You once earlier had said it sounds like socialized medicine to you. I do not quite know what that means.

Ninety-five percent of children in America are currently insured. I know about the chairman's interest in CHIP, the Children's Health Insurance Program. Ninety-five percent of American children are insured now, partly because of Medicaid expansion, partly because of CHIP.

You discussed the importance of using the right metrics, so my question is this. Funding for CHIP, I think you know, is set to expire in September. If confirmed, would you advise the President to support an extension of CHIP and the Pediatric Quality Measures Program beyond September of this year?

Dr. PRICE. Absolutely, but I want to expand a little bit because, after last week's hearing in the HELP Committee, the same question was asked, quoting me as saying that CHIP was socialized medicine. And so I went back and looked at that article, and as so often happens, as you well know, though this may have never happened to you, it was a characterization in the article by the author of the article to push a political point of view.

And I knew that was the case because I rarely, if ever, use that word. I talk about patients as being the focus. I do not talk about government being the focus.

Senator BROWN. Okay. I am sorry. That is fine. I want to ask you specifically on CHIP. Last week, MACPAC submitted a report to Congress advising we extend the current CHIP program and the Quality Measures Program for 5 more years. Do you agree with this?

Dr. PRICE. I think the CHIP program, with policymakers, has to be looked at, and I believe it ought to be extended.

Senator BROWN. For 5 years?

Dr. PRICE. Well, if we could extend it for 8, it would probably be better than 5.

Senator BROWN. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator.

Let us go to Senator Portman.

Senator PORTMAN. Thank you, Mr. Chairman.

I have a lot of questions, so I am glad you are letting people go a couple of minutes over, because I may need that time.

Dr. PRICE. I am not. [Laughter.]

The CHAIRMAN. We have been letting the other side go a couple of minutes over. We are not going to let our side go a couple of minutes over.

Senator PORTMAN. Okay, well I would like that time back.
[Laughter.]

First of all, Dr. Price, thank you very much for your willingness to serve. We need you.

As you know, a couple of weeks ago Congress passed a budget resolution to set up a process that gives us the possibility of replacing the Affordable Care Act with policies that work better, particularly to reduce skyrocketing health-care costs that affect my constituents in Ohio. It is not just premiums. It is deductibles and copays, and also, people need more choices in health care.

I did join with four of my colleagues, as you know—we talked about this—introducing an amendment that would have ensured we had enough time for the next step in the process. And I believe we got assurances for that to ensure that we have time to work with you, frankly. We need somebody at HHS in place who can work with us to be sure that the legislative and the administrative policies are working together and that this is done carefully.

Prior to the Affordable Care Act, we had a very competitive insurance market in Ohio; now we do not. In fact, if you look at what has happened due to the increased regulations and mandates, we have a dramatically decreased competitive market. We went from having 17 insurers offering plans last year on the exchanges to 11 now. We have 20 counties now in Ohio, over one-quarter of our counties, that only have one health-care insurance company offering plans. We used to have no counties in that situation.

I know we are doing better than the rest of the country, actually, because about a third of the counties only have one insurer, and some of them have only one insurer in the entire State.

Now that we have begun this process of replacement and the President has issued his executive order, what can we do, briefly? What actions can you take through your authority as Secretary to ensure that my constituents in Ohio have access to affordable health-care coverage with a healthy insurance market?

Dr. PRICE. Well, what you laid out is the challenge that we have all across the Nation. And Ohio is doing better than other States, as you noted.

But it is important to appreciate that things have gotten worse for the individual and small-group market, and we believe, I believe, that it is a direct result of policies that have come from Washington, DC, directly from the Affordable Care Act.

So if we are honest with ourselves and honest with our constituents about trying to solve the challenges that they have to gain access to coverage that they want, then we ought to look at that and say, how do we fix that? And the way that you fix that is to make it so that individuals have the choices—one of the principles I mentioned—that we allow for pooling mechanisms that provide for individuals to have opportunities to recreate and reconstitute that individual and small-group market, which now does not exist.

Senator PORTMAN. And by the way, I appreciate your response to my colleague from Ohio about protecting people who have pre-existing conditions. And one way you do that, obviously, is through those risk pools, and, again, many States had good risk pools that were working before the Affordable Care Act to help in that regard.

As you know, Congress recently passed legislation authored with Senator Whitehouse called CARA, our Comprehensive Addiction and Recovery Act. And it is meant to address this opioid crisis we face—heroin, prescription drugs.

We are now working to both fully fund—and the funding is there in place for this new program—and now to implement it. And a lot of the implementation goes through SAMHSA; almost half of the funding under new grant programs goes through HHS and SAMHSA.

What should be done to ensure access to addiction treatment for those individuals currently getting insurance coverage through the exchanges or Medicaid expansion? And do you commit to us today to fully implement and implement promptly the new legislation?

Dr. PRICE. Without a doubt. As you know, Senator, this is a scourge that has gone all across the country, and it is in communities large and small, destroying lives, destroying families, harming communities. And it is growing.

And so what we must do is absolutely commit to carrying out the law as it was passed, but also—as I have talked about with some other challenges—make certain that we have the right metrics in place. Are we actually helping with what we are doing?

There may be better things to do there, maybe things that we think we ought to do that in fact do not help, and we ought to be identifying those as much in real time as possible so that we can bring about a program that is actually making it work for the patients, for the individuals who are actually being harmed.

Senator PORTMAN. One example of that, quickly. You are aware, I think, of the Institution for Mental Disease rule that says if you have an inpatient treatment center, it has to be limited to 16 beds. Would you be willing to look at that rule to see if we can get that number up to be able to provide more of this treatment?

Dr. PRICE. I think that is one of the rules that has to be looked at. I think the 3-day stay rule in facilities is another, where often-times many of these individuals have some mental illness as well, and the limitation on being able to keep folks on an inpatient basis when all of the health-care professionals involved in their care say they ought to, but in fact that is not what is covered, makes no sense. And therefore, they are put back out on the street, and the challenge is, we just get in this revolving door.

Senator PORTMAN. A final question, and maybe you could respond to this in writing, because my time is expiring based on the allocation here.

With regard to the waivers, you know, Ohio applied for a waiver, and this was an 1115 waiver for Medicaid, to be able to better cover people under Medicaid. We were rejected by CMS. I know you have Seema Verma coming in who has worked on these over time.

Do you believe that during this replacement time we should cover people under Medicaid expansion but then move to a program that is more flexible to provide better care under Medicaid?

Dr. PRICE. I think there have to be better ways to provide care to the Medicaid population, because there are huge challenges right now, as I mentioned before. And the people whom we need to be listening to are the Governors and the State insurance commis-

sioners and the folks on the ground actually providing the care. And if we listen to them, I think they will guide us in the right direction in terms of policy.

The CHAIRMAN. Senator, your time is up.

Senator PORTMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman.

I want to thank my colleague from Ohio for his graciousness in not going too over.

Congressman Price, you have said a couple of times—I may mis-quote you a little, I hope not—that the goal here is access to the highest-quality coverage and the highest-quality health care for all Americans. Is that roughly where you would like to head? And I think that is a worthy goal.

Dr. PRICE. Yes.

Senator BENNET. And just piggybacking on what Senator Portman was asking you about, I am worried today—whether it is the Affordable Care Act or not the Affordable Care Act, whether it is the insurance market—that people, especially in rural parts of this country, in rural parts of my State, are not getting the access they need to high-quality health care, are not getting the access they need to high-quality choices in terms of insurance.

I worry a little bit, and whether we are trying to repeal the Affordable Care Act or we are trying to fix the Affordable Care Act, I think it is incumbent on all of us not to make matters worse for rural America in doing what we are doing. And I know you share that goal.

Dr. PRICE. Absolutely.

Senator BENNET. And you talked about pooling as one solution. I wanted to talk a little bit or ask you a little bit about your projected quality of insurance in these markets, because one answer that I have heard from folks, including yourself, over the weeks has been making sure that people have the opportunity to buy coverage for catastrophic care.

I wonder whether you also believe that it is essential that there be a floor for insurance providers. You know, some of the things that the Affordable Care Act requires for coverage include outpatient care, emergency services, hospitalization, maternity and newborn care, prescription drugs, rehab services, lab services, preventative care such as birth control and mammograms, pediatric services like vaccines, and routine dental exams for children younger than 19.

I am not going to ask you to go through each one of those. But directionally, are we headed to a world where people in rural America have to settle for coverage for catastrophic care? Are we headed to a place where there is regulation of insurance providers that says if you are going to be in the insurance market, particularly if we are in a world where you are selling across State lines, there has to be a floor on the services you are willing to pay for?

Dr. PRICE. I think there has to be absolutely credible coverage. And I think that it is important that individuals ought to be able to purchase the coverage that they want.

Senator BENNET. I just do not want us to get to a place where people in America have to settle for something that no one else in

the industrialized world has to settle for. Why should they have to pay out of pocket month after month after month for something that is not going to cover something as basic as a hospitalization or maternity services or, you know, the rest of this list? There may be certain things on the list we disagree with.

But I am worried that we are heading toward a place where somehow that choice is accepting a world that no one else in the industrialized world has to accept. And I applaud your goal, and I hope we can work together to make it so.

Dr. PRICE. As do I.

Senator BENNET. You mentioned that we should listen to the Governors, which brings me to my second question and your answer to Senator Portman.

In Colorado—you may have heard of this—we have something called the Accountable Care Collaborative that is a unique approach to Medicaid. It connects members with coordinated primary care providers while reducing barriers to access. It also provides coordinated care for those with dual eligibility for Medicare and Medicaid. I do not have it today, but I could show you that the cost curve there is really starting to turn around because of the coordinated care that is happening out there.

When asked about the need for more State flexibility, which is an argument that is made to carry out innovative programs like the one in Colorado, our Governor said that, quote, “Greater flexibility cannot make up for the lack of funding. Should the Federal Government pull back its financial commitments, we simply cannot afford to make up the difference.”

So I would ask you whether you agree with our Governor’s assessment that while flexibility is helpful, it is not a replacement for critical funding needs.

Dr. PRICE. I think so. And the decision for funding obviously is a legislative decision.

Senator BENNET. But that is a very fundamental component of the Affordable Care Act, the expansion of Medicaid, would you not agree?

Dr. PRICE. And that decision whether or not to change that is a decision that you and every member of the committee and Congress will be involved in. And if I am fortunate enough to serve as the Secretary of Health and Human Services, we will carry out the law that you pass.

Senator BENNET. I appreciate that. In your mind, though, does the repeal of the Affordable Care Act include a repeal of the expansion of Medicaid that was part of the passage of the Affordable Care Act?

Dr. PRICE. Any reform or improvement that I would envision for any portion of the Affordable Care Act would be one that would include an opportunity for individuals to gain coverage, the kind of coverage, again, that they want, the highest-quality health care.

Senator BENNET. But that is not the question I asked.

And I am sorry, Mr. Chairman; I realize I am at the end of my time.

Do you believe that a repeal—I mean, this is what the President ran on—of the Affordable Care Act includes the repeal of the ex-

pansion of Medicaid that was a fundamental part of the Affordable Care Act?

Dr. PRICE. Again, that is a decision that you all would make. Senator BENNET. That is true.

Dr. PRICE. What I believe is that any reform or improvement must include a coverage option and opportunity for every single American, including those who are either currently in or close to joining the Medicaid population in a given State, which changes depending on the State.

Senator BENNET. Okay.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Bennet.

Let us go to Senator Toomey.

Senator TOOMEY. Thank you, Mr. Chairman.

Congressman Price, thank you for joining us.

Dr. PRICE. Thank you.

Senator TOOMEY. Thanks for the great work you have done in the House and your willingness to serve in this extremely important post. I appreciate it, and I enjoyed the conversation that we had a little while back.

I do think it bears reminding everyone as we talk about Obamacare that certainly the individual market is in a classic death spiral. The adverse selection is destroying that market. It is in a freefall. In Pennsylvania, 40 percent of all Pennsylvanians in the Obamacare exchanges have a grand total of one choice, and that very typically does not include whatever they had before and were promised they could keep, which, of course, was never true.

So we have a system that is in collapse. And what we are trying to do is figure out what is a better way to go forward. Now, when we talk about repeal, sometimes I hear people say, well, but we have to keep coverage of preexisting conditions because, you know, we have to keep that. And when I hear that, I think that we are missing something here.

And here is what I am getting at. There are obviously a number of Americans who suffer from chronic, expensive health-care needs. They have had these conditions sometimes all their lives, sometimes for some other period of time. And for many of them, the proper care for those conditions is unaffordable.

I think we agree that we want to make sure those people get the health care they need. Now, one way to force it is to force insurance companies to provide health insurance coverage for someone as soon as they show up, regardless of what condition they have, which is kind of like asking the property casualty company to rebuild the house after it has burned down. But that is only one way to deal with this.

And so am I correct, is it your view that there are other, perhaps more effective ways, since, after all, Obamacare is in a collapse, to make sure that people with these preexisting, chronic conditions get the health care that they need at an affordable price without necessarily having the guaranteed issue mandate in the general population?

Dr. PRICE. I think there are other options. And I think it is important, again, to appreciate that the position that we currently find ourselves in with policy in this Nation is that those folks, in

a very short period of time, are going to have nothing because of the collapse of the market.

Senator TOOMEY. Right. The second topic is, I think you and I share a goal of having health care that is much, much more driven by individuals, families, patients, consumers—consumer-centric rather than bureaucrat-centric, which is what Obamacare is.

Do you agree with me that to get there we need to do more about the transparency of health-care outcomes so that informed consumers can evaluate among different physicians, different hospitals that really get the best outcomes? Do we need to do more there?

Dr. PRICE. Absolutely. And this is an important point. And it is not just in outcomes. Outcomes are important, and we need to be measuring what actually makes sense from a quality standpoint and allow patients and others to see what those outcomes are.

But it is transparency in pricing as well, and right now we do not have that. So if you are individual out there and you, in fact, want to know what something costs, it is virtually impossible to find out what that is. There are all sorts of reasons for that.

But if we are honest with ourselves as policymakers and we want to make the system patient-friendly, not insurance-friendly or government-friendly, but patient-friendly, then we would make that a priority. And if I am confirmed, I hope to do so.

Senator TOOMEY. I think Medicare and Medicaid, CMS, can play a big role in advancing that. Ultimately, I think the more we diminish dependence on third-party payers and allow the evolution of a market that responds to individuals, individuals will demand that information the way they do in every other market.

Dr. PRICE. Right.

Senator TOOMEY. The last point I want to touch on, if I could, has to do with NIH research and specifically Alzheimers. It is my view that we ought to think of Alzheimers as a disease in a category of its own. And I say that because there is no disease like it that we know of that afflicts Americans today. There are 5.2 million Americans with the disease right now. It is 100-percent fatal. It is the sixth-leading cause of death. There is no cure, there is no treatment; there is nothing.

And yet, for fiscal year 2016, NIH spending is a grand total of \$168 per diagnosed patient. It seems to me that the expenditures are wildly out of line with the severity and the breadth and the scope of this disease. And I wonder if you would commit to working with me and others who share this view to ensure that we have a better proportionality in terms of the allocation of resources in the breadth and severity of illnesses.

Dr. PRICE. I think it is absolutely imperative, Senator, and I look forward to working with you.

Senator TOOMEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

Dr. Price, welcome, and thank you for your willingness to serve in this very important capacity. We have a lot of challenges ahead that we need to take on.

As I met with you a couple of weeks ago, one of the issues that is of particular interest to me, which I conveyed to you, is this issue

of Indian Health Service. In 2010, there were some systemic problems that were uncovered in South Dakota. And an administrative action plan was set in motion to help remedy many of these findings. Similar issues popped up again throughout South Dakota in 2015, and they continue to this day. And after oversight hearings, it became abundantly clear that, time and again, there was a lack of follow-through by the agency.

And my question is, will you commit to follow up with me in writing that you will designate someone at HHS to be the point person that my staff and I can contact to ensure, one, that reforms are being implemented, and two, that we continue to collaborate on reform in the IHS?

Dr. PRICE. Absolutely, Senator. This is an area that is of significant concern, because it appears to me, as I know you shared with me, that in the Indian Health Service there are so many areas where we are not meeting the goal of the highest-quality care being provided to individuals accessing that system.

And so we are not doing what we ought to do in that system. And I am committed to making certain, should I be confirmed, to turn that system around.

Senator THUNE. And as I shared with you, Senator Barrasso and I introduced a bill last year called the IHS Accountability Act which we believe will bring about a lot of structural changes within the IHS. And as I have said many times, that act, although we think it addresses a lot of the problems that have cropped up—and it was based upon consultation that we received from the tribes—really is merely a first step in the process that is necessary to improve that agency.

If confirmed, what types of reforms could you see yourself supporting when it comes to the IHS and, obviously, starting perhaps with our legislation? I do not know, you probably have not had a chance to look carefully at that yet, so I will not ask you to comment specifically on it. But are there thoughts that you have with respect to the IHS when it comes to reforms that you could work with us on?

Dr. PRICE. Yes, I appreciate that. I have had the privilege of visiting some IHS facilities in the State of Wisconsin and a couple of facilities that were doing remarkable work. And it appears to me that what we have not done—and if I am confirmed, I look forward to getting into this area within the Department itself—is identified best practices within the IHS system itself and shared those and incentivized the ability to move that kind of activity that is providing high-quality care for individuals in that system in certain areas to make certain that we are able to extend that across the country in the IHS.

Senator THUNE. Okay. Well, we look forward to working with you on that. I think best practices is a good place to start. And obviously, those have not been employed in a lot of facilities in our State.

In 2009, CMS issued a final rule that required all outpatient therapeutic services to be provided under direct supervision. Every year since then, the rule has been delayed, either administratively or legislatively, for critical access and small and rural hospitals.

And I shared this with you as well. In my State, obviously, we have a lot of critical access hospitals, a lot of very rural areas, big geography to cover, and it is sometimes difficult to get providers out to these areas. So the question is, if confirmed, will you work to permanently extend the nonenforcement of this regulation of these hospitals in order to remove this regulatory burden?

Dr. PRICE. Yes, I look forward to working with you on it, Senator. I think there are areas, from a technological standpoint, where we are missing the boat, especially in our rural areas and the critical access hospitals. In every other industry out there, the information technology age has arrived and is moving across the land with rapid speed and has done so.

However, it seems that in health care we have put roadblocks up to the expansion of technology, especially into the rural areas. And we ought to be incentivizing that so that, again, the patients are able to receive the highest-quality care.

It is possible now, for example, in our State, if you are an individual who is suspected of having a stroke, you go to a critical access hospital in a rural area, it is possible by telemedicine to be able to access one of the world's foremost specialists in stroke treatment by telemedicine at the university health center. So that is improving the lives and care of patients across our State.

And I think there are so many things that we could do that would mirror that kind of technological expansion.

Senator THUNE. Thank you. There is one final point I will make, because my time is expiring. But I know you have probably been questioned already a good amount about what happens next with respect to replacing Obamacare. I would simply say that I hope we can work with you in beginning to shift a lot of the—giving the States, I guess I would say, more flexibility when it comes to designing plans that work in our States.

I think one of the problems that we have had with this is there is just too much dictation from Washington, DC and too much one-size-fits-all. And that is something I think that most States would probably agree with, and certainly, I think, most providers would agree with as well.

So we look forward to working with you and designing programs that get that flexibility to our States and put them more in charge of some of these issues in a way that removes that power from Washington, DC, where I think too many of the problems have been happening.

Thank you, Mr. Chairman.

Dr. PRICE. Yes, sir. I look forward to it.

The CHAIRMAN. Senator Casey?

Senator CASEY. Thank you, Mr. Chairman.

Dr. Price, good to be with you again.

Dr. PRICE. Thank you.

Senator CASEY. I want to ask you a couple of questions that center principally on children and individuals with disabilities.

First, with regard to children, I think if we are doing the right thing, not only as a government, but as a society, if we are really about the business of justice and if we are really about the business of growing the economy, we should invest a lot and spend a lot of time making sure that every child has health care. The good

news is, despite a lot of years of not getting to that point, not moving in the right direction, we have made a lot of progress.

The Urban Institute in an April 2016 report—I will not ask the report to be made part of the record, but I will read a line from this Urban Institute report “Uninsurance Among Children, 1997 to 2015,” dated April 2016. It said as follows on page 3: the “decline in children’s uninsurance rate occurred at a relatively steady pace and includes a significant drop following implementation of the Affordable Care Act’s key coverage provisions from 7.1 percent in 2013 to 4.8 percent in 2015.”

So that is a significant drop, 7.1 percent to 4.8. Millions of kids have health insurance today who would not have it absent the Affordable Care Act and including the Medicaid provisions as well. That 4.8-percent uninsured rate for kids is an all-time low. That means we are at a 95-percent insured rate across the country for children.

Kaiser Foundation, a separate authority, tells us that even with that, even with all that progress made in the last couple of years and even some progress before that, we still have more than 4.1 million children uninsured.

Would you agree with me, first of all, that we should get that number down, the number of uninsured children?

Dr. PRICE. I think that throughout our population we ought to identify individuals who are uninsured and strive to make certain that they gain coverage.

Senator CASEY. Right. And you would agree with me with regard to children especially?

Dr. PRICE. Everybody in the population. Children are precious and are our future.

Senator CASEY. Great. And just with regard to children, now that we have that number, we know the number that we have arrived at, we know the percentage, will you commit, if you are successful in your confirmation, to maintain or to even reduce that uninsured number even further—in other words, that you will be able to commit to us today that the number of uninsured children will not increase during your time as Secretary, were you to be confirmed, and the percentage of uninsured would not increase while you are Secretary?

Dr. PRICE. Our goal is to decrease the number of uninsured individuals in the population under age 18 and over 18.

Senator CASEY. Well, I hope you maintain that, because I think that is going to be critically important.

The reason I ask that question is not just to validate that as a critically important goal for the Nation, but your answer seems to be contrary or in conflict with what you have advocated for as a member of the House of Representatives, not only in your individual capacity, but as chairman of the Budget Committee.

Looking at now for reference an op-ed by Gene Sperling—you know who Gene Sperling is. He was head of the Council of Economic Advisers to two Presidents, both President Clinton and President Obama—Chair of that National Economic Council, I should say, is the proper title.

In an op-ed on Christmas Day, the fifth paragraph, here is what he said in a pertinent part referencing you and your budget pro-

posals. He said, quote, "Together," meaning the two areas of policy that you have a long record on, full repeal of ACA and block-granting of Medicaid, which we now know is Trump administration policy, "they would cut Medicaid and the Children's Health Insurance Program funding by about \$2.1 trillion over the next 10 years, a 40-percent cut."

How can you answer the questions that I just asked you about making sure that that number of uninsured children does not get worse under your tenure if that is the case with regard to your policies, the effect of what your policies would be—and now apparently, contrary to what was said during the campaign, it is now the policy of the Trump administration to block-grant Medicaid?

Dr. PRICE. Yes. With respect to both you and to Mr. Sperling, it is because you all are looking at this in a silo. We do not look at it in a silo. We believe that it is possible to imagine, in fact put in place, a system that allows for greater coverage for individuals, in fact coverage that actually equals care.

Right now, many of those individuals—the ACA actually increased coverage in this country. It is one of the things that it actually did. The problem is that a lot of folks have coverage, but they do not have care. So they have the insurance card, they go to the doctor, the doctor says, "This is what we believe you need," and they say, "I am sorry, I cannot afford that."

Senator CASEY. A cut of a trillion dollars, a combined cut of a trillion dollars that would adversely impact the Children's Health Insurance Program and the Medicaid program, is totally unacceptable, I think, to most Americans, Democrat, Republican, or otherwise.

Dr. PRICE. And you are looking at that in a silo. You are not looking at what the reform and improvement would be.

Senator CASEY. We will see the rebuttal to what not only Gene Sperling has said, but a whole long line of public policy advocates and experts. And I think the burden for you, sir, is to make sure that you fulfill your commitment to make sure that no children will lose health insurance coverage while you are Secretary.

Dr. PRICE. I look forward to working with you.

The CHAIRMAN. Okay. Senator Heller?

Senator HELLER. Thank you, Mr. Chairman.

And, Dr. Price, thank you for being here today. And thanks for your patience in working with us throughout this confirmation process.

Mr. Chairman, as you can imagine, I am committed to ensuring that all Nevadans have access to high-quality and affordable health insurance.

I have a letter here that came to my attention January 10th from the Nevada legislature. The letter comes directly from our majority leader of the State Senate and our Speaker of the Assembly. And they are good questions, five questions. Obviously, they want to get the same answers that all of us want here.

We have about 88,000 Nevadans who have health insurance through the health exchange, 77,000 Nevadans who are eligible for Federal tax credits, 217,000 Nevadans who receive health-care coverage under Medicaid expansion. Basic questions.

Mr. Chairman, if I may, can I submit this letter for the record, and also, if I may, ask Dr. Price if he would respond to this particular letter, to these legislators? Again, I think they are very good questions.

The CHAIRMAN. Without objection.

[The letter appears in the appendix on p. 89.]

Senator HELLER. Also, if I may add, if you could CC the Governor also. I think the Governor also would like answers to these questions. And I think you are in a great position to answer these particular questions.

Dr. PRICE. Thank you, sir.

Senator HELLER. Thank you.

If I may, can I get your opinion on the Cadillac tax?

Dr. PRICE. I think the Cadillac tax is one that has made it such that individuals who are gaining their coverage through their employer—there may be a better way to make it so that individuals gaining their coverage through their employer are able to gain access to the kind of coverage that they desire.

Senator HELLER. The Cadillac tax would affect about 1.3 million Nevadans: school teachers, union members, senior citizens. And there is some disagreement as to whether or not these individuals are wealthy or not. There are some on this committee who believe that the \$1.1-trillion tax increase in Obamacare does not affect the middle class. Do you agree with that?

Dr. PRICE. I think it does affect the middle class.

Senator HELLER. I do too. Do you believe that school teachers are wealthy?

Dr. PRICE. Everybody has their own metric of what wealthy is, and some people use things to determine wealth that are not the greenbacks in—

Senator HELLER. I would argue that most school teachers do not think they are wealthy.

Do you think most union members are wealthy?

Dr. PRICE. I doubt that they think they are wealthy.

Senator HELLER. Yes, I would agree with that.

Do you think most senior citizens are wealthy?

Dr. PRICE. Most senior citizens are on a fixed income.

Senator HELLER. They would argue that they are not wealthy. And that is my argument on this particular tax. In fact, Obamacare as a whole is just another middle-class tax increase of \$1.1 trillion.

I guess my request and question for you is if I can get your commitment to work with this committee and work with myself and the Treasury Secretary to repeal the Cadillac tax.

Dr. PRICE. Well, we will certainly work to make certain that those who gain their coverage through their employer have the access to the highest-quality care and coverage possible in a way that makes the most sense for individuals from a financial standpoint as well.

Senator HELLER. Does the Cadillac tax make the most sense?

Dr. PRICE. As I mentioned, I think there are other options that may work better.

Senator HELLER. And do you believe it is an increase, a health insurance increase, to middle-class America?

Dr. PRICE. I do.

Senator HELLER. Okay. I want to go to Medicaid expansion for just a minute. Nevada was one of 36 States that chose to expand eligibility for Medicaid. We went from—I think the enrollment went from 350,000 to over 600,000.

And I guess the concern, and I think it is part of the letter that I gave to the chairman, is whether or not that will have an impact and what we are going to do to see that those individuals are not impacted. Probably the biggest question that we have here for you today is, what are we going to do about those who are part of the Medicaid expansion and how that is going to impact them?

Dr. PRICE. Yes. Again, as I mentioned to a question on the other side, I believe this is a policy question that needs to be worked out through both the House and the Senate. We look forward to working with you and others, if I am able to be confirmed, on making certain that individuals who are currently covered through Medicaid expansion either retain that coverage or in some way have coverage through a different vehicle. But every single individual ought to be able to have access to coverage.

Senator HELLER. Dr. Price, thank you. Thank you for being here.

Mr. Chairman, thank you.

Dr. PRICE. Thanks, Senator.

The CHAIRMAN. Thank you.

Senator Warner?

Senator WARNER. Thank you, Mr. Chairman.

Good to see you again, Dr. Price.

Dr. PRICE. Thank you.

Senator WARNER. Let me start on something we discussed in my office. One of the issues I have been working on since I have been Governor, that I have been working on very closely with your friend, Senator Isakson, is the issue of how we as Americans address the end of life and sort through those issues. I think we both shared personal stories on that subject.

Senator Isakson and I have legislation that we call the Care Planning Act that does not remove anyone's choices, it simply allows families to have those discussions with their health-care provider and religious faith leader if needed or desired in a way to prepare for that stage of life.

This year, CMS took a step by introducing a payment code into the fee schedule to provide initial reimbursement for providers to have these conversations with, as mentioned, a multidisciplinary case team. It also ran a pilot program that allowed hospice-type benefits to be given to individuals who were still receiving some level of curative services, called the Medicare Care Choices.

I believe it is very important that we do not go backwards on these issues. And as I think we talked about, we are maybe the only industrial nation in the world that has not had this kind of adult conversation about this part of life. Again, it is not about limiting anyone's choices.

But would you, if you are confirmed, continue to work with Senator Isakson and me and others on this very important issue?

Dr. PRICE. I look forward to doing so—

Senator WARNER [continuing]. And not be part of any effort to kind of roll back those efforts that CMS has already taken?

Dr. PRICE. I think it is important to look at the broad array of issues here. And one of the issues is liability. And I cannot remember whether we discussed that in your office. But the whole issue of liability surrounding these conversations is real. We need to be talking about it openly and honestly and working together to try to find a solution to just that.

Senator WARNER. I would concur with that, but I also think this is something that more families need to take advantage of.

On Friday, January 20th, President Trump issued an executive order that says Federal agencies, especially HHS, should do everything they can to, quote, "eliminate any fiscal burden on any State or any cost, fee, tax penalty, or regulatory burden on individuals and providers."

Dr. Price, if you are confirmed in this position, will you use this executive order in any way to try to cut back on implementation or follow the individual mandate before there is a replacement plan in place?

Dr. PRICE. Well, I think that, if I am confirmed, then I am humble enough to appreciate and understand that I do not have all the answers and that the people at the Department have incredible knowledge and expertise, and that my first action within the Department itself as it relates to this is to gain that insight, gain that information, so that whatever decisions we can make with you and with Governors and others can be the most informed and intelligence decisions possible.

Senator WARNER. I am not sure you answered my question. What I would not want to see happen as we take—I understand your concerns with the Cadillac tax. I know there are concerns you and others have raised about the individual mandate. There are some who are concerned about the income tax surcharges.

It is just remarkable to me—and this is one of the reasons why I think so many of us are anxious to see your replacement plan—that the President has said he wants insurance for everybody, he wants to keep the prohibitions on preexisting conditions, he wants to keep young people on their parents' policies until 26, and it seems like there is at the same time a rush to eliminate all of the things that pay for the ability of Americans to have those kind of services.

And I would just want your assurance that you would not use this executive order prior to a legal replacement to eliminate the individual mandate, which I believe helps actually shore up the cost coverage and the shifting of costs that are required in an insurance system.

Dr. PRICE. Yes. No, a replacement, a reform, an improvement of the program, I believe is imperative to be instituted simultaneously or at a time—

Senator WARNER. But you will not use this executive order as a reason to kind of, in effect, bypass the law prior to a replacement being in place?

Dr. PRICE. Our commitment is to carry out the law of the land.

Senator WARNER. I want to, in these last couple of minutes, go on. I know you have been in the past a strong critic of the Center for Medicare and Medicaid Innovation, CMMI. I believe in your testimony last week you saw great promise in it.

To me, if we are going to move towards a system that emphasizes quality of care rather than simply quantity of care, we have to have this kind of experimentation. There is one such program, the Diabetes Prevention Program, that last year CMS certified saved money on a per-beneficiary basis.

And I know my time is running out, so let me just ask these questions. I think they can probably be answered "yes" or "no."

Do you support CMMI delivery system reform demonstrations that have the potential to reduce spending without harming the quality of care?

Dr. PRICE. The second clause is the most important one. I support making certain that we deliver care in a cost-effective manner. But we absolutely must not do things that harm the quality of care being provided to patients.

Senator WARNER. But if part of that quality of care—and I would agree with you—would mean bundled and episodic payment models that actually move us towards quality over volume, would you support those efforts?

Dr. PRICE. For certain patient populations, bundled payments make a lot of sense.

Senator WARNER. And if these experiments are successful, would you allow the expansion of these across the whole system?

Dr. PRICE. I think that what we ought to do is allow for all sorts of innovation, not just in this area. There are things I am certain that have not been thought up yet, that would actually improve quality and delivery of health care in our country, and we ought to be incentivizing that kind of innovation.

Senator WARNER. Well, I would simply say, Mr. Chairman, that CMMI seems to be one of the areas where I would like to have seen more, but I think it is a model and a tool we ought not to discard. Thank you.

The CHAIRMAN. Well, thank you, Senator.

Senator Scott?

Senator SCOTT. Thank you, Mr. Chairman.

Dr. Price, good to see you again.

Dr. PRICE. Tim.

Senator SCOTT. South Carolina launched the Nation's first state-wide pay-for-success project with Nurse Family Partnership with the use of Medicaid funds. Twenty percent of the babies born in South Carolina are born to first-time, low-income mothers. We also have a much higher than average infant mortality rate.

Nurse Family Partnership is evidence-based and has already shown real results, both in the health of the mother and the babies, but also in other aspects of the mother's life, such as high school graduation rates for teen moms and unemployment rates.

What are your thoughts on incorporating a pay-for-success model to achieve success metrics?

Dr. PRICE. Well, it sounds like a great program that actually has the right metric, and that is the quality of care and the improvement of lives. And as you state, if it is having that kind of success, it probably ought to be put out there again as a best practice for other States to look at and try to model.

Senator SCOTT. Yes, sir. Thank you.

I believe you were the director of the orthopaedic clinic at Grady Memorial Hospital in Atlanta.

Dr. PRICE. I was.

Senator SCOTT. You just mentioned something that I think is very important. I believe Grady Hospital had the highest level of uninsured Georgians. You talked about having coverage, but really not access. Can you elaborate on how your experience at Grady may help inform you and direct you as it relates to the uninsured population?

Dr. PRICE. Well, it was an incredible privilege to work at Grady for the number of years that I did. And we saw patients from all walks of life and many, many uninsured individuals. And they come with the same kinds of concerns, the same kinds of challenges that every other individual has. And they have an additional concern, and that is, is somebody going to be caring for me? Is somebody going to be able to help me?

And that is why it was so incredibly fulfilling to be able to have the privilege of working at Grady and assisting people at a time when they were not only challenged from a health-care standpoint, but challenged from a concern about whether or not people were going to be there to help them.

Senator SCOTT. Yes, sir. I know that you are aware of title I of the Every Student Succeeds Act. It allows for the population of Head Start to have access to resources. It seems to me that it would be imperative for the Secretary of HHS and the Secretary of Education to look at ways to synergize your efforts to help the underprivileged student, the underprivileged child.

Can I get your commitment that you will look for ways to work with the Secretary of Education where it makes sense to help those students? You know, we have Head Start under you and other programs under ESSA. It would be wonderful for us to take the taxpayer in one hand, the child in the other hand, and look for ways to make sure that they both win.

Dr. PRICE. Yes, you have identified an area that is a pet peeve of many of us, and that is that we do not seem to collaborate across jurisdictional lines, not just in Congress, but certainly on the administrative side. And so I look forward to doing just that and having as a metric how the kids are doing.

Senator SCOTT. Yes.

Dr. PRICE. Are they actually getting the kind of service and education that they need? Are they improving? Are we just being custodians? Are we just parking kids in a spot, or are we actually assisting and improving their lives? And are we able to demonstrate that?

And if we are not asking the right questions, if we are not looking at the right metrics, then we will not get the right answer that allows us to either expand what is actually working or to modify it and move it in a better direction.

Senator SCOTT. Thank you. I think that is one of the more important parts of your opportunity in this position: looking at those kids. I know that you know as well as anyone who is a doctor that those ages, before you ever get into pre-K or Kindergarten, the development of the child between those first 3 or 4 years is a power-

ful opportunity for us to direct a child's potential so that they maximize it.

And sometimes we are missing those opportunities. We think that somehow the education system will help that child catch up. But there are things that have to happen before they ever get in the education system. So I thank you for your willingness to work in that direction.

And my last question has to do with the employer-sponsored health-care system that we are so accustomed to in this country that provides about 175 million Americans with their insurance. In my home State of South Carolina, of course, we have about 2.5 million people covered by their employer coverage.

If confirmed as HHS Secretary, how would you support American employers in their effort to provide effective family health coverage in a consistent and affordable manner? Said differently, there has been some conversation about looking for ways to decouple having health insurance through your employer.

Dr. PRICE. I think the employer system has been absolutely a remarkable success in allowing individuals to gain coverage that they otherwise might not gain. I think that preserving the employer system is imperative.

That being said, I think that there may be ways in which employers—I have heard from employers who say, if you just give me an opportunity to provide my employee the kind of resources so that he or she is able to select the coverage that they want, then that makes more sense to them. And if that works from a voluntary standpoint for employers and for employees, then it may be something to look at.

Senator SCOTT. That would be more like the HRA approach where the employer funds an account and the employee chooses health insurance, not necessarily under the umbrella of the employer specifically.

Dr. PRICE. Exactly—and gains the same tax benefit.

Senator SCOTT. Yes.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator McCaskill?

Senator MCCASKILL. At the risk, Mr. Chairman, of being way, way away from you and you being someone I have worked with and respected greatly, I do want to gently correct something in your opening statement.

The first nominee of President Trump that this Senate considered was confirmed by a vote of 98 to one. I would not consider that a partisan vote.

The second nominee of President Trump was confirmed by a vote of 88 to 11. Once again, I would not consider that a partisan vote.

So I really do think we are all trying to look at each nominee individually. And I have had a chance to review Congressman Price's questioning of Secretary Sebelius, and I can assure you, Mr. Chairman, it was no beanbag. It was tough stuff.

So I think all of this looks different depending on where we are sitting. And I wanted to make that point.

And as to passing Obamacare without one Republican vote, we are about to repeal Obamacare without one Democratic vote. This

will be a partisan exercise under reconciliation. It will not be a bi-partisan effort. And what we have after the repeal is Trumpcare. Whatever is left after the dust settles is Trumpcare.

Now, I know the President likes to pay close attention to what he puts his name on. And I have a feeling, Congressman, that even though you keep saying today that Congress will decide, you are not really believing, are you, that your new boss is not going to weigh in on what he wants Congress to pass? We are not going to have a plan from him?

Dr. PRICE. Well, I think we look forward to working with you and other members of the House and Senate.

Senator McCASKILL. No, my question is, are we going to have a plan from the President? Will he have a plan?

Dr. PRICE. If I have the privilege to be confirmed, I look forward to working with the President and bringing a plan to you.

Senator McCASKILL. Great. So the plan will come from President Trump and you will have the most important role in shaping that plan as his Secretary of Health and Human Services, correct?

Dr. PRICE. I hope I have input, yes, ma'am.

Senator McCASKILL. Yes. Okay. So whatever Trumpcare ends up being, you will have a role in it. And I think it is really important to get that on the record.

Now, when we repeal Obamacare, we are going to do a tax cut. Does anybody in America who makes less than \$200,000—are any of them going to benefit from that tax cut?

Dr. PRICE. It's a hypothetical, and you all are the ones who are going to—

Senator McCASKILL. No, no, no, no, it's not a hypothetical. When we repeal Obamacare, there are taxes in Obamacare. And when it is repealed, there is no question the taxes are going to be repealed. I promise you the taxes are going to be repealed. When those taxes are repealed, will anyone in America who makes less than \$200,000 benefit from the repeal of those taxes?

Dr. PRICE. I look forward to working with you on that plan, and hopefully that will be the case.

Senator McCASKILL. No, no, no, no, no. I am asking, the taxes that are in there now, does anybody who makes less than \$200,000 pay those taxes now?

Dr. PRICE. It depends how you define the taxes. There are many individuals who are paying much more than they did prior to that point. The ACA—

Senator McCASKILL. No, I am talking about taxes.

Dr. PRICE. I understand.

Senator McCASKILL. Taxes, you know—the Cadillac tax has not been implemented, so that does not affect anybody. I am trying to get at the very simple question—and I do not think you want to answer it—that, in fact, when Obamacare is repealed, no one in America who makes less than \$200,000 is going to enjoy the benefit of that.

Dr. PRICE. As I say, I look forward, if I am confirmed, to working with you to make certain that that is the case.

Senator McCASKILL. That is not an answer, but we will go on.

Okay. We talked in my office. Ending Medicare as we know it, your plan that you have worked on for years is converting Medicare to private insurance markets with government subsidies. Correct?

Dr. PRICE. Not correct.

Senator McCASKILL. Well, we talked yesterday, and we kind of went through this in my office. And by the end of our conversation, you admitted to me, and I am going to quote you, that your plan for Medicare in terms of people getting either tax credits or subsidies or however you are going to pay for the Medicare recipients would be them having choices on a private market. And you said yes, it was pretty similar to Obamacare with the exception of the mandate. Did you not say that to me yesterday?

Dr. PRICE. That's a fairly significant exception.

Senator McCASKILL. Well, but these people are old. They do not need to be mandated to get insurance. It is not like a 27-year old who does not think he is going to get sick. You do not need a mandate for people who are elderly; they have to have health insurance. So the mandate is not as relevant. But did you not admit to me that Obamacare and the private markets are very similar to what you are envisioning for Medicare? Did you not use the phrase "pretty similar?"

Dr. PRICE. There are some similarities. I think what I said, though, was that the mandate was significant.

Senator McCASKILL. Well, the mandate I get in Obamacare is significant. But we do not need a mandate for seniors. Would you agree with that, that you do not have to tell seniors they need health insurance?

Dr. PRICE. What I hope is that we do not need a mandate for anybody so that they are able to purchase the kind of coverage that they want, not that the government forces them to buy.

Senator McCASKILL. Okay. Finally, you want to block-grant Medicaid for State flexibility and efficiency. Correct?

Dr. PRICE. I believe that Medicaid is a system that is now not responding necessarily to the needs of the recipients, and consequently, it is incumbent upon all of us as policymakers to look for a better way to solve that challenge.

Senator McCASKILL. Are you in favor of block-granting Medicaid?

Dr. PRICE. I am in favor of a system that is more responsive to patients in the Medicaid system.

Senator McCASKILL. Are you in favor of block-granting Medicaid? It is a really simple question, Congressman. I mean, you are at your confirmation hearing for the most powerful job in health care in the country. I do not know why you would not be willing to answer whether or not you are in favor of block-granting Medicaid. That is not complicated.

Dr. PRICE. I am in favor of making certain that Medicaid is a system that responds to patients, not the government.

Senator McCASKILL. Okay. I do not understand why you will not answer that. And I do not have time. I know I am over. I will probably—I do not know if we are going to get another round, Mr. Chairman. Should I ask my last question, or are we going to get another chance?

The CHAIRMAN. I am going to allow additional questions. I hope that not everybody will take the opportunity. [Laughter.]

Senator McCASKILL. Okay. I will disappoint you; I am sorry. The CHAIRMAN. I will not call it a second round, however.

Senator McCASKILL. Not many, I just have one more.

The CHAIRMAN. Let me just on that point say that Obamacare raised taxes on millions of American families across income levels. The nonpartisan Joint Committee on Taxation analysis in May 2010 identified significant, widespread tax increases on taxpayers earning under \$200,000 contained in the ACA.

And then, for example, for 2017, 13.8 million taxpayers with incomes below \$200,000 will be hit with more than \$3.7 billion—with a “b”—in Obamacare tax hikes from an increase in the income floor for the medical expense deductions.

Obamacare has led to middle-class tax hikes, without question. It has led to fewer insurance options, higher deductibles and higher premiums.

So I think those are facts that cannot be denied.

Senator McCASKILL. I will look forward to looking at those facts, because somewhere in this mix we have alternative facts. [Laughter.]

Senator WYDEN. Well, and just on that—

The CHAIRMAN. Well, I think these are right, I can tell you that.

Senator McCASKILL. Well, I think mine are right.

Senator WYDEN. Mr. Chairman, just a point of privilege to respond.

The CHAIRMAN. Yes, sir. Yes, sir.

Senator WYDEN. On this point, no alternative facts. The Republicans in last year’s reconciliation bill cut taxes for one group of people. They cut taxes for the most fortunate in the country. That is a matter of public record. It is not an alternative fact or universe. People making \$200,000 and up got their taxes cut. That was in the reconciliation bill of the Republicans last year.

The CHAIRMAN. Well, let us see who is next here. I do not agree with that, but we will see who is next.

Senator Cassidy and then Senator Grassley.

Senator CASSIDY. Thank you, Mr. Chairman.

Dr. Price, how are you?

Dr. PRICE. I am well, Senator.

Senator CASSIDY. Let us talk a little about Medicaid, because we are getting this kind of rosy scenario of Obamacare and of the Republican attempt to replace it. It does seem a little bit odd.

First, I want to note for the record that President Trump has said in various ways that he does not want people to lose coverage. He actually would like to cover as many people as under Obamacare. He wishes to take care of those with preexisting conditions and to do it without mandates and lower cost. Those will be your marching orders. Fair statement?

Dr. PRICE. Absolutely.

Senator CASSIDY. Now let us go to—you and I, we talked at a previous meeting. We have both worked in public hospitals for the uninsured and for the poorly insured, folks on Medicaid.

Now, let us just talk a little bit about Medicaid. Why would we see patients on Medicaid at a hospital for the uninsured? If they wanted to see an orthopaedist in private practice, does Medicaid

pay a provider well enough to cover the cost of seeing an orthopaedic patient?

Dr. PRICE. Oftentimes it does not. And in fact, as you well know and as mentioned before, one out of three physicians who ought to be able to see Medicaid patients in this Nation does not take any Medicaid patients. And there is a reason for that, whether it is reimbursement or whether it is the hassle factor or whether it is regulations or the like.

But that is a system that is not working for those patients. And we ought to be honest about that and look at that and answer the question "why?" and then address that.

Senator CASSIDY. I will note that when the House version of the ACA passed, Robert Pear in *The New York Times* wrote an article about a Michigan physician, an oncologist, who had so many Medicaid patients from Michigan Medicaid that she was going bankrupt. And she had to discharge patients from her practice.

Now, the ranking member said we cannot have alternative facts. I agree with that. We also know that a *New England Journal of Medicine* article spoke about Medicaid expansion in Oregon, about how when they expanded Medicaid in Oregon outcomes did not improve. So I suppose that kind of informs you—as you say, we need to make Medicaid something that works better for patients.

Dr. PRICE. Absolutely. And we need to look at the right metrics. Just gaining coverage for individuals is an admirable goal, but it ought not be the only goal. And we must have a goal in health care especially to keep the patient at the center and realize what kind of care and coverage we are providing for people on the ground, for real people in real lives, and whether or not we are affecting them in a positive way or a negative way.

If we are affecting them in a negative way, then, again, we need to be honest with ourselves and say, how can we improve that?

Senator CASSIDY. Now, a lot of times there is this kind of conflation of per-beneficiary payments to the States per Medicaid enrollee and block grants, which to me is a conflation.

I will note that Bill Clinton on the left and Phil Gramm and Rick Santorum on the right proposed per-beneficiary payment some time ago. And that is actually how, would you agree with this, how the Federal Employees Health Benefits Program pays for these Federal employees? They pay a per-beneficiary payment to an insurer. Fair statement?

Dr. PRICE. Correct.

Senator CASSIDY. Would it not be great if Medicaid worked as well as the Federal Employees Health Benefits Program in terms of improved outcomes?

Dr. PRICE. It would indeed. In fact, when you talk about the Medicaid population, it is not a monolithic population, as you well know. There are four different demographic groups within it: seniors, disabled, and then healthy moms, and kids, by and large. And we treat each one of those folks exactly the same under the Medicaid rules.

Senator CASSIDY. So when you are pressed on whether, by golly, you believe in block grants, is there any nuance? I do not hear any of the nuances that we are discussing offered in that question.

Dr. PRICE. Not at all.

Senator CASSIDY. But frankly, you cannot address that. Are you speaking about a per-beneficiary payment? Are you speaking about each of those four, one of those four? How do you dice that? New York is an older State, demographically. Utah is a very young State. Fair statement?

Dr. PRICE. Absolutely. And those are the things that I think we tend not to look at, because they are more difficult to measure. They are more difficult to look at. But when we are talking about people's lives, when we are talking about people's health care, then it is imperative that we do the extra work that needs to be done to determine whether or not, yes, indeed, the public policy that we are putting forward is going to help you and not harm you.

Senator CASSIDY. Now, let me ask, because there is also some criticism of your proposal about Health Savings Accounts. I love them because they activate the patient. I think we are both familiar with the Healthy Indiana Plan where, on a waiver, they gave folks of a lower income Health Savings Accounts and had better outcomes, decreased ER usage. Can you comment on that?

Dr. PRICE. Just that when people do engage in their health care, they tend to demand more, they tend to demand better services. And individuals who have greater opportunity for choices of who they see, where they are treated, when they are treated, and the like have greater opportunity to gain better health care.

Senator CASSIDY. So going back to not wanting to have alternative facts, if we contrast the experience in Healthy Indiana with the experience in Oregon where the National Bureau of Economic Research—I think, if I got that acronym correct—published in the *New England Journal of Medicine* that they found no difference in outcomes in those who are fulfilled through a Medicaid expansion program in Oregon, contrast that absence of good effect, if you will, in outcomes with that in which Indiana attempted to engage patients to become activated in their own care. ER usage actually fell, but outcomes improved.

I think in our world of standard facts, I kind of like your position. Thanks for bringing a nuanced, informed view to the health-care reform debate, Dr. Price.

Dr. PRICE. Thank you, sir.

The CHAIRMAN. Thanks, Senator.

Senator Grassley?

Senator GRASSLEY. Two statements before I ask a couple of questions. One is, it is kind of a welcome relief to have somebody of your profession in this very important role, particularly knowing the importance of the doctor/patient relationship. Because in my dealing with CMS and HHS over a long period of time, I think that the bureaucracy has been short of a lot of that hands-on information that people ought to have.

And secondly, when you were in my office, we discussed the necessity of your responding to congressional inquiries. And you very definitely said you would. I tongue-in-cheek said maybe you ought to say "maybe" because a lot of times nominees do not do it. But since you said you would, I will hold you to that and appreciate anything you can do to help us do our oversight.

As a result of oversight, I got legislation passed a few years ago called the Physicians Payment Sunshine Act. And the only reason

I bring this up is because it took Senator Wyden and me, last December, working hard to stop the House of Representatives from gutting that legislation in the Cures Act that passed.

And I want to make very clear that the legislation I am talking about does not prohibit anything. It only has reporting requirements because it makes it very, very—well, it brings about the principle of transparency, brings accountability.

And I have some studies here that we did and some newspaper reports on them, particularly one about a psychiatrist at Emory University who was not reporting everything that he should report, and even the president of Emory University came to my office and said, "Thank you for making us aware of this stuff."

I want to put those in the record.

[The studies and reports appear in the appendix beginning on p. 77.]

Senator GRASSLEY. But since you are administering this legislation and since Senator Blumenthal and I will think about expanding this legislation to include nurse practitioners and physician assistants, I hope that I could get your commitment that you will enforce this act the way it was intended to be enforced, because even under the Obama administration, after we got it passed, it was 3 years getting these regulations, getting it carried out. So effectively, it has only been working for about 2 or maybe 2½ years.

So I would like to know, if you are confirmed, would you and the Department of Health and Human Services work with me to ensure that this transparency initiative is not weakened?

Dr. PRICE. We look forward to working with you, sir. I think transparency in this area and so many others is vital, again, not just in outcomes or in pricing, but in so many areas, so that patients are able to understand what is going on in the health-care system.

Senator GRASSLEY. Thank you. Now, the last question deals with vaccine safety. You are a physician. I believe you would agree that immunization is very important for modern medicine and that we have been able to get rid of small pox way back in 1977, worldwide polio I think in 1991, at least in the Western Hemisphere, and all that.

So as a physician, would you recommend that families follow the recommended vaccine schedule that has been established by experts and is constantly reviewed?

Dr. PRICE. I think that science and health care have identified a very important aspect of public health, and that is the role of vaccinations.

Senator GRASSLEY. Thank you very much.

I yield back my time.

The CHAIRMAN. Thank you, Senator.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

First, I would ask unanimous consent that a series of stories from individuals at a public forum that was held last week with my colleagues—people concerned about policies that our nominee has authored and about issues we are talking about today—be included in the record.

The CHAIRMAN. Without objection.

[The information appears in the appendix beginning on p. 253.]
Senator STABENOW. Thank you very much.

Welcome, Congressman Price.

Dr. PRICE. Senator.

Senator STABENOW. And I appreciate our private discussion as well as the discussion this morning. I want to start right out—lots of questions—to see if we can move through some things quickly.

You have said this morning that you would not abandon people with preexisting conditions. Is that basically what you are talking about with high-risk pools? Is that one of the strategies that you are thinking about? I have heard that talked about this morning.

Dr. PRICE. I think high-risk pools can be incredibly helpful in making certain that individuals who have preexisting illness are able to be cared for in the highest-quality manner possible.

I think there are other methods as well. We have talked about other pooling mechanisms. The destruction of the individual and small-group market has made it such that folks cannot find coverage that is affordable for them. And one of the ways to solve that challenge is to allow folks in the individual and small-group market to pull together. In fact, I think we talked about this in your office, with the Blue Shield model being the template for it—

Senator STABENOW. Yes, right.

Dr. PRICE [continuing]. Where individuals who are not economically aligned are able to pool together their resources solely for the purpose of purchasing coverage.

Senator STABENOW. But let me just stress that, for about 35 years, we have tried high-risk pools. Thirty-five States had them before the Affordable Care Act. And frankly, they did not produce great results.

In 2011, .2 percent of the people with preexisting conditions—.2 percent—were actually in a high-risk pool. And the premiums were 150- to 200-percent higher than standard rates for healthy individuals, and they had lifetime and annual limits on coverage and cost States money. So that was the reality before we passed the Affordable Care Act.

So let me also ask you, when President Trump said last weekend that insurance was going to be much better, do you think that insurance without protections for those preexisting conditions or without maternity coverage or without mental health coverage or insurance that would reinstate caps on cancer treatments is better?

Dr. PRICE. Well, I do not know that that is what he was referring to. I think that—

Senator STABENOW. Well, he said that it would be better. And if we in fact took away, if we went to high-risk pools instead of covering people with preexisting conditions, or if we stop the other coverage we have now, I am just wondering if you define that as better.

Dr. PRICE. Well, I mean, you would have to give me a specific instance. What is better for you may not be better for me or somebody else. And that is the important thing that I am trying to get across, and that is that patients need to be at the center of this, not government.

Should government be deciding these things, or should patients be deciding things?

Senator STABENOW. Prior to the Affordable Care Act, about 70 percent of the private plans that a woman could purchase in a marketplace did not cover basic maternity care. Do you think that it is better not to cover basic maternity care?

Dr. PRICE. And I presume that she would purchase that coverage if she needed it then.

Senator STABENOW. She would have to pay more, just as in general for many women. Just being a woman was a preexisting condition. That is the reason why we have a basic set of services covered under health care. So it is just a different way of looking at this.

This is something where, sure, if a woman wanted to pay a premium, wanted to pay more, she could find maternity care. We said in the Affordable Care Act, that is pretty basic. And for over half the population who are women, maternity care ought to be covered.

Let me go to another one. Do you believe that mental health services should be a guaranteed benefit in all health insurance plans?

Dr. PRICE. I have been a supporter of mental health parity inclusion, yes.

Senator STABENOW. So mental health should be a defined benefit under health insurance plans?

Dr. PRICE. I think that mental health illnesses ought to be treated with the same model as other physical illnesses.

Senator STABENOW. I agree with you. On Medicare, there has been a lot of discussion—and I have to say also, with the nominee for the Office of Management Budget talking today about Medicare and Social Security, I personally believe people on Medicare should be very worried right now in terms of what we are hearing overall.

But I did want—and my time is up—I did want, Congressman, just to relay a message from my mom who is 90 years old, who said she does not want more choices, she just wants to be able to see her doctor and get the medical care that she needs. She is not at all supportive of the idea of Medicare in some way being changed into premium support, into a voucher.

So I am conveying to you this is somebody who is getting great care right now and is not interested in more choices, she just wants to keep her care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Dr. PRICE. Well, if I may, Mr. Chairman, I would just convey to the Medicare population in this Nation that they do not have reason to be concerned. We look forward to assisting them in gaining the care and coverage that they need.

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

Congressman Price, sorry we have not had a chance to talk.

Dr. PRICE. I apologize.

Senator CANTWELL. No, I think both of us have tried, and it is just a myriad of consequences.

Dr. PRICE. Weather.

Senator CANTWELL. But I wanted to ask you broadly, I know a lot of my colleagues have been asking you about Medicaid, but

what do you think is behind the rise in Medicaid costs? What is it due to?

Dr. PRICE. Well, I think it is multifactorial. I think that we have a system that has many, many controls that are creating greater costs to the provision of the care that is being provided.

I think that, oftentimes, we are not identifying the best practices in the Medicaid system so that patients move through the system in a way that is much more economical and much more efficient and effective, not just from a cost standpoint, but from a patient standpoint. There are so many things that could be done for, especially the sickest of the sick in the Medicaid population, where we could put greater resources and greater individual attention to individual patients.

As you know, in a bell curve of patients in any population, there are those who are the outliers on the high side, where the resources spent to be able to provide their care is significant. And if you focus on those individuals specifically, then you oftentimes can provide a higher level of care and a higher quality of care for those folks and a more responsive care for those folks at a lower cost to move them down into the mainstream of the bell curve.

Senator CANTWELL. Okay. Well, you have brought up a couple of interesting points, and I want to follow up on them. But specifically, if I started that conversation, I would start with two big phenomena: one, people living longer, because the longer they live, the more Medicaid they are going to consume. If they are living 10 or 15 years longer than we have had in the past, they are going to consume more health care. And second, the baby boomer population is reaching retirement age. Those two things are ballooning the cost of health care in general, and specifically for the Medicaid population.

And I want to make sure I understand where you are, because I feel like the administration is creating a war on Medicaid. You are saying that you want to cap and control the cost. And what we have already established in the Affordable Care Act are best practice incentives and ways to give the Medicaid population leverage in getting affordable health care. So I want to understand if you are for these things.

For example, we provided resources in the Affordable Care Act to rebalance Medicaid patients out of nursing home care into community-based care. Why? Because it is more affordable.

So, do you support that rebalancing effort?

Dr. PRICE. I would respectfully, Senator, take issue with your description of a war on Medicaid. What we desire and want to do is to make certain that the Medicaid population is able to receive the highest-quality care.

I have cared for thousands of Medicaid patients. The last thing that we want is to decrease the quality of care that they have access to. And clearly, the system is not working right now. So moving toward home-based care is something that is, if it is right for the patient, a wonderful thing to be able to do, and we ought to incentivize that.

There are so many things we could do in Medicaid that would provide greater quality of care that we do not incentivize right now.

Senator CANTWELL. We did incentivize it in the Affordable Care Act, and your State and about 20 other States actually did it. They took the money from the Affordable Care Act. In fact, Georgia was approved for \$57 million to make sure Medicaid beneficiaries got care in community-based care, and it has been able to shift 10 percent of its long-term costs from institutional care to that community-based care. So it is working. So are you for repealing that part of the Affordable Care Act?

Dr. PRICE. What I am for is making certain, again, that the Medicaid population has access to the highest-quality care possible. And we will do everything to improve that, because right now so many in the Medicaid population do not have access to the highest-quality care.

Senator CANTWELL. I would hope you would look at this model and you would also look at the Basic Health Plan model. Again, what I think you are proposing and what the administration is refusing to refute is, when the President said, "I am going to protect these things," and my colleague, Senator Sanders, brought this up and asked, "Are you going to protect this?" and then senior White House staff are now saying, "No, no, no, we are going to basically cap Medicaid spending," it is a problem.

What we want to do is, we want to give these individuals leverage in the marketplace. That is what the Basic Health Plan does. That is what the community-based care plan does. It gives them the ability to get more affordable care and better outcomes, and it is saving us money.

So if you could give us a response—I see my time is expired—look at those two programs and tell me whether you support those delivery system reforms in the Affordable Care Act.

Dr. PRICE. I would be happy to.

Senator CANTWELL. Thank you.

The CHAIRMAN. Well, thank you, Senator.

That would end our first round. I would like to not go through a full second round, but we have some additional Senators here who would like to ask some more questions, so I guess we will start with Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Congressman, I have several ideas on how to lower the price of medicine. But I would like to set those aside and start with the President's idea: lower drug prices through bidding or negotiation.

If confirmed, you are going to be the captain of the President's health team, and you are going to have to persuade Republicans to change the law so that the President can fulfill his pledge: more affordable prices for medicine through bidding.

As captain of the health team, will you do that?

Dr. PRICE. As you know, Senator, we are committed to making certain that drug prices are affordable for individuals so they can have access to the high-quality care. Right now, that negotiation from a Part D standpoint, which I would remind folks is a real success story—the cost for medications for seniors is about half of what it was projected to be when Part D passed—the Pharmacy Benefit Managers are doing that negotiation right now.

I think it is important to have a conversation about whether or not—

Senator WYDEN. Congressman, I am asking about a specific idea, and it is not mine, it is the President's.

Dr. PRICE. I was going—

Senator WYDEN. And the question is, will you advocate to Republicans for authority to negotiate? It is "yes" or "no."

Dr. PRICE. What I was going to respond, Senator, if you will allow me, is to say right now the PBMs are doing that negotiation. I think it is important to have the conversation and look at whether or not there is a better way to do that. And if there is, then I am certainly open to it.

Senator WYDEN. On Saturday, hundreds of thousands of women of all ages and backgrounds came to Washington to speak out in support of policies that you have opposed. This includes the Violence Against Women Act, provisions in the Affordable Care Act to prevent insurance companies from charging them more because they are women, access to no-cost contraceptive coverage, and the choice to see the provider they trust.

Now, Speaker Ryan has publicly stated that no one will be worse off if the Affordable Care Act is repealed. But the nonpartisan Congressional Budget Office does not share that view. They have indicated nearly 400,000 women would lose access to care, including lifesaving cancer screenings, in the first year if Planned Parenthood is defunded and cut off from Medicaid.

So again, Congressman, this is not my opinion as Democrat or Republican, this is the nonpartisan Congressional Budget Office.

You are going to be the point person for health. Will you advise the President to reject any proposal that cuts coverage for or otherwise limits a woman's ability to see the provider she trusts?

Dr. PRICE. Well, there were multiple inaccuracies in your premise, Senator, and I would take significant issue with the Congressional Budget Office conclusion because, again, as I mentioned to a question over here, it looks at it in a silo, looks at it as saying, this is what you are doing without doing anything else to provide coverage for individuals. And that is simply—that is not anybody's plan.

Senator WYDEN. Well, again, this is what is in the bill you wrote. And these silos—you know, we keep hearing all kinds of happy talk about silos and dreams and the like. What we want to know is one thing above everything else: is there going to be a replacement before there is repeal?

And you have been asked this now by a whole host of members. We have not been able to get any answers on it. It seems to me that your own bill is out of step with what the new President has said. The new President said the two were going to be intertwined. Your own bill was repeal and run, repeal it now, come back some other time.

So I want to let my other colleagues have a chance to ask their questions. But when you talk about silos, that is the view of someone—I respect your right to state it—who would like to be confirmed.

The nonpartisan Congressional Budget Office says women, who were speaking out in communities across this country, women are going to lose access to those vital cancer screenings. And that is not a partisan statement. That is from a nonpartisan agency.

Dr. PRICE. I respect—

Senator WYDEN. I hope you will reconsider your position.

Dr. PRICE. I respectfully disagree with the conclusion.

The CHAIRMAN. Okay, hopefully we can finish in the next 20 minutes.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

Again, thank you, Dr. Price, for your response to our questions.

One of the major objectives of the Affordable Care Act was to deal with the historic discrimination against minority communities in our health-care system. And we can give you chapter and verse—the medical research that was done was very much not directed towards the priorities in the minority community. The access to providers was always challenging in minority communities. The affordability and quality of insurance products were not the same in minority communities.

So there were various provisions included in the Affordable Care Act to deal with that. One was an amendment that I offered that elevated the National Institute for Minority Health and Health Disparities to a full institute, as well as creating offices for minority health and health disparities within the health-related agencies.

Are you committed to continuing progress so that we have a focal point, so that we draw attention to the needs of minority communities?

Dr. PRICE. Senator, this is a really important question, because there are many in our society in the minority community who, if you look at the right metrics, are not having the same outcomes or same quality of health that others in society are.

And I believe that it is incumbent upon us as individuals administering these programs to ask the question why, why is that, and then reach a plan, a strategic plan, to be able to help correct that. Whether that is through the current offices or a different mechanism, you have my commitment to look at that and make certain—

Senator CARDIN. I appreciate that. The National Institute for Minority Health and Health Disparities funded a program in Maryland, in Baltimore, to show disparities, and that has been extremely helpful. And I would just encourage you to look at that institute as a real, valuable resource to you to carry out that commitment.

The Affordable Care Act also increased dramatically the funding for Qualified Health Centers that allow access to care in minority communities. Are you committed to maintaining the support for Qualified Health Centers?

Dr. PRICE. Qualified Health Centers play a vital role in our Nation's health-care delivery system right now. And so I think it is imperative that we retain them or improve the delivery of care in that area.

Senator CARDIN. So now I am going to get to the subject that has been talked about by many members: Medicaid. And the reason I mention Medicaid—and I appreciate your response that you do not want to disadvantage anyone who is currently on the Medicaid system—is blacks, Latinos, American Indians, and Native Alaskans

are almost twice as likely to be in Medicaid than the white population. In my State, 70 percent of our Medicaid population are people of color, so it is by far the dominant population that relies on Medicaid.

So I hope you understand our concern, that when we talk about changing Medicaid, talk about block-granting Medicaid, talk about new approaches to Medicaid, it sends a signal that what we are going to do is cut the Federal Government's commitment to access for minorities. And it is a major area of concern.

We have seen budget rounds where cuts to Medicaid dollar-for-dollar would have reduced access to minority communities for their health-care needs. We know States have challenged budgets, and the more you put on the State, the more likely it is that many States will not be able to meet their full commitments to the Medicaid population.

Can you just share with me a little bit more your vision. When you look at the resources we are putting into health care—everybody wants to do it more efficiently—but if you just look at the Medicaid population, what you are doing is taking resources away from minority communities and making the problem even worse.

How can you give me a comfort level that you are committed to the minority communities that depend so heavily on the Medicaid program?

Dr. PRICE. Well, Senator, let me try to assuage your concerns. I think, of the individuals at the dais and at this table, I am the only one who has ever treated a patient in the Medicaid system, in fact treated thousands of patients in the Medicaid system.

And when we as a society use as the only major metric for determining whether or not we are providing care for individuals in the Medicaid system, the amount of money that we are putting into the system instead of the outcome, whether or not people are getting covered, whether they are able to see the doctor they want to see, whether they are able to get the kind of care that they want—

Senator CARDIN. And I agree with that. I agree with what you are saying, but I would just make this point—

Dr. PRICE [continuing]. Then we are measuring the wrong thing.

So my commitment to you is to make certain that we measure the right things.

Senator CARDIN. I agree with you, but if you look at the relative resources that are going into the Medicaid population versus the general population, you will find in many cases it is less resources. And as we said on quality education, money is not the only thing, but it is part of the problem.

I just really urge us to recognize, yes, we want a better outcome, we all want a better outcome in our health-care system. But you do not do that by taking money away from our most vulnerable.

Dr. PRICE. Thank you.

Senator CARDIN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Congressman, just to follow up our last conversation, you said that you did not recall having said it is a terrible idea. I quoted the source, *Politico*, and that was "Most Republicans support"—and

I am quoting from the *Politico* article of 2002, April the 30th, "Most Republicans—"

Dr. PRICE. 2002?

Senator NELSON. 2012.

Dr. PRICE. 2012.

Senator NELSON. April 30th. "Most Republicans support the health law's requirement that insurance companies accept all applicants. But the replacement plan on preexisting conditions put forth by the most prominent Republican ignores the idea"—talking about preexisting conditions.

Dr. PRICE. Yes, I would disagree.

Senator NELSON. Quote, "It is a terrible idea," Representative Tom Price, the sponsor of the plan, told *Politico*."

So, Mr. Chairman, I would like to insert that *Politico* article into the record for clarification.

The CHAIRMAN. Without objection.

[The article appears in the appendix on p. 138.]

Senator NELSON. You and I had the opportunity yesterday to talk about Puerto Rico. We do not know the origin of this, but they are not treated like the States where the poorer of the population that you have, the more Federal assistance for Medicaid that you get. Instead it is a block grant, and the block grant is going to run out this year. And they are in a heck of problem, not only financially on the island, but now with a third of the population, according to the CDC, being infected with the Zika virus.

Do you want to comment on what you might do going forward?

Dr. PRICE. Well, as we talked about in your office yesterday, Senator, we absolutely need to find the resources to be able to make certain that they have access to the care that they need. These are American citizens, and it is incumbent upon us to take that responsibility seriously.

Senator NELSON. I mentioned earlier, and I did so yesterday, that senior citizens—we have 4 million in Florida on Medicare, but there are almost 2 million people in Florida who now get their health care through the ACA.

And on Medicare Part D, the drugs, what we have tried to do is close the amount of money that seniors have to pull out of their own pocket, otherwise known as the doughnut hole.

Do you want to comment, Congressman, about whether or not seniors should have retained that Federal ability to purchase their drugs?

Dr. PRICE. Well, in view of the fact that two of those senior citizens in your State are my mother-in-law and my father-in-law, I need to tread very carefully here.

One of the concerns that I have about drugs being available for seniors is the accessibility of the drugs that they need and desire. So we need to make certain that formularies are not limited, that we are not decreasing the access and availability of medications that seniors have available to them for the care that they receive.

Senator NELSON. And so, the part of the ACA that closed that doughnut hole for senior citizens, you would support that part?

Dr. PRICE. As I say, I think it is imperative that we provide the greatest amount of opportunity for individual seniors to be able to gain access to the drugs that they need.

So oftentimes in these discussions, we think that whatever we are doing right now is the only solution that is possible. And I just, again, I am humble enough to believe that there are better ideas out there. And if we find a better idea that actually provides greater coverage at a lower cost more efficiently and is more responsive to patients, then we ought to be able to admit to ourselves that we would embrace that if it were to come along.

Senator NELSON. Congressman, as their Senator and as their protector of senior citizens in Florida, I cannot get away with an answer like that. I have to tell them that I am going to support their right to get drugs under Medicare Part D just like they are getting them now and not take that away from them.

Dr. PRICE. And I understand that. And I would respectfully suggest that if we used, as a society, the line, we are going to maintain the kind of quality coverage that we have right now unless we are able to improve it, then we might just be able to do that for you.

Senator NELSON. And if I gave them that answer, I would get run out of the room by a group of senior citizens.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

Congressman Price, one of the main policy priorities that you share with Speaker Ryan is to radically reform or alter, I should say, Medicare from its current structure to one where seniors would, in essence, receive a coupon to buy coverage. Now, despite the fact that President Trump has made repeated promises throughout the campaign that he will not touch Medicare, it seems that it is still one of your top agenda items.

I have heard serious concerns about privatizing Medicare, not only from seniors worried about increased costs and decreased coverage, but also from providers in my State concerned about the serious negative impacts such underfunding will have on their ability to continue caring for Medicare seniors.

So if the stated goal of Medicare privatization is to reduce Federal expenditures on health care for seniors, then does it not stand to reason that every dollar the Federal Government saves is going to have to come out of the pocket of seniors on Medicare?

Dr. PRICE. Well, I disagree with the characterization of the program as you described it. I think it is inaccurate.

Senator MENENDEZ. Okay. So let us go through the specifics. Do you not seek to privatize Medicare?

Dr. PRICE. No.

Senator MENENDEZ. Do you not seek to ultimately offer a voucher as your way of creating greater affordability?

Dr. PRICE. No.

Senator MENENDEZ. Well, it is interesting you say that, because studies that have been done on your and Speaker Ryan's Medicare privatization plans have shown that an average 65-year old will pay more than twice what they pay now since the vouchers that you would give out are, by design, far short of what the current Medicare program covers.

Dr. PRICE. Well, Senator, with respect, I have no reason to believe that the President, in his statement that he is not interested

in modifying Medicare, that that position of the President has changed.

If you want to talk about what my role as a legislator was in fashioning legislation and trying to solve the challenges that we have in Medicare, I am happy to do that. But that is not the role that I would play if I am given the privilege of being confirmed to serve as the Secretary of Health and Human Services; that would be to administer the changes that you all come up with in the Congress of the United States and the programs that are—

Senator MENENDEZ. Well, let me respond to that, because I know I have heard you at various times, both here and before the HELP Committee, say that you are going to have more of an administrative role, not a legislative role. And I said to you privately, I think that that is a little disingenuous.

I noticed last week, the day of the hearing before the HELP Committee, Vice President Pence was on TV, and he said, quote, “I could not be more enthusiastic that someone with his background,” referring to yourself, “in medicine, but also his understanding of the President-elect’s vision for health-care reform and his ability to help us shape what that replace bill looks like once we repeal Obamacare. . . .”

Clearly, they think, the President and the Vice President, that you are going to be playing a policy development role, not just simply the administration of whatever the Congress decides.

So in your advocacy with the President as he deals with his desire to replace Obamacare, the reality is, you are going to have more than an administrative role; you are going to have a policy role. And if past is prologue, then your views as a legislator as to what you think is best for the American people is of concern to me because that, in essence, is a plan towards privatizing Medicare.

So if that is not the case, would you commit to ensuring that, under your watch, Medicare will not increase costs or limit the coverage to current or future beneficiaries as a result of a change in the plan?

Dr. PRICE. Senator, a couple of things. One, the comments that you referenced, I think, were related to the ACA, not to Medicare.

Second, as I mentioned to you yesterday in our conversation in your office and as I have said before here, I am humble enough to understand and appreciate that the work that I did as a legislator is not necessarily the work that I would promote as Secretary of Health and Human Services.

The work that has been done within the Department—the experts within the Department have significant knowledge and expertise in the work that they have done—

Senator MENENDEZ. Well, I appreciate that. But the essence of my question, then, if you dispute that your past views are going to be your future views, that your past views and legislative activity are not going to be your advocacy with the presidency, then I would ask you to go to the core of my question. Are you willing to commit that we will not see increased costs or less coverage for seniors under a revision of Medicare as you might advocate or the President might pursue?

Dr. PRICE. What I can commit to you and will commit to you and have committed to you, sir, and others on this committee and in

other conversations, is that our goal is to make certain that seniors have access to the highest-quality health care possible at an affordable price.

Senator MENENDEZ. Well, access without the ability to afford it—and I will end on this.

Dr. PRICE. That is what I said: affordable price.

Senator MENENDEZ. Well, affordability, still a question, is not just an affordable price; it is your ability to have the wherewithal even to access an affordable price.

Medicare guarantees as a right, it guarantees care for seniors, like my late mother who worked in the factories of New Jersey as a seamstress, was not in a unionized factory, did not have private insurance. After working a lifetime of hard work to help her family achieve what they did, she faced an enormous struggle with Alzheimer's that ultimately took her life. For her, her health-care security was Medicare. And without it, she would not have lived with the dignity that she deserved in the twilight of her life.

So changing Medicare from a commitment and an entitlement to vouchers that might hope to create affordability but do not guarantee it, that is a fundamental shift in the nature of how we take care of seniors in this country. And that is why I am so passionate about it.

I said this to you privately, and I just wanted to explore it with you publicly, but your answer does not assuage me that, in fact, you are committed to Medicare as we know it today in terms of the guarantee. Can we improve? I am always open to improving it, but the guarantee is what I am concerned about.

Dr. PRICE. I share those concerns as well, but I disagree with your characterization and can also share with you a story of my mom, who, in the twilight of her years, had an illness that took her from us. And she enjoyed the benefits of Medicare and, without that, would not have been able to have the care that she received.

Senator MENENDEZ. Well, I hope that will be compelling to you in the days ahead, that it will instruct you as to how we should pursue Medicare.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Brown?

Senator BROWN. Thank you, Mr. Chairman.

I began with the comments of Congressman Price about not using the word “socialized medicine,” the term. In 2007 in the Congressional Record, debating CHIP, he talked about being eligible for government-run socialized medicine, referring to CHIP. But I do not want to debate that, I just want to point that out. You may have forgotten—it has been 10 years—I certainly understand that.

I want to follow up on what Senator Menendez said about Medicare, with a slightly different twist. In December, you said you expected lawmakers to push forward an overhaul of Medicare, and I quote, “in the first 6 to 8 months of the Trump presidency.”

Today, Congressman Mulvaney, the Budget Director designee, said that he would support raising the eligibility age for Social Security. He seemed to be open to raising the eligibility age for Medicare too, in his comments. And like you, he supported efforts to raise it in legislation, in Speaker Ryan’s so-called A Better Way plan.

That is in exact contradiction, I understand, of what President Trump has said; he said he opposes both cuts and raising the eligibility age.

I would like you to—I asked you to clarify your position in a letter. I have not received a response yet. I know you are busy. But my question is this: if Congress passes legislation to raise the eligibility age for Medicare, as laid out in Speaker Ryan's A Better Way plan, will you advise President Trump to veto that legislation?

Dr. PRICE. I do not anticipate a single piece of legislation related to just that. So we would have to look at the constellation, if I am confirmed.

Senator BROWN. So if something else is part of it, you would consider supporting raising the eligibility age? If you are not willing to say, no matter what else is in it—you stand firm on that?

Dr. PRICE. If I am confirmed, it would be my responsibility to talk with the President about the various aspects of any piece of legislation, lay out the pros and cons and the consequences of the decisions that would be made by the Congress of the United States and make a recommendation.

Senator BROWN. When I think about a barber in Warren, OH or a factory worker in Logan, OH or a woman who works in a diner in Mansfield, OH or someone working construction in Troy, OH and saying to them, you know, I know that you think Medicare's eligibility age is 65, you have worked all your life, you do not have these jobs where we can work to older ages—you and I are close to the same age; unfortunately I am a bit older—but I just cannot imagine the morality of telling these people who have worked all their lives and their bodies have broken down more than ours do in these jobs, that we would even consider the possibility, as you all did in Congressman Ryan's bill, you did, Budget Director Mulvaney did, raising the eligibility age for Medicare. It is just stunning to me.

Let me talk about something—

Dr. PRICE. Senator, if I may, I struggle with the morality of a system that looks at Medicare, which is broken and is—

Senator BROWN. Yes, I know. I know what you are going to say. You have said that already. I appreciate that. I do not agree with that. I do not agree that Medicare is broken the way you say.

Let me talk about something else. You said good things about innovation. I want to bring up one really quick issue and ask you to continue to work with us on it.

Last summer, Secretary Burwell visited my hometown of Mansfield, OH to witness firsthand the effective and cost-efficient role of community health workers in reducing infant mortality rates. I will talk to you more privately—and thank you for trying to get together in the last few days—about working to ensure that community health workers are recognized and included in new payment and delivery system reforms. They have been very effective at bringing down the low birth weight baby rate and cutting back the rate of infant mortality.

My State is, unfortunately, maybe last in black infant mortality and pretty bad overall in infant mortality. I just want a commitment from you to at least sit and work with us on what Secretary Burwell and I began for dealing with community health workers.

Dr. PRICE. Absolutely.

Senator BROWN. Okay, thank you.

Last question—and thank you for your indulgence, Mr. Chairman, on this second round.

Do you support guaranteed health care for our Nation's veterans?

Dr. PRICE. I think the commitment that has been made by this Nation is that veterans should receive health care, yes.

Senator BROWN. But we do not. I mean, not all veterans qualify for care through the VA. On Tricare they do and there are a lot of them in your State as in my State. But because of these gaps, additional coverage options, like those provided through the ACA, are critical to ensure that they are covered.

So what is the answer? The VA does not do it alone; the ACA complements the VA. So if we repeal the ACA, how do you guarantee health care for my State's thousands, your State's thousands of veterans who served their country, but do not have real health care?

Dr. PRICE. Right. Well, currently, as you know, Senator, there are real challenges in the VA system. Again, I think I am the only individual on the dais here who has ever taken care of a patient in a VA hospital. And I know the challenges. And I know—

Senator BROWN. Well, but you want to repeal—thank you—but you want to repeal the Affordable Care Act, and we have used the Affordable Care Act in such a way that these veterans now have guaranteed health care. Almost all veterans have guaranteed health care, yet you are going to repeal the Affordable Care Act with no plans that anybody has seen yet to make sure these veterans have guaranteed health care.

Dr. PRICE. I understand and appreciate the promise that has been made to veterans. And sadly, in many instances, we are not keeping that promise right now.

Senator BROWN. So is that part of your—

Dr. PRICE. And I look forward to working with you to put together a better system that will—

Senator BROWN. Well, I appreciate that. I appreciate that, Congressman.

Dr. PRICE [continuing]. Allow us to care for veterans in the way that we should.

Senator BROWN. Now, you had said when I asked you about President Trump saying he has been working with you on this repeal and replace plan, you said he has not really been working with you. So, I mean, you did not call the President a liar, but, you know, putting two and two together is pretty easy; it adds up to four.

What does that mean? If you and he are working together, are you going to suggest to him that we find a way in repeal and replace to make sure there is guaranteed health care for our Nation's veterans?

Dr. PRICE. Well, I think it is vital, again, as I have mentioned before, that every single American have access to affordable coverage that is of high quality. And that is our goal, and that is our commitment.

Senator BROWN. And so when we replace the Affordable Care Act after your party repeals it in this Congress, you will find a way for

all 22 million Americans, including a lot of those who are veterans, to have health insurance, so they do not lose it with the replace part of repeal and replace?

Dr. PRICE. I look forward to working with you to make that happen, sir.

Senator BROWN. That is not quite a "yes," Congressman.

Dr. PRICE. That is my answer.

Senator BROWN. Okay. Inadequate, but thank you.

The CHAIRMAN. Okay. Thank you.

Senator Casey?

Senator CASEY. Thank you, Mr. Chairman. Thanks for the additional round of questioning.

Representative Price, I want to move to the topic I hoped I would have gotten to in the first round, which is individuals with disabilities, many of whom, I do not have the exact number, but many of whom rely upon Medicaid.

One of them is actually a young child whom I just got a letter from his mother about—Pam Simpson, who is from Coatesville, PA, which is in southeastern Pennsylvania—talking about her son, Rowan Simpson, who was diagnosed in 2015 with autism. And among the things she said about the great care they get, that he gets in their family benefits from Medicaid, she says, without Medicaid, quote, "we would be bankrupt or my son would go without the therapies he sincerely needs."

Can you guarantee today that his family is going to benefit from and he, Rowan Simpson, will have that kind of coverage and protection that Medicaid provides, that he will have that if you are Secretary of Health and Human Services?

Dr. PRICE. We are absolutely committed to making certain that that child and every other child and every other individual in this Nation has access to the highest-quality care possible.

Senator CASEY. Okay, not access, he will have the medical care that he has right now, or better. If you can come up with a better level of care, that is fine. But he will have at least the coverage of Medicaid and all that that entails that he has right now? And that is either "yes" or "no," that is not—

Dr. PRICE. No, it is not a "yes" or "no," because the fact of the matter is that, in order for the current law to change, you all have to change it. If I am given the privilege of leading at the Department of Health and Human Services—

Senator CASEY. Yes. Here is why it is "yes"—

Dr. PRICE [continuing]. And I am responsible for—

Senator CASEY. Look, you should stop talking around this. You have led the fight in the House, backed up by Speaker Ryan, for years—

Dr. PRICE. To improve Medicaid.

Senator CASEY [continuing]. To block-grant Medicaid, okay?

Dr. PRICE. To improve Medicaid.

Senator CASEY. To block-grant Medicaid. What that means is, States will have to decide whether or not this child gets the Medicaid that he deserves. That is what happens. So you push it back to the States and hope it works out.

One estimate by the Center on Budget and Policy Priorities, long before you were named, said that—here is the headline of a chart:

“House budget chair’s plan would slash Medicaid by one-third by 2026.” This was not developed because you are now in front of this committee. That is what they were saying, that Medicaid would be cut by a third and by a trillion dollars.

So let me ask you this question.

Dr. PRICE. May I respond?

Senator CASEY. Let me just get this question in. Can you commit to us right now that no person with a disability who is currently covered by Medicaid, so that is everyone—that is Rowan and that is everyone else—that no person with a disability who is currently covered by Medicaid will lose health-care coverage, not access but coverage, under the block-granting plan that the administration now embraces as of Sunday?

Dr. PRICE. What I can commit to you is that in our Medicaid system, if I am given the privilege of service, working with CMS administrators, the metrics that we will use for Rowan and every single other patient are the quality of care that they are receiving—

Senator CASEY. That is fine—

Dr. PRICE [continuing]. And whether or not they are receiving that care. The metric that you want to use—

Senator CASEY. Metrics are fine. What I am asking you again is, will you commit to ensure that Rowan and every other person in the country who has a disability, who benefits from Medicaid today, will they have that same coverage and the same health care and coverage they have today?

Dr. PRICE. Our commitment is to make it so that they have that coverage or greater.

Senator CASEY. That is a commitment you are making.

Dr. PRICE. That is a commitment.

Senator CASEY. For every person with a disability who benefits from Medicaid.

Dr. PRICE. As I said, the goal is and our desire is to make sure that people have better health care, not less health care. And it is astounding to me—

Senator CASEY. Well, here is the problem with that. Here is the problem with your answer. Until Sunday, there was a question as to whether or not President Trump or his administration would fully embrace block-granting of Medicaid, because he said when he was campaigning that he would not cut Medicare and Medicaid and Social Security. As of Sunday, the administration has said on the record, in at least one and maybe two interviews, that they are going to pursue a block-granting policy with regard to Medicaid.

What flows from that are the following: he has a majority in both houses, so what you have been working on in the House for years that you could vote for now may become the law of the land. So this is a live issue; this is not theory or some policy among House Republicans. This is a potential enactment of law to block-grant Medicaid.

And I hope you can keep your promise to make sure that no one with a disability suffers any diminution of care or coverage. That is the promise you just made, and I hope you can keep that in light of a trillion-dollar cut in Medicaid pursuant to block-granting.

The CHAIRMAN. Senator McCaskill, you are the last one.

Senator McCASKILL. Thank you. And thank you for your patience in letting us have another round of questions, Mr. Chairman. We sincerely appreciate it.

I would like to put in the record a table prepared by the Tax Policy Center on December 15, 2016 that lays out what happens with a repeal of all ACA taxes, including premium credits based on income level, if I could make that part of the record.

The CHAIRMAN. Without objection, it will be placed in the record.

[The table appears in the appendix on p. 91.]

Senator McCASKILL. You were chairman of the Budget Committee. I am going to try not to be—I get frustrated when people will not answer, especially when your record is so clear on this, Congressman. I do not really understand why you want to divorce yourself from your record.

You were chairman of the Budget Committee, correct?

Dr. PRICE. Yes.

Senator McCASKILL. And in that role, you had the most important—we all know the power of the chairman around here. You had incredible power to influence what was in that document, correct?

Dr. PRICE. Which document do you refer to?

Senator McCASKILL. The budget that you prepared for 2017.

Dr. PRICE. Absolutely, along with my colleagues.

Senator McCASKILL. Along with your colleagues. Was there anything in that document that you disagreed with on principle when you supported it?

Dr. PRICE. Oh, absolutely.

Senator McCASKILL. Okay. What was in the document you disagreed with on principle when you supported it?

Dr. PRICE. I would have to go back and look.

Senator McCASKILL. All right.

Dr. PRICE. But it was a combined effort. But again, you know, as I mentioned before, if I am given the privilege of serving as Secretary of Health and Human Services, I appreciate and understand that that is a completely different role than as a legislator.

Senator McCASKILL. I know it is a completely different role. That is not what I am asking you, Congressman. I am not asking you about the difference.

Dr. PRICE. Each of your questions refers to that role.

Senator McCASKILL. I am not asking you about the difference in your roles. What I am asking you is, what do you believe in? What do you believe in? You have been respected around these halls for a man of integrity because you believed in certain principles. And one of those was the principle that you embraced as chairman of the Budget Committee to block-grant Medicaid.

Dr. PRICE. No, on the contrary. What I believe in is this great country and the people of this great country and the principles of health care that I defined earlier. And those are the principles that we all share, I believe, and they are that we need a system that is affordable for everybody, we need a system that is accessible for everybody.

Senator McCASKILL. I get that.

Dr. PRICE. We need a system that is of the highest quality—

Senator McCASKILL. You have said that over and over again—

Dr. PRICE [continuing]. That is responsive to patients, not to insurance companies and government.

Senator McCASKILL. I am just trying to figure out—

Dr. PRICE. We need a system that incentivizes innovation, and a system that provides choices to patients. That is what I believe.

Senator McCASKILL. I understand. I understand the aspirational goal you have. But there is a record, Congressman. That is on record. And the record is that as chairman of the Budget Committee, controlled by your party, you put out a budget document, and you said over and over again that you favored block-granting Medicaid.

In fact, your budget in 2017 when you were the chairman, you want to run away from that today as if it never happened, and I cannot figure out why. You are going to be influential. What you really believe matters. And you want to run away from that.

You cut Medicaid by a trillion dollars in your 2017 budget. And yet today, you want to stand on some notion that, well, whatever you guys do is fine. And that is just not reality, Congressman.

What is reality is, you have been chosen because of your beliefs, and your beliefs are reflected in your budget that you wrote as chairman of the Budget Committee. And that is the point I am trying to make.

Dr. PRICE. Can I respond?

Senator McCASKILL. And I have a hard time understanding why you will not say, listen, it may not turn out the way I believe, but yes, I favored block grants to Medicaid.

Dr. PRICE. What I believe in is a Medicaid system that is responsive to the patients and provides the highest-quality care possible.

And I would respectfully suggest to you that that is not the Medicaid system that we currently have. So it is incumbent upon you, it is incumbent upon me, if I am given the privilege of serving in this capacity, to work together to find the solution so that we provide the highest-quality care for Medicaid patients and everybody else in this country.

Senator McCASKILL. And I understand. And by the way, the argument being made in favor of block grants is, they give more flexibility and efficiency to the States. That is the argument you have made before, that is the argument that was made around the budget that you crafted, that when you block-grant things to States, it gives them more efficiency.

So I want to turn to a block grant that we have now, which is the Social Services Block Grant, which you have voted repeatedly to repeal. You have said that you wanted to zero it out. And you have voted that way as a member of Congress. And I want to make sure that you understand that that efficiency and effectiveness that you say you get with a block grant of Medicaid is what is happening in my State with the Social Services Block Grants, which, by the way, came about with Ronald Reagan.

They are deciding where to use that money. And right now, just so you know where it is being used—in case you want to advise the President, the same way you voted—it is being used for residential treatment for detoxing off heroin, it is being used for daycare for seniors to keep them in their home so we are not paying the bill on Medicaid in a nursing home, it is being used for adoption serv-

ices, and it is being used for case management to save money so that the cases are being managed effectively and efficiently in terms of accessing Federal safety net programs.

Will you continue to advocate, as you have in Congress, for a repeal of the Social Services Block Grants?

Dr. PRICE. Senator, with respect, I think there is likely a better way to provide those services in a much more efficient, effective, and economical way for the individuals receiving the care. And I would also respectfully suggest to you that another State flexibility model that is held up by many is the TANF program that has been extremely successful, and so there are different ways to do things.

And again, it ought to be a collegial conversation that we have to lay out what the challenges are before us, working together to solve those challenges. And that is what I would like to do.

Senator McCASKILL. I just was trying to point out the inconsistency of saying block grants to Medicaid are good because of flexibility and efficiency and block grants to States on social services are bad. And that has been your record in Congress, Congressman, and that is why I brought it up.

Dr. PRICE. And with respect, for individuals to say that State flexibility for Medicaid is bad, but State flexibility for TANF is fine, again, is a little bit inconsistent as well.

Senator McCASKILL. I understand.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Now, we are going to close this, Senator Wyden and myself, so we will just ask Senator Wyden to make his closing remarks, and then I will make mine.

Senator WYDEN. Thank you very much, Mr. Chairman.

As we wrap up another quiet, subdued hearing in the Finance Committee [laughter], I just have a couple of thoughts. And the first is for you, Congressman. Despite our policy differences, I want you to know I very much respect your willingness to serve. As you know—we have talked about it—you and I have a lot of mutual friends, and I know they are very supportive of your career. And I want you to know I respect your willingness to serve.

Here is where we are in terms of the substance. Several hours ago, I asked you, with respect to the executive order on the Affordable Care Act, will you commit that no one will be worse off? And you ducked it. I asked you, will you guarantee that no one will lose coverage? You ducked that. I asked you, would there be a replacement before all of this went into effect to avoid hurting working families? And that was ducked as well.

And it just seems to me there is a big gap between the answers you have given on the executive order with respect to repealing the Affordable Care Act and what the new President said all through the campaign. Everybody was going to be okay, nobody would be worse off, there would be no gap between repeal and replace.

My colleagues have gone through in great length the debate about the Medicaid block grant. Prediction? I think some of your biggest critics are going to be Republican Governors on this, because I think Republican Governors—and they will be probably more diplomatic than I—are going to see this as a Trojan horse to

cut spending. And that is why a lot of us are concerned about shredding the safety net.

I asked you about women's health care, and here the concern is that women all across the country are going to lose the choice of providers that they want and they have today and coverage. And you just said, "Hey, I disagree with the Congressional Budget Office."

I asked about drugs and how we are going to lower these pharmaceutical prices, and you told me about pharmaceutical benefit managers. You told me about Part D—I voted for Part D, one of the relatively few Democrats who did—but you did not answer the question about whether you would get Republicans to help you fulfill the President's pledge on bargaining. So that is what concerns me about all of this.

On the ethics questions, we want to correct one key point that was said earlier in the hearing, that the Congressman does not have control over his brokered accounts. First, the Congressman has not provided copies of the agreements that would clarify his level of control.

Second, last week the Congressman told Senator Murray regarding the purchase of Innate, quote, "I did it through a broker, I directed the broker to purchase the stock, but I did it through a broker."

And third on this point, these are not blind trusts. I just want the record to reflect that.

I am also going to put an article in the record, Mr. Chairman, that ran this morning about investments in other health-care stocks, specifically in four companies that manufacture products in Puerto Rico.

The CHAIRMAN. Without objection.

[The article appears in the appendix on p. 286.]

Senator WYDEN. And so, Mr. Chairman, I will wrap up with just one last point. Ever since I was director of the Gray Panthers, the Oregon Gray Panthers—I did it for almost 7 years—I was interested in one thing: changing a system that was largely for the healthy and the wealthy.

And as you and I have talked about, I had eight Democrats and eight Republicans on a bipartisan bill that would do that. I did not get my way. But the Affordable Care Act had many, many good features, and one of them was, it made clear all across this country we were not going to go back to the days when health care was for the healthy and wealthy.

And I am especially troubled as we wrap up this morning—we have been at it close to 4 hours—that when you take all of these policies together that you have described this morning, that is really where we are headed, that is where we are going to be. And that is why I am so strongly opposed to these positions.

My hope is—we still have some additional questions to look at with the ethics issues. I can just tell the Congressman that George W. Bush's ethics lawyer was in the paper this morning talking about your stock trades, and he said "I have not seen anything like this before, and I have been practicing and teaching about securities law for 30 years."

So I think there are very troubling questions that remain, Mr. Chairman, with respect to this. I know that we are being told that members have to get any written questions in by this evening. But with respect to what we have heard this morning and the lodestar that I see, that America will end up with health care that works for the healthy and wealthy, I am going to oppose it. I am very troubled by what we have heard today. And I appreciate the chance to make these closing remarks.

The CHAIRMAN. Well, thank you, Senator.

If we keep going the way we are going, there will not be any health care for anybody. We will not be able to afford it; we will not be able to provide for it. There are so many things that are wrong with the current system, but it is just pathetic, and it is gradually eating up the whole doggone Federal budget.

Now, I have been around here only 40 years, but I will tell you I have never had a witness for any position in government who has performed as well as you have, who has an impeccable reputation in medicine and in the Congress. And to be treated like, if you do not agree with some concepts that some of my colleagues do, there is something wrong with you, is just beyond the pale.

Like I say, you not only have a great deal of experience in medicine, but you have been a great Congressman, and you have been trying to get things under control around here. And you have found that it is almost impossible, because we have all these people saying we have to do everything in the world, and they do not care what the costs are. And that is why this country is broke.

We have to find some way of delivering all these health-care benefits to people without totally ruining the country so nobody gets any health-care benefits, which is where we are headed. I do not know how in the world we can continue to buy into this liberal claptrap that you do not have to pay the piper.

Now, what you have said is, we are going to try, within this current system, to make it work and to cover everybody and to help people, whether they be poor or whether they be rich.

Now, I do not know if you can say much more than that. But I get a kick out of how many of these people are constantly blathering about, we have to do everything for everybody when we know we are \$20 trillion in debt. And this money does not grow on trees, and yet every one of us wants to make sure health care works, every one of us wants to make sure every deserving person in our society is cared for.

And I say that as a person who, over the last 40 years, almost every health-care bill that works has my name on it, starting with the Orphan Drug Act. How about Hatch-Waxman that created the modern generic drug industry? Name it all.

The fact of the matter is that you have been very forthright, very honest, and you have indicated that, in spite of all the problems of trying to fund health care and all the problems around health care, you are going to do your doggone level best to make sure health care is delivered to our American people.

You know, I wonder how many of my colleagues on the other side are going to vote for you. And if they do not, it kind of says something about what is happening in this country.

Now, I want to thank you for being here today. You know, I do not think you ducked any questions. You answered them forthrightly. It might not have pleased the individual Senators, but you did. And I look forward to Dr. Price being confirmed and assuming his position so he can begin working with us here in Congress to improve the Nation's health and the whole health-care system and to ensure that taxpayer dollars are used efficiently and effectively.

Now, we owe that to the dedicated taxpayers and citizens of this great country. And to that end, several groups and individuals have submitted letters of support for Dr. Price. And I would like to ask that those be entered into the record at this point, without objection.

[The letters appear in the appendix beginning on p. 82.]

The CHAIRMAN. In closing, this committee takes its responsibilities very seriously. As you can see, this is a very intelligent committee. We have a lot of really great people on both sides on this committee, and they are serious about what goes on. But that is why we have such a thorough review process for nominees. This is why the committee is following and will continue to follow our long-standing process in the future.

Now, I would ask that any written questions for the record be submitted by 8 p.m. tonight, which is 2 hours more than what the Democrats gave us. This is a timeline that is consistent with the committee's consideration of previous nominees for HHS Secretary. And that's a direct quote, by the way.

Now, I want to thank you and your family for sitting through this and for answering these questions. I think this was the best I have ever heard them answered, understanding that there are no answers to some of these problems.

And I just want to personally thank you. My gosh, you could have such a great life without doing this kind of stuff, and you are willing to give your life to working for the American people and in trying to do what really needs to be done in the area of health care. And I want to commend you for it, because I just do not think there is a justifiable reason to vote against you.

Dr. PRICE. Thank you, sir.

The CHAIRMAN. Well, with that—

Senator WYDEN. Mr. Chairman, just a unanimous consent request.

The CHAIRMAN. Yes, sir.

Senator WYDEN. I would just like to put in a statement by me under this unanimous consent request—

The CHAIRMAN. That would be fine.

Senator WYDEN [continuing]. On how important it is that Congressman Price respond to the questions he has been asked by the HELP Committee. It is a different committee, but it is something of great importance to me. And I appreciate it.

The CHAIRMAN. Well, that is fine. But see, in my estimation, the HELP Committee should not have held a hearing to begin with. This is the committee of jurisdiction. This is the committee that has to stand up and vote on whether or not our congressional friend is going to serve this country in this great capacity. And I believe we will vote for him and get him out of here. And by getting him out of here, I do not mean out of this room, okay, we have to

get him out of the Congress and get him up there where he can really help with all this medical expertise that he has.

And it is apparent that you have it. I mean, there is no question about that in my mind. And it is hard for me to understand why anybody would give you a rough time. It is good to ask tough questions, and we have had a lot of tough questions here today, but you have answered them very, very well, as far as I am concerned, much better than a lot of other people who have held this position.

Many of the others, even recently, could not answer these questions that you have been asked. And it is wonderful that we have a doctor who has had a long life in medical practice willing to give up that life, give up the freedoms that you have to have to repeatedly come up here and justify everything you do down there. I think it is a wonderful thing, and I just personally want to congratulate you and your wife and family for giving so much to this country.

With that, we will recess, and we will reconvene again to vote on you promptly.

[Whereupon, at 1:54 p.m., the hearing was adjourned.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

SUBMITTED BY HON. CHUCK GRASSLEY

The Wall Street Journal, October 3, 2008

GRASSLEY SAYS EMORY PSYCHIATRIST DIDN'T REPORT \$500,000 IN PAYMENTS

By Jacob Goldstein

For a while now, Senator Chuck Grassley has been writing to universities around the country to ask about ties between high-profile doctors and the drug industry—an interest related to a bill he's sponsoring that would require drug makers to report payments to doctors.

In the latest letter, Grassley says a prominent Emory psychiatrist failed to disclose a half-million dollars in payments from GlaxoSmithKline.

Charles Nemeroff, the chair of Emory's psychiatry department, was paid by Glaxo to give speeches to doctors around the country, the Grassley letter said. Nemeroff was also the main investigator on a federally funded trial of Glaxo drugs.

Emory requires its doctors to disclose potential conflicts of interest when they receive payments of over \$10,000. In a statement to the WSJ, Emory said the allegations made by Senator Grassley are "serious" and that the university is "working diligently to determine whether our policies have been observed consistently with regard to the matters cited" by Grassley.

The New York Times posted a copy of a 2004 letter from Emory to Nemeroff telling him that he had to limit his Glaxo consulting fees to less than \$10,000 a year to avoid a conflict that would violate federal regulations. This week's letter from Grassley says Glaxo paid Nemeroff more than \$70,000 in 2005 and more than \$30,000 in 2006, according to reports from the company.

Nemeroff didn't return a call from the WSJ, but the university said Nemerov told Emory officials that "to the best of my knowledge, I have followed the appropriate university regulations concerning financial disclosures." Glaxo said it has "rigorous guidelines governing our interaction with healthcare professionals who participate in GSK-supported speaking events," and that it requires them to disclose those relationships.

Grassley has previously investigated similar issues regarding psychiatrists at Harvard, Stanford, the University of Cincinnati and the University of Texas Medical Branch. For more on Grassley's investigations, check out the recent interview from the HealthCare Channel.

The Physician Payment Sunshine Act, which Grassley sponsors, would require drug makers to report payments to doctors. The industry supports the bill—finding it preferable to a patchwork of state laws—which has been working its way through Congress for a while now.

Money and Policy, October 3, 2008

TOP PSYCHIATRIST DIDN'T REPORT DRUG MAKERS' PAY

By Gardiner Harris

One of the nation's most influential psychiatrists earned more than \$2.8 million in consulting arrangements with drug makers from 2000 to 2007, failed to report at least \$1.2 million of that income to his university and violated federal research rules, according to documents provided to Congressional investigators.

The psychiatrist, Dr. Charles B. Nemeroff of Emory University, is the most prominent figure to date in a series of disclosures that is shaking the world of academic medicine and seems likely to force broad changes in the relationships between doctors and drug makers.

In one telling example, Dr. Nemeroff signed a letter dated July 15, 2004, promising Emory administrators that he would earn less than \$10,000 a year from GlaxoSmithKline to comply with federal rules. But on that day, he was at the Four Seasons Resort in Jackson Hole, WY, earning \$3,000 of what would become \$170,000 in income that year from that company—17 times the figure he had agreed on.

The Congressional inquiry, led by Senator Charles E. Grassley, Republican of Iowa, is systematically asking some of the nation's leading researchers to provide their conflict-of-interest disclosures, and Mr. Grassley is comparing those documents with records of actual payments from drug companies. The records often conflict, sometimes starkly.

"After questioning about 20 doctors and research institutions, it looks like problems with transparency are everywhere," Mr. Grassley said. "The current system for tracking financial relationships isn't working." The findings suggest that universities are all but incapable of policing their faculty's conflicts of interest. Almost every major medical school and medical society is now reassessing its relationships with drug and device makers.

"Everyone is concerned," said Dr. James H. Scully Jr., the president-elect of the Council of Medical Specialty Societies, whose 30 members represent more than 500,000 doctors.

Dr. Nemeroff is a charismatic speaker and a widely admired scientist who has written more than 850 research reports and reviews. He was editor-in-chief of the influential journal *Neuropsychopharmacology*. His research has focused on the long-term mental health risks associated with child abuse as well as the relationship between depression and cardiovascular disease.

Dr. Nemeroff did not respond to calls and e-mail messages seeking comment. Jeffrey L. Molter, an Emory spokesman, wrote in an e-mail statement that the university was "working diligently to determine whether our policies have been observed consistently with regard to the matters cited by Senator Grassley."

The statement continued: "Dr. Nemeroff has assured us that: 'To the best of my knowledge, I have followed the appropriate university regulations concerning financial disclosures.'" On Friday night, Emory announced that Dr. Nemeroff would "voluntarily step down as chairman of the department, effective immediately, pending resolution of these issues."

Mr. Grassley began his investigation in the spring by questioning Dr. Melissa P. DelBello of the University of Cincinnati after *The New York Times* reported her connections to drug makers. Dr. DelBello told university officials that she earned about \$100,000 from 2005 to 2007 from eight drug makers, but AstraZeneca alone paid her \$238,000 during the period, Mr. Grassley found.

Then in early June, the Senator reported to Congress that Dr. Joseph Biederman, a renowned child psychiatrist at Harvard Medical School, and a colleague, Dr. Timothy E. Wilens, had reported to university officials earning several hundred thousand dollars each in consulting fees from drug makers from 2000 to 2007, when in fact they had earned at least \$1.6 million each.

Then the Senator focused on Dr. Alan F. Schatzberg of Stanford, president-elect of the American Psychiatric Association, whose \$4.8 million in stock holdings in a drug development company raised concerns.

Mr. Grassley has sponsored legislation called the Physician Payment Sunshine Act, which would require drug and device companies to publicly list payments to doctors that exceed \$500. Several states already require such disclosures.

As revelations from Mr. Grassley's investigation have dribbled out, trade organizations for the pharmaceutical industry and medical colleges have agreed to support the bill. Eli Lilly and Merck have announced that they would list doctor payments next year even without legislation.

The National Institutes of Health have strict rules regarding conflicts of interest among grantees, but the institutes rely on universities for oversight. If a university fails, the agency has the power to suspend its entire portfolio of grants, which for Emory amounted to \$190 million in 2005, although the agency rarely takes such drastic measures.

Dr. Nemeroff was the principal investigator for a 5-year \$3.9 million grant financed by the National Institute of Mental Health for which GlaxoSmithKline provided drugs.

Income of \$10,000 or more from the company in any year of the grant—a threshold Dr. Nemeroff crossed in 2003, 2004, 2005 and 2006, records show—would have required Emory to inform the institutes and take steps to deal with the conflict or to remove Dr. Nemeroff as the investigator.

Repeatedly assured by Dr. Nemeroff that he had not exceeded the limit, Emory did nothing.

“Results from N.I.H.-funded research must not be biased by any conflicting financial interests,” John Burklow, a spokesman for the health institutes, said in the kind of tough statement that in the past has rarely been followed by real sanctions. “Officials at Emory are investigating the concerns.”

“Failure to follow N.I.H. standards” on conflict of interest, Mr. Burklow continued, “is very serious, and N.I.H. will take all appropriate action to ensure compliance.”

In 2004, Emory investigated Dr. Nemeroff's outside consulting arrangements. In a 14-page report, Emory's conflict of interest committee detailed multiple “serious” and “significant” violations of university procedures intended to protect patients.

But the university apparently took little action against Dr. Nemeroff and made no effort to independently audit his consulting income, documents show.

Universities, too, can benefit from the fame and money the deals can bring—a point Dr. Nemeroff made in a May 2000 letter stamped “confidential” that he sent to the dean of Emory's medical school. The letter, which was part of a record from a Congressional hearing, addressed Dr. Nemeroff's membership on a dozen corporate advisory boards (some of the companies' names have since changed).

“Surely you remember that Smith-Kline Beecham Pharmaceuticals donated an endowed chair to the department and that there is some reasonable likelihood that Janssen Pharmaceuticals will do so as well,” he wrote.

“In addition, Wyeth-Ayerst Pharmaceuticals has funded a Research Career Development Award program in the department, and I have asked both AstraZeneca Pharmaceuticals and Bristol-Meyers [sic] Squibb to do the same. Part of the rationale for their funding our faculty in such a manner would be my service on these boards.”

Universities once looked askance at professors who consulted for more than one or two drug companies, but that changed after a 1980 law gave the universities ownership of patents discovered with federal money.

The law helped give birth to the biotechnology industry and led to the discovery of dozens of life-saving medicines. Consulting arrangements soon proliferated at medical schools, and Dr. Nemeroff—who at one point consulted for 21 drug and device companies simultaneously—became a national model.

He may now become a model for a broad reassessment of industry relationships. Many medical schools, societies and groups are considering barring doctors from giving lectures on drug or device marketing.

For all his fame in the world of psychiatry, Dr. Nemeroff has faced ethics troubles before. In 2006, he blamed a clerical mix-up for his failing to disclose that he and his co-authors had financial ties to Cyberonics, the maker of a controversial device that they reviewed favorably in a journal he edited.

The Cyberonics paper led to a bitter e-mail exchange between Dr. Nemeroff and Claudia R. Adkison, an associate dean at Emory, according to Congressional records. Dr. Adkison noted that Cyberonics had not only paid Dr. Nemeroff and his co-authors but had also given an unrestricted educational grant to Dr. Nemeroff's department.

"I can't believe that anyone in the public or in academia would believe anything except that this paper was a piece of paid marketing," Dr. Adkison wrote on July 20, 2006.

Two years earlier, unknown to the public, Emory's conflict of interest committee discovered that Dr. Nemeroff had made more serious blunders, including failing to disclose conflicts of interest in trials of drugs from Merck, Eli Lilly and Johnson and Johnson.

His continuing oversight of a federally financed trial using GlaxoSmithKline medicines led Dr. Adkison to write Dr. Nemeroff on July 15, 2004, that "you must clearly certify on your annual disclosure form that you do not receive more than \$10,000 from GSK."

In a reply dated August 4, Dr. Nemeroff wrote that he had already done so but promised again that "my consulting fees from GSK will be less than \$10,000 per year throughout the period of this N.I.H. grant."

When he sent that letter, Dr. Nemeroff had already earned more than \$98,000 that year from GlaxoSmithKline. Three weeks later, he received another \$3,844.56 for giving a marketing talk at the Passion Fish Restaurant in Woodbury, NY.

From 2000 through 2006, Dr. Nemeroff earned more than \$960,000 from GlaxoSmithKline but listed earnings of less than \$35,000 for the period on his university disclosure forms, according to Congressional documents.

Sarah Alspach, a GlaxoSmithKline spokeswoman, said via e-mail that "Dr. Nemeroff is a recognized world leader in the field of psychiatry," and that the company requires its paid speakers to "proactively disclose their financial relationship with GSK, and we believe that healthcare professionals are responsible for making those disclosures."

<http://www.nytimes.com/2008/10/04/health/policy/04drug.html>

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin G. Hatch (R-Utah) today delivered the following opening statement at a hearing to consider the nomination of Rep. Tom Price (R-Georgia) to head the Health and Human Services (HHS) Department:

Today we will consider the nomination of Dr. Tom Price to be the Secretary of the Department of Health and Human Services.

I want to welcome Dr. Price to the Finance Committee. I appreciate his willingness to serve in a position of this magnitude, especially at this crucial time.

When Obamacare was pushed through on a series of party-line votes, Republicans in Congress warned that the new health law would harm patients, families, and businesses.

Not to put too fine a point on it, but, we were right. And, the next HHS Secretary will play a pivotal role as we work to repeal Obamacare and replace it with patient-centered reforms that will actually address cost. This will be an important endeavor, one that will and should get a lot of attention here today, but it should not be the sole focus of the next HHS Secretary.

HHS has an annual budget of well over \$1 trillion. Let me repeat that: One department, \$1 trillion.

HHS encompasses the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, and many others. It is no exaggeration to say that HHS touches more of the U.S. economy and affects the daily lives of more Americans than any other part of the U.S. Government.

I firmly believe that Dr. Price has the experience and qualifications necessary to effectively lead this large and diverse set of agencies, and many people share that view.

For example, past HHS Secretaries Mike Leavitt and Tommie Thompson strongly support his nomination.

Physician organizations that know Dr. Price's work—including the American Medical Association and most surgical specialty groups—enthusiastically support him. The American Hospital Association and other health-care stakeholder groups do as well.

Perhaps the Healthcare Leadership Council, representing the broad swath of health-care providers, said it best in stating that, "It is difficult to imagine anyone more capable of serving this Nation as the Secretary of HHS than Congressman Tom Price."

Unfortunately, in the current political environment, qualifications, experience, and endorsements from experts and key stakeholders don't seem to matter to some of our colleagues. At least, that appears to be the case, as none of those who say they oppose Dr. Price's nomination seem to be talking about whether he is qualified.

Instead, we've heard grossly exaggerated and distorted attacks on his views and his ethics. On top of that, we've heard complaints and a series of unreasonable demands regarding the confirmation process itself.

Of course, these tactics haven't been limited to Dr. Price. My Democratic friends have taken this approach with almost all of President Trump's cabinet nominees as Senate Democrats' unprecedented efforts to delay and derail the confirmation process and apply a radically new set of confirmation standards has continued unabated.

To that point, let me say this: I have been in the Senate for 40 years and I think my record for being willing to reach across the aisle is beyond any reasonable dispute. In fact, from time to time, I've taken lumps in some conservative circles for working closely with my Democrat colleagues.

I have, on some occasions, voted against confirming executive branch nominees, but far more often than not, I have opted to defer to the occupants of the White House and allow them to choose who serves in their administrations. I've taken some lumps for that too.

I'm not bringing any of this up to brag or to solicit praise from anyone in the audience. I raise all of this today so that people can know I'm serious when I say that I am worried about what my colleagues on the minority side are doing to the Senate as an institution. While the overriding sense of comity and courtesy among Senators has admittedly been in decline in recent years, I have never seen this level of partisan rancor when it comes to dealing with a President from an opposing party. I have never seen a party in the Senate—from its leaders on down—publicly commit to not only opposing virtually every nomination, but to attacking and maligning virtually every single nominee.

Let me be clear: I'm not suggesting that the Senate start rubber-stamping nominees. Nor am I suggesting that any member of the Senate should vote against their conscience or preferences simply out of respect for tradition or deference. What I am saying is that the same rules, processes, courtesies, and assumptions of good faith that have long been the hallmark of the Senate confirmation process should continue to apply regardless of who is President. If what we're seeing now is the new normal for every time control of the White House changes hands, the Senate, quite frankly, will be a much lesser institution.

Unfortunately, our committee has not been entirely immune to the hyper-politicization of the nomination process. We saw that last week with the Mnuchin hearing, and I regret to say that I think we're likely to see more of it today.

Case in point: I expect that, during today's hearing, we're going to hear quite a bit about process, with claims that Dr. Price's nomination is being rushed and that the nominee hasn't been fully vetted.

This is simply untrue.

President Trump announced his intent to nominate Dr. Price just 3 weeks after the election. Dr. Price submitted the required tax returns and completed questionnaire on December 21st. That was 35 days ago, and, by any reasonable standard, that is sufficient time for a full and fair examination of the nominee's record and disclosures.

By comparison, the committee held a hearing on the nomination of Secretary Sebelius 16 days after she submitted her paperwork. For Secretary Burwell, it was 17 days. In other words, the time between the completion of Dr. Price's file and his hearing has been more than that of the last two HHS Secretaries combined. And, by the way, both of those nominees received at least a few Republican votes on this committee and on the floor.

Outside of extraordinary process demands, Dr. Price has faced a number of unfair attacks on both his record as a legislator and his finances.

On the questions surrounding finances, I'll defer on any substantive discussion and first allow Dr. Price to defend himself from what are, by and large, specious and distorted attacks. For now, I'll just say that I hope that my colleagues don't invent new standards for finances, ethics, and disclosure that are different from those that have generally applied in the past.

There is a saying involving both stones and glass houses that might be applicable as well.

With regard to Dr. Price's views and voting record, I'll simply say that virtually all the attempts I've witnessed to characterize Dr. Price's views as being "outside of the mainstream" have been absurd, unless, of course, the only ideas that are in the "mainstream" are those that endorse the status quo on healthcare and our entitlement programs.

In conclusion, I just want to note that the overly partisan treatment of nominees and distortions of their records is a relatively new development on this committee. My hope is that we can begin today to reverse recent trends and have a fair and open discussion of the nominee and his qualifications.

AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION

1445 New York Avenue, NW, Suite 800

Washington, DC 20005-2134

Main: 202-842-3555

Fax: 202-842-4355

Website: www.aad.org

January 30, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The American Academy of Dermatology Association (Academy), which represents more than 13,500 dermatologists nationwide, wishes to express its support for the nomination of Representative Tom Price, M.D., for the position of U.S. Secretary of the Department of Health and Human Services (HHS).

Dr. Price, in his active role in health care policy in Congress as well as his years of service at the state level of government, has demonstrated a proven understanding of the intricate complexities of our nation's health care system. Additionally, as someone who has worked as a practicing physician, Dr. Price would bring to the position of Secretary a personal understanding of how the policies enacted in Washington impact the practice of medicine and delivery of care to patients across the country.

Specifically, Dr. Price understands the importance of the physician-patient relationship and recognizes the critical role that physicians play in the delivery of care to their patients. He has often supported dermatology's position on integrated electronic health care records and the challenges of meaningful use. Dr. Price has also been a leading voice to reduce burdensome regulations which have limited the time physicians can devote to caring for and treating patients.

During his time in Congress, Dr. Price worked with colleagues on both sides of the aisle to enact a new Medicare physician payment system that streamlines multiple reporting requirements for physician practices within Medicare. More recently, with the roll out of the new Medicare Quality Payment Program (QPP), Dr. Price sought input regarding proposed regulations and their potential impact on physicians and

patients, working with stakeholders and advocating with the Centers for Medicare and Medicaid Services (CMS), to help provide flexibility for physician practices both small and large.

The Academy appreciates your consideration of Dr. Price's nomination as Secretary of Health and Human Services, and supports his nomination as Secretary. At this important time in health care for our nation, Dr. Price's experience as a physician and his in-depth understanding of health care policy will provide HHS and our nation the direction needed to guide our health care system as it addresses the needs of a growing and diversifying patient population. Should you have any questions or need additional information, please contact Shawn Friesen, the Academy's Director, Legislative, Political and Grassroots Advocacy at sfriesen@aad.org or (202) 712-2601.

Sincerely,

Abel Torres, M.D., JD, FAAD
President, American Academy of Dermatology Association

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

Kathleen T. Craig, *Executive Director*
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AND

CONGRESS OF NEUROLOGICAL SURGEONS

Regina Shupak, *CEO*
10 North Martingale Road, Suite 190
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Phone: 877-517-1CNS
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info@1CNS.org

January 4, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

SUBJECT: Rep. Tom Price Nomination for HHS Secretary

Dear Chairman Hatch:

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), representing more than 4,000 practicing neurosurgeons in the United States, we are writing in strong support of Representative Tom Price, M.D. (R-GA) to become the next Secretary of the U.S. Department of Health and Human Services (HHS).

Throughout his time in Congress, Dr. Price, an orthopaedic surgeon, has been a staunch advocate for the preservation of the doctor-patient relationship, a fierce protector of private practice, and a stalwart supporter of academic medicine. As a practicing physician, and because of his work on key congressional committees with jurisdiction over health care issues, he understands all aspects of the health care system, which is essential to run HHS effectively.

We have every confidence that Dr. Price will work tirelessly to create a health care delivery system that promotes high-quality, high-value, and better-coordinated care for our nation's patients. We, therefore, urge the Senate Finance Committee to favorably report Dr. Price's nomination to the full Senate vote swiftly.

Thank you for considering our views.

Sincerely,

Frederick A. Boop, M.D., President
American Association of Neurological
Surgeons

Alan M. Scarro, M.D., President
Congress of Neurological Surgeons

Staff Contact:

Katie O. Orrico, Director
 AANS/CNS Washington Office
 725 15th Street, NW, Suite 500
 Washington, DC 20005
 Direct: 202-446-2024
 Email: korrico@neurosurgery.org

AMERICAN PODIATRIC MEDICAL ASSOCIATION (APMA)
 9312 Old Georgetown Road
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 Fax: 301-530-2752
[https://www.apma.org/](http://www.apma.org/)

January 11, 2017

The Honorable Orrin Hatch
 Chairman
 Committee on Finance
 U.S. Senate
 219 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Ron Wyden
 Ranking Member
 Committee on Finance
 U.S. Senate
 219 Dirksen Senate Office Building
 Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The American Podiatric Medical Association (APMA) respectfully requests your Committee affirmatively recommend Representative Thomas Price, M.D., to the full Senate for Secretary of Health and Human Services (HHS). Founded in 1912, the APMA is the leading organization and represents the majority of the estimated 15,000 podiatrists in the country.

Dr. Price is highly qualified for this position and brings years of experience as a physician and the leading health policy expert in Congress. Dr. Price has been supportive of policies that will free providers of overly burdensome regulations which hinder the delivery of care to patients and has encouraged additional pathways for providers to play a more significant role in regulatory decision-making. He has consistently provided healthcare solutions that are patient-centered and emphasize consumer choice, which will be critical as Congress moves forward with changes to the Patient Protection and Affordable Care Act.

Again, we support the nomination of Congressman Tom Price as HHS Secretary and ask for your favorable consideration.

Sincerely,
 R. Dan Davis, DPM
 President

CORINTHIAN MEDICAL IPA
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www.corinthianmedicalipa.com

January 16, 2017

The Honorable Lamar Alexander
 Chairman,
 Committee on Health, Education, Labor, and Pensions
 U.S. Senate
 Washington, DC 20510

Re: Letter in support of Dr. Tom Price

Dear Honorable Lamar Alexander:

I have practiced medicine in the United States for 25 years. Throughout that time, I have focused my practices exclusively on improving outcomes for lower-income communities, who face extreme health disparities in our current system. Many of my patients are immigrants; and I am proudly an immigrant myself.

Today, I head a nonprofit network, Advocate Community Providers. We consist of over 2,000 physicians and healthcare providers and are responsible for over 700,000 lives across four boroughs in New York City. To put this population in perspective, this is larger than the populations of all but the seventeen largest cities in the country. Nearly all of our patients are Medicaid recipients; most are concentrated in the Hispanic and Asian communities. Our network came together as a result of New York's transformative Delivery System Reform Incentive Payment program, or DSRIP, which uses state and federal dollars to cut costs stemming from unnecessary hospital usage by lower-income patients by switching to a community-based preventative care system as opposed to one that depends on emergency room visits, and switching a value-based system instead of one based on exorbitant fee-for-service.

I have had the opportunity to meet with Congressman Tom Price last year in New York; Dr. Price was particularly interested in knowing about health-care issues and care-enhancing, cost-saving methods that are showing promise in lower-income communities in New York, especially regarding the DSRIP initiative.

I sincerely support his nomination and I hope that after his confirmation as Secretary of Health and Human Services, he will look closely at our work and this model and that we can work together to discuss support and scalability. The reforms that my network and the 24 other similar networks in New York are pioneering can and should be thoughtfully considered in urban areas and rural states alike with heavy Medicaid populations. We stand ready to work with him.

There is no question that a new Administration taking office presents a key opportunity. Hopefully, it will be a historic moment for a renewed national dialogue on health-care reform that is apolitical and places patients first. The eventual outcome is uncertain, but there is no doubt that the Affordable Care Act will undergo significant changes. No matter the changes, I hope that Dr. Price and President-Elect Trump will be as committed to raising outcomes and creating healthier, stronger and more prosperous communities through better quality care and lower expenditures as the previous administration. I trust that they share that goal, and as a doctor who has worked in the Medicaid network, I can confirm that using this system as the place to make change is where the strongest potential exists.

I look forward to welcoming Dr. Price back to New York this year and convening a round table of providers who are leading on care-enhancing, cost-saving reforms that can flourish anywhere. I hope to serve as a laboratory for results that will have positive national implications and that Dr. Price and the Department of Health and Human Services will take every advantage of under his leadership.

With regards,

Dr. Ramon Tallaj
Chairman, Corinthian Medical IPA (CMIPA) (ACP)

STATE OF GEORGIA
Office of the Governor
Atlanta 30334-0090

Nathan Deal
Governor

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

January 23, 2017

Dear Chairman Hatch and Senator Wyden:

It is with great pride that I write to you to support the nomination of Congressman Tom Price, M.D. as the Secretary of Health and Human Services. As an orthopaedic surgeon, in private practice for twenty years, Rep. Price knows firsthand the intricacies of the healthcare landscape. Representative Price has served in both the State Senate and as a Representative for Georgia's 6th District. During this time, he has become a champion for healthcare. As such, he is uniquely situated to serve as the Secretary for Health and Human Services. Representative Price has been working for the past several years to craft a solution to the many woes of the Affordable Care Act, passed and signed into law in 2010.

As a Governor, charged with balancing a state budget, I know the many challenges that the Affordable Care Act has brought to states like Georgia. Since taking office, we have seen the portion of our state budget consumed by health expenses continue to grow. Continued growth in healthcare expenses means that other critical spending areas like education, transportation, and public safety are put at risk.

I look forward to the confirmation of Representative Price so that Georgia can craft a Medicaid program that is sustainable and best suited to fit the needs of our unique population.

Sincerely,
Nathan Deal

GRADY HEALTH SYSTEM
80 Jesse Hill Jr. Drive, SE
Atlanta, GA 30303
(404) 616-1000
www.gradyhealth.org

January 20, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

It is an honor to submit these comments as you deliberate the confirmation of Dr. Tom Price, M.D. as this country's next Secretary of Health and Human Services. I am Chairman of the Grady Health System Board of Directors (Grady Memorial Hospital) in Atlanta, Georgia, one of the largest, essential safety net health systems in the country. Grady has a vital stake in the future of this Nation's healthcare policy.

Grady was founded with a mission to care for the underserved and is celebrating its 125th anniversary this year. Our health system consists of the 953-bed Grady Memorial Hospital, 6 neighborhood health centers, Crestview Health and Rehabilitation Center, and Children's Healthcare of Atlanta at Hughes Spalding, which is operated as a Children's affiliate. In 2016, Grady had over 620,000 patient visits, including more than 130,000 emergency room visits. Over 28% of our patients are uninsured, 28% are covered by Medicaid, and 24% are enrolled in Medicare. The remainder have other forms of coverage, including commercial insurance.

With its nationally acclaimed emergency medical services, Grady has the premier level I trauma center in all of North Georgia and serves as the 911 ambulance provider for the city of Atlanta and six rural counties. Grady's American Burn Association/American College of Surgeons verified Burn Center is one of only two in the State. And the Marcus Stroke and Neuroscience Center is a Joint Commission designated Advanced Comprehensive Stroke Center.

Other key services include Grady's Regional Perinatal Center with its Neonatal Intensive Care Unit, Georgia's first Cancer Center for Excellence, The Avon Breast

Health Center, the Georgia Comprehensive Sickle Cell Center, and the Ponce de Leon Center—one of the top three HIV/AIDS outpatient clinics in the country.

As the cornerstone of healthcare in Atlanta, Grady serves Americans from every walk of life in every possible circumstance and does it with limited resources. Grady's funding, like other safety net hospitals in the country, is often determined by the changing priorities of government—local, State or Federal. And it's the place where changes in public policy can have an immediate and direct impact on the lives of our patients and the hospital's ability to meet the demand for services.

Dr. Price completed his residency program in orthopedics at Grady and later returned to serve as Medical Director of the Orthopedics Clinic. We believe there is no better training or opportunity to gain personal perspective on the health-care needs of all Americans than working at a safety net institution like Grady. While at Grady, Dr. Price trained the next generation of clinicians and provided care to the vulnerable—particularly the uninsured and Georgia's Medicaid recipients.

No clinician has been in charge of our Nation's health-care system since Dr. Louis Sullivan, a former board member of Grady. With so much change being contemplated and considered in both houses of Congress, it reassures us to know that Dr. Price will view changes in policy with Grady and the community we serve in mind.

As our Nation continues to discuss how best to deliver health care to all Americans, but especially to the indigent and uninsured, we believe Dr. Price's experience as a physician at Grady will serve him well. We are grateful for Dr. Price's work with us throughout his time in public office. We look forward to working with him in this important role to improve access to care for all Americans.

Sincerely,
Francis S. Blake
Chairman

NATIONAL CONFECTIONERS ASSOCIATION (NCA)
1101 30th Street NW, Suite 200
Washington, DC 20007
(202) 534-1440
<https://www.candyusa.com/>

January 13, 2017

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor,
and Pensions
U.S. Senate
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor,
and Pensions
U.S. Senate
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairmen Hatch and Alexander, Senator Wyden, and Senator Murray:
I am writing to you to express support from the National Confectioners Association in regard to the nomination of Representative Tom Price as Secretary of the Department of Health and Human Services.

The National Confectioners Association is the trade organization representing the \$35 billion U.S. chocolate, candy, gum and mints industry. Confectionery is manufactured in all 50 states, directly employing 55,000 workers in more than 1,000 facilities. In addition to these jobs in manufacturing, the industry supports an additional 410,000 U.S. jobs in fields like retail, transportation and agriculture. The confectionery industry generates more than \$10 billion in U.S. taxes and more than \$2 billion in exports annually.

Dr. Price's experiences as a surgeon and his significant legislative background at the state and federal levels have uniquely positioned him to lead the Department. His

considerable experience will also have a positive influence on the Food and Drug Administration, an agency with significant oversight on regulations that impact the confectionery industry. Dr. Price is a principled man and strong leader who will underscore the importance of making policy using the best science available after thorough and practical deliberation.

NCA respectfully asks for Dr. Price's prompt consideration by both of your committees and confirmation by the United States Senate as our next Secretary of the Department of Health and Human Services.

Sincerely,

John H. Downs, Jr.
President and CEO

SMALL BUSINESS AND ENTREPRENEURSHIP COUNCIL (SBE COUNCIL)
301 Maple Avenue West, Suite 100
Vienna, VA 22180
(703) 242-5840

January 23, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor,
and Pensions
U.S. Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate

The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor,
and Pensions
U.S. Senate

Dear Chairmen Hatch and Alexander, and Ranking Members Wyden and Murray:
On behalf of the Small Business and Entrepreneurship Council (SBE Council) and our more than 100,000 members nationwide, I am writing to express our strong support for the confirmation of U.S. Representative Tom Price, M.D. as Secretary of the U.S. Department of Health and Human Services (HHS).

Congressman Price is a serious and successful physician, legislator, and policy thought leader who naturally transferred his Hippocratic Oath to policymaking and legislative initiatives across many areas. Over the course of his career in Congress, he has worked hard to propose and fight for policies that empower and help all Americans, while warning against those that do harm and undermine opportunity.

Congressman Price is a great friend of entrepreneurs and small business America, and understands that government policies and actions—if not carefully thought through—can take a disproportionate toll on the ability of small businesses to compete, grow, innovate and create jobs. Regarding health care policy, his insights and experience have been invaluable in developing positive solutions, while also correctly warning about the unintended consequences of poor policy or actions.

Congressman Price has been a leader on common sense reforms to lower health costs, improve quality, drive more choice and innovation in the market, and create true access for all health care consumers. His “do no harm” ethic is extraordinarily important now as the Congress and policymakers carefully unwind a health care law that has undermined people’s health, access to health coverage, as well as their personal finances. Small businesses and the self-employed have especially been burdened by the higher costs and limited choices that have resulted from the Affordable Care Act.

Congressman Price is the right person, with the precise set of skills, experience and temperament to guide us to a system where all people have access to high quality, affordable care, and a system that is innovating for the future. This is a system—a market—that desperately needs more entrepreneurial ideas, but excessive regulation and government control are barriers that prevent the type of rapid innovation we are benefitting from in other industries and sectors.

SBE Council strongly supports Congressman Price's confirmation, and we urge the Senate to move quickly on a full vote to ensure HHS has the leadership it needs in many important areas, including navigating the type of reforms we need to make health coverage more affordable and competitive for the self-employed, small busi-

nesses and their employees. Please do not hesitate to contact me if you have questions about SBE Council's support for Congressman Price's confirmation as HHS Secretary.

Sincerely,
 Karen Kerrigan
 President and CEO

SCOTT WALKER
 Office of the Governor
 State of Wisconsin
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January 17, 2017

The Honorable Orrin Hatch
 Chairman
 Committee on Finance
 U.S. Senate

The Honorable Lamar Alexander
 Chairman
 Committee on Health, Education, Labor,
 and Pensions
 U.S. Senate

Dear Chairmen Hatch and Alexander, and Ranking Members Wyden and Murray:
 I write today in support of President-elect Trump's nomination for Secretary of the U.S. Department of Health and Human Services, Dr. Tom Price.

Secretary-designee Price is uniquely positioned to work with Wisconsin and other states to reform health care and help curb years of federal overreach. In addition to his leadership roles in congress, he spent more than 20 years caring for patients in Georgia as an orthopaedic surgeon and medical professional. If confirmed, Dr. Price will bring years of medical knowledge and federal lawmaking experience to the department.

In Wisconsin, we share Dr. Price's commitment to quality healthcare as we rank one of the best states in the nation for health insurance coverage and our reforms allowed us to cover everyone living in poverty under Medicaid. His decades of medical knowledge and firsthand experience as a licensed physician and orthopaedic surgeon, combined with his years as a lawmaker make him the perfect candidate to begin tackling critical reforms to empower the states.

Again, I strongly support the confirmation of Dr. Price as the next U.S. Health and Human Services Secretary. I look forward to working with him in this new role.

Sincerely,
 Scott Walker
 Governor of Wisconsin

SUBMITTED BY HON. DEAN HELLER, A U.S. SENATOR FROM NEVADA

Nevada Legislature

January 10, 2017

The Honorable Dean Heller
 324 Hart Senate Office Building
 Washington, DC 20510

Dear Senator Heller:

We are writing to express our concern regarding plans to repeal the Affordable Care Act. Specifically, we are concerned that Republicans in Congress are pushing ahead with a repeal of the Affordable Care Act despite having no viable replacement legislation ready to enact.

Failure to immediately enact replacement legislation risks creating uncertainty in the insurance marketplace. Such uncertainty will likely result in higher out-of-pocket costs and fewer insurance options for Nevada's families while simultaneously placing an increased burden on our State budget.

As you are aware, Governor Sandoval worked closely with the Legislature and ultimately signed legislation creating the Silver State Health Exchange in 2011. Subsequently, more than 300,000 Nevadans have gained access to health care coverage, either by purchasing it on the exchange or by meeting the expanded Medicaid eligibility requirements.

In light of these facts, we hope that you will address the following questions regarding the planned repeal of the Affordable Care Act:

1. What steps do you plan to take to ensure that the more than 88,000 Nevadans who have purchased health insurance through the Silver State Health Exchange continue to have the ability to purchase health insurance with adequate coverage in a transparent marketplace?
2. What steps do you plan to take to ensure that the more than 77,000 Nevadans who are eligible for Federal tax credits under the Affordable Care Act to help purchase private insurance will continue to have access to affordable health insurance options with adequate coverage?
3. What steps do you plan to take to ensure that the 217,000 Nevadans who are receiving health care under the Medicaid expansion remain covered?
4. The Affordable Care Act guarantees coverage vital to preventative services for women, including cancer screenings and birth control. What steps do you plan to take to ensure that the Affordable Care Act's coverage guarantees remain intact for women's health?
5. The Affordable Care Act guarantees that Nevadans with pre-existing conditions will not be denied health care and ends lifetime minimums on coverage. It also allows younger people, many of whom are saddled with college debt and cannot afford insurance, to stay on their parents' insurance until they are 26. What steps do you plan to take to preserve those coverage guarantees?

The lack of clarity regarding viable alternatives to the Affordable Care Act from the incoming administration and Republican congressional leadership is troubling. While Congress has expended considerable time and energy over the past several years talking about the law, hundreds of thousands of Nevadans have relied in good faith on the Affordable Care Act to obtain health insurance. Repealing the law without implementing an adequate replacement will put those Nevadans' health and well-being at risk.

Further, any congressional action that creates a large gap in insurance coverage will likely result in more Nevadans relying on state-funded social service programs. Most of these programs are already under resourced. Nevada cannot afford to shoulder this new financial burden created by politicians in Washington failing to live up to guarantees that the Federal Government previously made to our citizens.

We hope you will use your position as Nevada's senior U.S. Senator and a member of the majority party to protect the thousands of Nevada families who are now at risk of losing their health insurance. We also hope you will take steps to ensure that our State does not bear any unfair and unnecessary costs of caring for people who stand to lose that coverage in the near future.

We look forward to your prompt reply.

Sincerely,

Aaron D. Ford
Majority Leader
Nevada State Senate

Jason Frierson
Speaker
Nevada State Assembly

SUBMITTED BY HON. CLAIRE McCASKILL, A U.S. SENATOR FROM MISSOURI

Table T16-0285

Repeal all ACA Taxes, Including Premium Credits

Baseline: Current Law

Distribution of Federal Tax Change by Expanded Cash Income Level, 2017¹
Summary Table

<http://www.taxpolicycenter.org/>

Expanded Cash Income Level ²	Tax Units with Tax Increase or Cut ³				Percent Change in After-Tax Income ⁴	Share of Total Federal Tax Change	Average Federal Tax Change (\$)	Average Federal Tax Change (% Points)	Average Federal Tax Rate ⁵					
	With Tax Cut		With Tax Increase											
	Pct. of Tax Units	Avg. Tax Cut	Pct. of Tax Units	Avg. Tax Increase										
Less than 10	7.3	-1,150	0.0	7,140	1.6	3.5	-80	-1.5	5.3					
10-20	6.6	-1,210	4.2	3,850	-0.5	-5.8	80	0.5	2.6					
20-30	7.2	-960	9.9	4,020	-1.3	-22.1	320	1.3	4.4					
30-40	41.6	-170	9.2	4,600	-1.1	-18.2	350	1.0	7.7					
40-50	83.9	-90	6.1	5,630	-0.6	-11.2	260	0.6	10.4					
50-75	93.6	-100	3.1	6,400	-0.2	-8.3	100	0.2	13.1					
75-100	97.3	-140	1.3	5,840	0.1	3.1	-60	-0.1	15.6					
100-200	98.8	-190	0.4	6,540	0.1	14.8	-160	-0.1	18.8					
200-500	99.8	-540	0.0	8,320	0.2	18.0	-540	-0.2	23.0					
500-1,000	99.9	-4,590	0.0	0	0.9	17.9	-4,580	-0.7	28.0					
More than 1,000	99.9	-50,200	0.0	0	2.2	108.4	-50,130	-1.5	32.6					
All	60.0	-600	3.8	4,720	0.3	100.0	-180	-0.2	19.6					

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0516-2).

Number of AMT Taxpayers (millions). Baseline: 5.5; proposal: 5.5.

* Non-zero value rounded to zero. ** Insufficient data.

¹ Calendar year. Baseline is current law. Proposal would repeal all ACA taxes: the 3.8 percent Net Invest Income Tax, the 0.9 percent additional HI tax, the excise tax on employers offering inadequate health insurance coverage, the excise tax on individuals without adequate health insurance, the increase in threshold for medical expense deductions, and the excise taxes on health insurance providers, pharmaceutical manufacturers and importers, and medical device manufacturers and importers. Analysis includes the Premium Tax Credit which is not treated as a tax in the TPC baseline due to its similarity to a spending program. Simulations of Premium Tax Credit calibrated to match results from Urban Institute's Health Insurance Policy Simulation Model (HIPSM). For a description of TPC's current law baseline, see <http://www.taxpolicycenter.org/tactomics/BaseLine-Definitions.cfm>.

² Includes both filing and non-filing units but excludes those that are dependents of other tax units. Tax units with negative adjusted gross income are excluded from their respective income class but are included in the totals. For a description of expanded cash income, see <http://www.taxpolicycenter.org/TaxModel/income.cfm>.

³ Includes tax units with a change in federal tax burden of \$10 or more in absolute value.

⁴ After-tax income is expanded cash income less: individual income tax net of refundable credits, corporate income tax, payroll taxes (Social Security and Medicare), estate tax, and excise taxes.

⁵ Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, the estate tax, and excise taxes) as a percentage of average expanded cash income.

A Premium Support System for Medicare: Analysis of Illustrative Options

Summary

Over the past two decades, numerous proposals have been advanced for the establishment of a premium support system for Medicare. Under such a program, beneficiaries would purchase health insurance from one of a number of competing plans, and the federal government would pay part of the cost of the coverage. The various proposals have differed in many respects, including the way in which the federal contribution would be set and how that contribution might change over time.

This Congressional Budget Office (CBO) report presents a preliminary analysis of the ways two illustrative options for a premium support system would affect federal spending and beneficiaries' choices and payments. The agency has developed significant new tools to analyze such a system in greater depth than in the past; the specifications of the options examined here also differ from those CBO analyzed previously. As the agency refines its modeling approach and considers alternative options for a premium support system, its findings could change. CBO's analysis to date indicates the following:

- Both options for premium support considered here would reduce federal spending for Medicare net of beneficiaries' premiums and other offsetting receipts.
- Under the *second-lowest-bid* option, the option with the greater reduction in net federal spending, beneficiaries' premiums and total payments for Medicare's Part A and Part B benefits would each be higher on average than they would be under current law. (Total payments consist of premiums and out-of-pocket costs for deductibles, copayments, and coinsurance.) Under the *average-bid* option, the option with the smaller reduction in net federal spending, those amounts would each be lower on average than they would be under current law.
- Under both options, combined spending by the federal government and by beneficiaries (that is, premiums and out-of-pocket costs) would be less than that if current law remained in place.
- Under both options, effects on premiums and total payments for some beneficiaries would differ greatly from the national averages. In particular, in most regions, the premiums and total payments of beneficiaries enrolled in the fee-for-service (FFS) program would be higher than they would be under current law.
- Alternative specifications for key features of a premium support system would yield different results.

What Premium Support Options Did CBO Analyze?

The two premium support options analyzed in this report differ in terms of the formula by which the federal contribution would be determined. Otherwise, they are very similar. The nation would be divided into regions within which competing private insurers would submit bids indicating the amounts they would accept to provide Medicare benefits to a beneficiary of average health. The FFS program would be part of the system as a competing plan, and its "bid" would be based on the projected FFS spending for an enrollee of average health in a given region. Insurers would bid to provide a benefit package that would encompass the same services covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare under current law and that would have the same actuarial value as Parts A and B combined (that is, each package would cover the same percentage of total expenses for a given population that Medicare's FFS program would cover under current law). Beneficiaries who were eligible for the premium support system would not

Notes: Unless otherwise indicated, the years referred to in this report are calendar years. The estimates for the next 10 years were generated using the Congressional Budget Office's March 2012 baseline projections of Medicare spending, and the analysis of longer-term effects was based on the agency's June 2012 long-term projections of Medicare spending. (Those were the most recent projections available when much of the analysis was performed.)

Numbers in the text, figures, and tables may not add up to totals because of rounding.

be permitted to enroll in Part C (the current Medicare Advantage system, offered by private insurers that contract with Medicare to provide Part A and Part B benefits). Part D (Medicare's prescription drug benefit program), which is now delivered through a competitive system, would continue as it is under current law and would be administered separately from the new program.

The federal government would pay insurers for each enrollee who was in average health an amount that was equal to a "benchmark" set for that region minus the standard premium paid by enrollees; insurers would receive larger or smaller government payments for beneficiaries whose health was worse or better than average. Beneficiaries who enrolled in a plan with a bid that equaled the benchmark would pay the plan a standard premium, which would equal one-quarter of the estimated cost of providing the Part B portion of benefits and would be the same across the nation (set by the same formula as that used under current law for the Part B premium). Beneficiaries who chose a plan with a bid less than the benchmark would pay a premium that was lower by the full amount of the difference between the bid and the benchmark, and those who chose a more expensive plan would pay a premium that was correspondingly higher.

The benchmarks that would be used to set the federal contribution are the defining features of the two options CBO examined:

- Under the second-lowest-bid option, the benchmark in a region would be the lower of a pair of bids—the region's second-lowest bid submitted by a private insurer and Medicare's FFS bid.
- Under the average-bid option, the benchmark in a region would be the weighted average of all bids, including the FFS bid. Each bid would be weighted by the proportion of beneficiaries enrolled in that plan in the year immediately preceding.

CBO assumed that no cap would be imposed on the amount or the rate of growth of the federal contribution and that insurers would be required to provide coverage to all beneficiaries who selected a particular plan.

The agency made detailed assumptions about many other specifications of the premium support system. Some were chosen to illustrate the potential for savings from a highly competitive system; others were chosen for feasibility of implementation or to simplify the analytical process. The specifications adopted for this analysis are not recommendations, and many alternative specifications are possible.

For this analysis, CBO assumed that dual-eligible beneficiaries—people who are simultaneously enrolled in Medicare and Medicaid—would be excluded from the premium support system and that federal spending for their health care would continue as it would under current law. Anyone else who was enrolled in Medicare when the premium support system was implemented (assumed to be 2018 for this report) would enter the system immediately, and anyone other than dual-eligible beneficiaries who became eligible subsequently would enroll in the new system. (See below for a brief discussion of policy alternatives that would exclude certain other Medicare beneficiaries from a premium support system.) The starting date of 2018 was chosen to allow for a period during which the federal government could develop the necessary administrative structures and beneficiaries and insurers could learn about and prepare for the new system.

How Would the Premium Support Options Affect Federal Spending?

CBO estimates that the second-lowest-bid option would reduce net federal spending for Medicare by about \$45 billion in 2020 and that the average-bid option would reduce such spending in that year by about \$15 billion (see Table 1). For this analysis, CBO reports those effects as a percentage of two different measures of spending projected under current law: net federal spending on Medicare as a whole and net federal spending on Medicare's Part A and B benefits for beneficiaries who would be affected by the options (that is, everyone other than dual-eligible beneficiaries who would have enrolled in Medicare under current law).

- Net federal spending for Medicare is total Medicare spending, including spending on dual-eligible beneficiaries and prescription drugs covered by Part D, minus beneficiaries' premiums and other offsetting receipts. The second-lowest-bid option would reduce that spending in 2020 by 6 percent and the average-bid option would reduce that spending by 2 percent, CBO estimates.
- Net federal spending on Medicare Part A and B benefits for affected beneficiaries includes amounts that would be paid for hospital and medical benefits provided by the FFS program and private plans under current law and the premium sup-

port options, but excludes net spending for dual-eligible beneficiaries, Part D benefits, and certain items and services that are not covered by the bids of Medicare Advantage plans under current law. Beneficiaries' premiums and other offsetting receipts are subtracted from that amount to arrive at net spending. The second-lowest-bid option would reduce such spending in 2020 by 11 percent and the average-bid option would reduce such spending by 4 percent, CBO estimates. Those percentages are larger than the percentages for total Medicare spending because the savings are measured relative to the portion of Medicare spending that would be for the beneficiaries who are directly affected by the premium support system rather than to total Medicare spending.

Federal savings under either option would be substantially lower over an extended period if all current beneficiaries stayed in the existing Medicare system and only new enrollees participated in the premium support system.

The savings to the federal government would stem, in part, from greater price competition. Because all plans would offer a basic benefit package covering the same services and having the same actuarial value and because the government's contribution within a region would not vary from plan to plan (except to adjust for differences in the health status of enrollees), the full difference between plans' bids would be reflected in the premiums that enrollees would pay. Thus, the two options would generate more price competition among private insurers than would be the case under current law, which would induce insurers to offer plans with lower premiums as a way to attract more enrollees. To reduce premiums, private insurers could, for example, strengthen utilization management (which insurers use to control costs by influencing the quantity and type of services provided) or tighten provider networks (that is, limit the number of providers to be covered by a plan). In most regions, the benchmark would be lower under the second-lowest-bid option than under the average-bid option, so the federal contribution for a plan with a given bid would be lower, and the premium would be higher under the second-lowest-bid option.

Heightened price competition would probably restrain the growth of Medicare spending over the long term by curtailing demand for costly new technologies and treatments and by boosting demand for technologies that reduced costs—although the magnitude of any such changes is highly uncertain. Those effects on the growth of spending would be larger under the second-lowest-bid option than under the average-bid option, CBO anticipates, because the higher premiums under the second-lowest-bid option would cause a larger fraction of beneficiaries to choose private plans with lower bids.

Under current law, the growth of Medicare spending will be restrained in other ways during the next two decades, thus limiting the potential for the government to realize further savings from a premium support system. For example, updates to Medicare's payment rates for most providers in the FFS program are generally scheduled to be smaller than the increases in the costs of their inputs (such as labor and equipment), and the federal government has broad authority under current law to make regulatory changes to expand demonstration projects that successfully reduce spending for Medicare. How effective the various incentives and possible administrative actions under current law ultimately will be at restraining growth in spending, however, is not known.

CBO estimates that the rate of growth in Medicare spending in the 2020s under the two premium support options would be similar overall to the rate under current law. Thus, the estimated savings relative to current law would be roughly the same in percentage terms throughout that period as in 2020, although the dollar amount of the savings would increase. That estimate is subject to considerable uncertainty but, in CBO's judgment, lies in the middle of the distribution of possible outcomes. Beyond the next two decades, the federal savings from the premium support system would probably increase slightly in percentage terms, but CBO has not quantified the amounts because the uncertainties are even greater for that longer period.

How Would the Premium Support Options Affect Beneficiaries' Premiums?

CBO estimates that the premiums that affected beneficiaries would pay for Medicare Part A and B benefits under the second-lowest-bid option in 2020 would be about 30 percent higher, on average, than the current-law Part B premium projected for that year. CBO expects that much of the increase would occur because many beneficiaries would remain in the FFS program and pay much higher premiums than would be the case under current law. Two-fifths of the beneficiaries who chose the FFS program would spend at least 6 percent of their household in-

come on premiums for each beneficiary, CBO estimates. (For comparison, CBO estimates that under current law about one-fifth of FFS enrollees would do so.)

In contrast, under the average-bid option, affected beneficiaries would pay premiums that were 6 percent *lower*, on average, than the current-law Part B premium in 2020. Because of the higher federal contribution, premiums would be substantially lower under the average-bid option than they would be under the second-lowest-bid option. The impact of either option on premiums would vary geographically, depending on regional differences in plans' bids.

Because CBO estimates that total Medicare spending would be reduced under either option, and the standard premium would equal the same share of spending that the Part B premium equals under current law, the standard premium under either premium support option would be lower than the current-law Part B premium. In each region, beneficiaries would be offered at least one plan at or below the standard premium (given the manner in which the regional benchmarks would be calculated), and in most cases, at least one plan with a premium that is below (not just at) the standard premium would be offered, CBO anticipates. Beneficiaries who chose such a low-cost plan would pay a lower premium than they would under current law. (Beneficiaries subject to the income-related premium under current law—that is, the additional Part B premium required of beneficiaries whose income exceeds specified thresholds—would still be required to pay that additional amount.)

Under both options, most beneficiaries who wanted to remain in the FFS program would face higher premiums than they would for private plans. In addition, in many regions, the bid for the FFS program would exceed the benchmark, so beneficiaries who chose to remain in the FFS program would pay higher premiums than they would under current law. Although many beneficiaries would switch to lower-bidding private plans, CBO estimates, a substantial proportion of beneficiaries would still prefer to remain in the FFS program.

How Would the Premium Support Options Affect Beneficiaries' Total Payments for Medicare Services?

CBO's analysis of beneficiaries' total payments focuses on premiums and out-of-pocket costs for deductibles, copayments, and coinsurance for Medicare's Part A and B benefits for affected beneficiaries. The analysis accounts for the loss of the federally subsidized supplemental benefits that enrollees in Medicare Advantage plans would receive under current law (projected to average about \$400 per enrollee annually in 2020), which would not be available under the options analyzed here. In 2020, beneficiaries' total payments would be about 11 percent higher, on average, under the second-lowest-bid option and about 6 percent lower, on average, under the average-bid option than they would be under current law (see Table 2).

Under the second-lowest-bid option, the premiums that beneficiaries would pay generally would be higher than current-law premiums, but out-of-pocket costs generally would be lower than under current law because more beneficiaries would enroll in lower-bidding private plans, which would tend to reduce the total costs of care while maintaining the required actuarial value. The lower out-of-pocket costs would offset part, but not all, of the increase in premiums. (On average, according to CBO's estimates, out-of-pocket costs would account for a higher share of beneficiaries' total payments than premiums would, but under the second-lowest-bid option, they would decline by a smaller percentage than premiums would increase relative to amounts under current law.)

Under the average-bid option, the estimated reduction in beneficiaries' total payments results from the combination of lower average premiums and lower out-of-pocket costs. As with the second-lowest-bid option, the difference in out-of-pocket costs would be attributable primarily to increased enrollment in lower-bidding private plans.

Under both options, the change in total payments for particular beneficiaries could differ markedly from the national average. For example, those who chose to remain in the FFS program would generally face higher premiums and would not see a reduction in out-of-pocket costs.

How Would the Premium Support System Affect Combined Spending by the Government and by Beneficiaries?

The sum of net federal spending for Medicare and beneficiaries' total payments as discussed above would be about 5 percent lower in 2020 under the second-lowest-bid option than under current law, CBO estimates. Under the average-bid option, combined payments would be about 4 percent lower than under current law. The

estimated effects under both options are measured as a percentage of projected net federal spending and beneficiaries' total payments for benefits covered by Parts A and B, in each case focusing on the beneficiaries who would be affected by the premium support system. The second-lowest-bid option would yield slightly more savings overall than would accrue from the average-bid option because the smaller federal contribution under the second-lowest-bid option would increase competitive pressure. The federal savings under the second-lowest-bid option would be much larger than those under the average-bid option, but beneficiaries' payments would be higher.

What Are the Implications of a “Grandfathering” Provision in a Premium Support System?

Under some premium support proposals, all beneficiaries who became eligible for Medicare before the system took effect would remain in the current-law Medicare program and only those who became eligible after that time would enroll in the premium support system. Such an arrangement would substantially reduce federal savings relative to a system without a grandfathering provision—for an extended period—because, in the early years, only a small portion of the Medicare population would be covered under the new system. Moreover, because newly eligible beneficiaries entering the system would have health care costs that were lower than the average for Medicare beneficiaries as a group, the potential savings would be limited even more.

CBO estimates that if a premium support system began in 2018 and existing Medicare beneficiaries remained in the current system, only about 25 percent of the Medicare population would be covered under the new system after five years (assuming dual-eligible beneficiaries were excluded), and those beneficiaries would account for only about 15 percent of net Medicare spending in total for that year under current law (including spending for dual-eligible beneficiaries and for Part D). After 10 years, about 45 percent of the Medicare population would be covered, accounting for about 30 percent of net Medicare spending in total.

Although in order to simplify the modeling, CBO decided for this analysis not to consider grandfathering provisions, the agency expects to complete such a study soon. A very rough approximation (made on the basis of the estimated share of Medicare spending that would be covered each year) suggests that federal savings after five years of operation under a system with grandfathering would be about 15 percent of the savings achieved if all beneficiaries other than those with dual eligibility entered the new system in 2018; after a decade, about 30 percent of those savings would be realized.

Thus, the cumulative savings would be substantially less than would be possible if all beneficiaries entered a premium support system immediately. Grandfathering also would reduce, for an extended period, the incentives to modify the development and adoption of new technologies, so the restraint in the growth of Medicare spending that would probably occur under a premium support system would be substantially smaller for many years.

What Key Specifications of a Premium Support System Would Affect Federal Spending and Beneficiaries' Payments?

On the basis of its preliminary analysis, CBO identified several important features of premium support proposals that would significantly affect federal spending and beneficiaries' payments:

- A smaller federal contribution would yield greater federal budgetary savings; on average, beneficiaries' premiums would be higher, however.
- Including the FFS program as a competing plan would boost federal savings, both because the rates the program pays providers (which generally are below rates paid by commercial plans) would serve to hold down the rates paid by competing private insurers and because in some regions the FFS program would be the lowest-bidding plan and therefore could lower the benchmark relative to what it would be otherwise.
- Excluding some groups of beneficiaries from the premium support system—say, people born before a particular year or dual-eligible beneficiaries—would reduce federal savings; however, including certain groups could pose additional challenges for administering the system and could have unintended consequences for members of those groups. (Dual-eligible beneficiaries, for example, might face limited provider networks and complex issues of care coordination.)

- Features that make beneficiaries more responsive to differences in premiums would boost enrollment in plans with lower bids and thus increase the incentive for plans to submit lower bids.

Many other aspects of a premium support system also would significantly affect federal spending and enrollees' payments. CBO will continue to develop its capacity to estimate the effects of varying those features.

Two Illustrative Options for a Premium Support System for Medicare

In designing a premium support system for Medicare, lawmakers would confront many choices affecting federal costs, beneficiaries' payments, and, perhaps, beneficiaries' access to care and the quality and nature of the care that they would receive—both in the short term and over the longer term. To project the potential effects of such a system, CBO developed detailed illustrative specifications regarding eligibility for the program and the timing of its implementation, the structure of the market for Medicare benefits, and the determination of federal contributions and beneficiaries' payments.

CBO analyzed two illustrative options, both of which would require insurers to submit bids specifying the payment they would accept to provide a basic package of Medicare benefits for an enrollee of average health. Under each option, the federal contribution toward beneficiaries' health care costs would be determined on the basis of a benchmark set for each region of the country. The two options differ in that under the first, determination of the benchmark would involve the second-lowest bid in each region; under the second, the benchmark would be set on the basis of a weighted average of bids in the region. For this analysis, CBO adopted a variant of the second-lowest-bid approach that is similar to those included in several recent proposals.¹ Under such an approach, the benchmark would equal the lower of two bids: the second-lowest bid from a private insurer and Medicare's FFS bid. Thus, in any region, the benchmark could be no higher than the bid of the FFS program. (For a summary of the program's operations under the second-lowest-bid option, see Figure 1. The operations under the average-bid option would be the same except for the determination of the benchmark.)

Medicare would continue to be divided into Parts A, B, and D under both options, and financing for federal outlays would come mostly from the same sources as under current law (see Box 1).

The specifications outlined in this report are not recommendations. Some were chosen to illustrate the potential for savings from a premium support framework; others were chosen for feasibility of implementation or to simplify the modeling approach. Many other variants of these options are possible. (For additional discussion, see the section "Implications of Key Specifications and Alternatives.")

Eligibility and Timing

CBO assumed that dual-eligible beneficiaries would be excluded from the premium support system and that gross federal spending for their health care would continue as it would if current law remained in place. (In 2009, those beneficiaries made up 19 percent of the Medicare population and accounted for 29 percent of total spending for Medicare's Part A and Part B benefits.)² CBO made that assumption because of the additional complexity of specifying how the system would work if such beneficiaries were included, although alternative systems could be designed to include them. CBO did not make any explicit assumptions about the system of care that would be in place for dual-eligible beneficiaries, and it assumed that their exclusion from the premium support system would not affect the number of Medicare beneficiaries who enrolled simultaneously in Medicaid.

Everyone else who was enrolled in Medicare when the premium support program took effect in 2018 would enter the new system at once, and people who reached eligibility after 2018 (other than dual-eligible beneficiaries) would enter the new sys-

¹ See House Committee on the Budget, *The Path to Prosperity: A Responsible Balanced Budget: Fiscal Year 2014 Budget Resolution* (March 2013), <http://go.usa.gov/bAAV> (PDF, 7 MB); Pete Domenici and Alice Rivlin, *Domenici-Rivlin Protect Medicare Act* (Bipartisan Policy Center, June 2012), <http://tinyurl.com/nherwb4>; and Ron Wyden and Paul Ryan, *Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future* (House Committee on the Budget, December 15, 2011), <http://go.usa.gov/bAsz>.

² See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), www.cbo.gov/publication/44308.

tem when they became eligible. The Medicare Advantage program would not be available as an option after 2017 for beneficiaries in the premium support system.

The Structure of the Market for Medicare Benefits

CBO made several assumptions about the structure of the market for Medicare coverage, including the required scope of benefits, the bidding process, and the process by which beneficiaries would choose a plan.

Scope of Benefits. Under each premium support option, insurers would offer a basic package of benefits with services and an actuarial value that matched those provided by Medicare's FFS program under Parts A and B. CBO assumed that hospice services and certain services provided to beneficiaries with end-stage renal disease would not be included in the basic benefit package and that spending for those services would continue as it would under current law. Those services were excluded so that the plans' benefits would be identical to those that are included in the bids of Medicare Advantage plans under current law. That assumption simplified CBO's modeling.

Insurers would be permitted to offer an additional package with enhanced benefits, however, and would submit separate bids for providing prescription drug benefits through Medicare's Part D, as under current law. Enrollment in Part D would remain voluntary.

Bids. To simplify the choices for beneficiaries (and thereby heighten competition based on differences in premiums), private insurers would be allowed to submit bids for just one or two plans for the basic Medicare package in each region. (The two plans could have different features—offering a larger or smaller provider network, for example—but both would need to have the same actuarial value.) Insurers would submit bids reflecting their costs for a combined package of Part A and Part B benefits (as insurers do for Medicare Advantage) and not separate bids for Parts A and B. Bids would be the amount that insurers would charge to provide care for a beneficiary of average health. Insurers also could offer one package of enhanced benefits (with a single, fixed higher actuarial value that would be the same for all insurers) to go along with each basic package offered. Enrollees would pay the full additional cost of the enhanced packages through higher premiums. Under such rules regarding packages with enhanced benefits, beneficiaries would find it easier to compare plans, and thus competition would be heightened.

Bidding Regions. Regional boundaries would be determined by the government and designed to coincide with health care markets within states. Regions would be the same for all prospective bidders, and insurers would be required to serve the entire regions for which they submitted bids.

Fee-for-Service Medicare. Medicare's FFS program would act as a competing plan. Its bid in each region would be based on the amount it would cost the program in that region to provide care for a beneficiary with average health as projected by the Medicare program. Support for disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease would be excluded from that projection. CBO assumed that such spending would continue outside the premium support system at the amounts projected under current law. The government's administrative costs for the FFS program, however, would be included in the bid. The FFS program would be required to maintain a contingency reserve fund equal to a specified percentage of projected expenses, and if the program's actual expenses differed from its projected expenses, future bids would be adjusted to maintain adequate reserves. CBO assumed that there would be no changes to current law concerning either the mechanisms for setting the rates paid to providers or the tools available to the FFS program to help it contain costs. As under current law, enrollees in the program could purchase supplemental (medigap) coverage from private insurers. CBO assumed that the same standard medigap plans that are currently available would be available under the two premium support options.

Coverage for Retirees. CBO assumed that employers and unions that provide coverage for retirees who are Medicare beneficiaries would make cash payments to their retirees to be applied toward the purchase of a basic package offered in the bidding region, an enhanced-benefit package (on top of a basic package) from any of the private plans in that region, or supplemental coverage for the FFS program. In that way, the choices of beneficiaries with retiree coverage would be the same as those of other beneficiaries, and they would have no additional incentives to select a particular plan (as typically occurs now when employers pay part of the pre-

mium if retirees enroll in a plan offered by the employer). CBO assumed that the premium support system would be implemented so as to not affect the percentage of beneficiaries with retiree coverage. Those assumptions simplified CBO's modeling.

Requirement Regarding Issuance. Insurers would be required to issue insurance to all Medicare beneficiaries who applied and to charge the same premium for all enrollees in a particular plan within a bidding region.

Plan Selection. Beneficiaries would receive information about premiums, cost sharing, and other plan attributes to help them compare plans. Enrollees would choose a plan during an annual enrollment period and would be required to remain in that plan for a year. Once beneficiaries chose a plan, they would automatically remain in that plan in subsequent years unless they chose a different one.

Initial Choice. Beneficiaries would not automatically remain in their current plan when the premium support system began in 2018. In 2018 and later years, beneficiaries who entered the premium support system and did not make an affirmative choice for enrollment would be assigned (with equal probability) to plans that presented bids at or below the benchmark, including the FFS program if it met that criterion. (If more than four plans in a region did so, beneficiaries would be assigned to one of the four lowest-bidding plans.) After their first year in the system, beneficiaries who were initially assigned to a plan would remain in that plan unless they chose a different plan during a future enrollment period or the plan to which they were assigned was no longer one of the lowest-bidding plans in their region (in that case, the beneficiaries would be assigned to one of the new low-bidding plans in their region). Beneficiaries who had been assigned to a plan and then subsequently chose another plan, as well as beneficiaries who affirmatively chose a plan when they entered the premium support system, would remain in that plan in subsequent years unless they chose a different one.

Enrollment in Part A and Part B. For this analysis, CBO assumed that enrollment in Part B would remain voluntary and that beneficiaries with coverage under Part A or Part B (or both) could enroll in any plan within a bidding region. Federal payments to plans for enrollees with Part A coverage only would be reduced proportionately on the basis of the share of total Medicare spending nationally for Part A services, and federal payments to plans for people covered under Part B only would be reduced in a similar manner.³

Federal Contributions and Beneficiaries' Payments

CBO also made assumptions about the determination of the amounts the federal government would pay insurers for providing Medicare coverage and the amounts beneficiaries would pay for that coverage under the illustrative premium support options.

Federal Contributions and Risk Adjustment. The benchmarks for setting the federal contribution would be based on the bids for the basic package of benefits. A benchmark would be calculated in each bidding region for a beneficiary of average expected health. For each enrollee of average health, the federal government would pay insurers an amount that was equal to the regional benchmark minus the standard premium. To compensate for a higher or lower cost implied by an individual beneficiary's "risk score," insurers would receive a larger or smaller payment for a beneficiary whose health was worse or better than average—as is the case under current law for Medicare Advantage and Part D.⁴ Neither the amount nor the rate of growth in federal payments would be capped.

Beneficiaries' Payments. Medicare beneficiaries who joined plans with bids that equaled the regional benchmark and were enrolled in Parts A and B would pay the insurer a standard premium, which would be set at 25 percent of total costs for covered services in Part B (physicians' services, hospital outpatient care, durable med-

³That approach to enrollment of beneficiaries who are not enrolled in both Parts A and B of Medicare was adopted to simplify the modeling for this analysis. In fact, including such beneficiaries in a premium support system would raise complex issues that are not addressed in this report.

⁴CBO assumed that a risk adjustment mechanism comparable to that used for the Medicare Advantage program would be used for a premium support system. That mechanism assigns each beneficiary a risk score, based on the person's medical conditions and demographic characteristics, that represents the expected spending in the FFS program relative to the national average for the Medicare population. A beneficiary with a risk score of 1.0 has average expected spending. To simplify the discussion, this report refers to beneficiaries with risk scores that are less than or greater than 1 as being in better or worse than average health—although personal characteristics other than health also influence spending for Medicare services.

ical equipment, and other services, including some home health care)—using the same formula as that for the standard Part B premium under current law. The premium for beneficiaries with Part A coverage only would be proportionately smaller than the standard premium based on the share of total Medicare spending nationally for Part A services (about half); a similar calculation would be used to set the premium for enrollees in Part B only.

Beneficiaries who joined plans with bids that were higher than the benchmark would pay the insurers the standard premium *plus* the difference between the bid and the benchmark. Those who selected plans below the benchmark would pay the insurers the standard premium *minus* the difference between the benchmark and the bid. In contrast to the rules for the current Medicare Advantage program, insurers with bids below the benchmark could not use such differences to enhance benefits or reduce premiums for Part D prescription drug insurance and the result would be heightened competition based on differences in premiums for the basic benefit package.

For the most part, premiums would be paid directly to insurers, as is generally the case for Part D, rather than withheld from Social Security benefits, as is generally the case under current law for Parts A and B. Income-related premiums for Part B specified in current law would continue and would be withheld from Social Security benefits.

Hypothetical Examples of Determining Premiums

Several examples show how premiums would be determined under the illustrative premium support options considered here. The hypothetical bids for regions with high and low levels of FFS spending per beneficiary are roughly consistent with the bids CBO has projected for such regions under the two options. In regions where FFS spending is high, premiums under the second-lowest-bid option would generally be higher than those under the average-bid option because the benchmark would be set at a low bid rather than at the average bid, and low bids would be much lower than the average bid. In regions where FFS spending is low, the low bids and the average bid would be closer and premiums under the two options would be more similar.

The Second-Lowest-Bid Option. Consider a region with high FFS spending in which the FFS program's bid in 2020 was \$14,000 and the bids from the region's five private plans were in the range of \$11,000 to \$11,800 (see Table 3). Under the second-lowest-bid option, the regional benchmark would be \$11,200, equal to the bid of the second-lowest-bidding private plan. The annual premium for enrollees in that plan would be \$1,500, the standard premium nationwide. Premiums for the other plans would differ from that amount depending on how the bids compared with the benchmark. Because the FFS bid would be \$2,800 more than the benchmark, the premium for FFS enrollees would be \$4,300 (\$1,500 plus \$2,800). The annual premium for the lowest-bidding private plan would be \$1,300.

Next, consider a low-spending region in which the FFS program's bid was \$9,900 and the bids of the five private plans ranged from \$9,300 to \$10,100. The regional benchmark would equal that of the second-lowest-bidding private plan (\$9,500), and enrollees in that plan would pay the standard premium of \$1,500. Because the bid of the FFS program would be \$400 more than the benchmark, FFS enrollees would pay an annual premium of \$1,900.

The Average-Bid Option. Consider again the high-spending region in which the FFS bid was \$14,000. The private plans' bids would be slightly higher in this region—ranging from \$11,200 to \$12,000—because the share of income that beneficiaries would spend on premiums would be lower, on average, thus reducing the sensitivity of beneficiaries' choice to differences in premiums and reducing competition among plans to lower bids. As a simple example, assume that, in the previous year, 25 percent of the people in the region enrolled in the FFS program and 75 percent enrolled in private plans, with an equal number enrolled in each private plan. Then the benchmark (the enrollment-weighted average bid) would be \$12,200. Under this option, the standard premium would be \$1,500 nationwide. Because the FFS program's bid would be \$1,800 more than the benchmark, the FFS premium would be \$3,300. The annual premium for the lowest-bidding private plan would be \$500 because that plan's bid would be \$1,000 less than the benchmark.

Finally, consider the low-spending region in which the FFS program's bid would be \$9,900. The bids of private plans would be about the same as that for the second-lowest-bid option in this region, ranging from \$9,500 to \$10,300. Assume that, because FFS spending is low, in the previous year 75 percent of the region's bene-

ficiaries enrolled in the FFS program and 25 percent enrolled in private plans, with an equal number enrolled in each private plan. The benchmark would be the enrollment-weighted average bid of \$9,900. Because the FFS bid would be the same as the benchmark, the FFS premium would be the standard premium of \$1,500. The annual premium for the lowest-bidding private plan would be \$1,100.

Comparison With the Current Medicare Program

Although some aspects of a premium support system would make it similar to the current Medicare program, there also would be significant differences. Under both illustrative options analyzed here, insurers would be required to provide a benefit package that encompassed the same services that were covered under Parts A and B of Medicare (with the few exceptions noted above) and that had the same actuarial value as Parts A and B combined. However, under both options, the federal contribution per beneficiary in each bidding region would be determined prospectively each year on the basis of the bids submitted by participating insurers. In contrast, except for Part D, federal spending for Medicare under current law is either on a fee-for-service basis or, in the case of Medicare Advantage enrollees, is tied to spending in the FFS program.

Under current law, the premium paid by enrollees in the FFS program is the same regardless of where a beneficiary lives. That premium has two components, both for enrollment in Part B: the standard amount (referred to in this report as the Part B premium), and the income-related amount. Under either illustrative option, by contrast, the FFS program would be one of the bidders, and its premium would vary by region depending on how its bid compared with the benchmark.

Although the current Medicare Advantage program is similar in some ways to a premium support system, several features limit the extent of price competition among private insurers, and the FFS program is not a bidder in Medicare Advantage. For example, benchmarks for Medicare Advantage (which determine the maximum federal payment for an enrollee) are set by law as a specified percentage of the average FFS spending in a given county and are announced before insurers submit bids (see Box 1).⁵ In contrast, benchmarks for the premium support options would be determined from plans' bids. Another difference concerns the incentives offered to beneficiaries to enroll in plans with lower bids. Under Medicare Advantage, beneficiaries who enroll in a plan with a bid below the benchmark receive some of the difference between the two, generally in the form of additional benefits. Under the two premium support options, by contrast, beneficiaries who enrolled in a plan with a bid below the benchmark would receive the entire difference between the two in the form of a lower premium.

Effects on Federal Spending

Projecting the effects of a premium support system in the first several years after implementation is difficult, given the substantial changes to the Medicare program that such a system would entail, the lack of historical experience with similar systems, the rapid evolution of health care and health insurance, and the significant changes in the Medicare program occurring under current law. (For additional details about the methods used in the analysis, see Appendix A.) Projections are even more uncertain for the period following the first several years of implementation. One reason is that growth in Medicare spending—and for health care more generally—has slowed markedly over the past several years, although it is not clear how much of the slowdown is attributable to persistent changes in the health care system.⁶ Moreover, spending for Medicare is projected to be restrained by provisions of the Affordable Care Act that will change the ways and amounts that health care providers and insurers are paid.⁷ The implications of those changes for long-term growth in Medicare spending are difficult to assess, thus adding to the uncertainty concerning the difference in spending that might occur as a result of policy changes—including the adoption of a premium support system.

⁵This description reflects the method of determining Medicare Advantage benchmarks that will be fully phased in by 2017. The benchmark for each county will be set at a specified share (ranging from 95 percent to 115 percent) of local FFS costs.

⁶See Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), www.cbo.gov/publication/44513.

⁷The Affordable Care Act comprises the Patient Protection and Affordable Care Act and the health care provisions of the Health Care and Education Reconciliation Act of 2010.

Effects in the First Several Years

CBO assumed that the premium support system would be implemented in 2018. This analysis reflects the assumption that dual-eligible beneficiaries would be excluded from the premium support system and that federal spending for their health care would continue as projected under current law. Everyone else enrolled in Medicare in 2018 would enter the new system in that year, and people who became eligible for Medicare subsequently (other than dual-eligible beneficiaries) would enter the new system. For this analysis, CBO chose 2020 as an illustrative year shortly after implementation for which to report results about federal spending. Additional information—both about the bids of private plans and about the uncertainty in the estimates—provides context for understanding those results.

In 2020, the second-lowest-bid option would reduce net federal spending for Medicare by about \$45 billion, or 6 percent, from the approximately \$700 billion projected under current law, CBO estimates (see Figure 2). The average-bid option would reduce net spending in that year by about \$15 billion, or 2 percent, the agency estimates.⁸ Those percentage savings were estimated relative to net federal spending on all services covered by Parts A, B, and D, including spending on benefits for dual-eligible beneficiaries. (The estimated savings in percentage terms were generated using CBO's March 2012 baseline projections of Medicare spending—because the agency's work on the estimates in this report began in earnest in early 2012—and the estimated savings in dollar terms were obtained by applying the percentages to the agency's latest baseline projections of Medicare spending, which were released in May 2013).⁹

The second-lowest-bid option would reduce net federal spending on Parts A and B of Medicare in 2020 by about 11 percent for beneficiaries who would be affected and the average-bid option would reduce such spending by about 4 percent, CBO estimates. Those savings are larger than the savings for net federal spending on all of Medicare because the amount of spending to which the savings are compared is restricted here to include only the beneficiaries and the portions of Medicare that would be covered by the new system. (The ratios of the two estimates for each premium support option are nearly identical, and the difference reported here is attributable primarily to rounding).¹⁰

For either option, during the first several years of a premium support system, Medicare savings would be similar in percentage terms to the savings estimated for 2020, with one main exception. Under the average-bid option, the federal savings estimated for 2018 would be much smaller than the amount estimated for 2020 in percentage terms because the FFS bid would receive a greater weight in constructing benchmarks in the first year of the new system than it would in later years. (CBO assumed that the weight would equal the proportion of enrollment in the FFS program under current law in 2017.) Thus, under the average-bid option, most regions would have higher benchmarks in 2018 than they would later.

Federal savings would be greater under the second-lowest-bid option than under the average-bid option because the benchmarks that determine the federal contribution would be lower. Under either option, CBO projects, the benchmarks in most regions would be lower than the FFS program's bid.

Although federal costs would decrease if more people declined Medicare coverage under either option than did so under current law, CBO projects that few people

⁸This analysis presents estimated changes in net federal spending because the allocation of financial flows to the budget categories of gross outlays and offsetting receipts would differ from those under current law in complicated ways. The two options would eliminate withholding of basic premiums from Social Security benefits; instead, beneficiaries would pay the basic premium directly to a plan. The reduction in gross spending attributable to that change in the way premiums were collected would be accompanied by a corresponding reduction in the government's collections of offsetting receipts. However, the proposals also would establish a new source of offsetting receipts consisting of the premiums paid by beneficiaries who enrolled in the FFS program—that is, the basic premiums plus the amount by which the FFS program's bid exceeded the benchmark (or minus the amount by which the benchmark exceeded the FFS program's bid).

⁹See Congressional Budget Office, "Medicare—March 2012 Baseline" (March 13, 2012), www.cbo.gov/publication/43060, and "Medicare—May 2013 Baseline" (May 14, 2013), www.cbo.gov/publication/44205.

¹⁰The ratios also differ because of small effects on net spending for dual-eligible beneficiaries. Although CBO assumed that gross federal spending for dual-eligible beneficiaries would not change, net spending would increase by a small amount relative to that under current law because premiums for dual-eligible beneficiaries would decrease. Those premiums would be linked to total Part B spending in Medicare, which would decline under the premium support options.

would do so. Beneficiaries would have plans available that cost less than, or about the same as, Medicare under current law. Also, beneficiaries who did not actively choose a plan would be assigned to one, and CBO expects that few would choose to drop out of the Medicare program rather than remain in an assigned plan for the required one-year period.

Effects on Private Plans' Bids. The options' effects on federal spending would be determined in part by how they influenced the bids of private plans. Various factors, such as competition and the reduced importance of the administratively determined payment rates of the FFS program, would affect the bids that determined the benchmarks. CBO used its projection of the bids that Medicare Advantage plans would submit under current law as a starting point in estimating the bids of private insurers under premium support. On net, CBO's analysis indicates that private insurers' bids in 2020 under the two options would be below the current-law bids for Medicare Advantage by about 4 percent, on average, and that the differences between those types of bids would vary regionally. That outcome would be the net result of different types of downward and upward pressures on bids.

On the one hand, CBO expects, both options would create more competitive pressure than the Medicare Advantage program, encouraging insurers to reduce their costs (primarily by constraining the volume and intensity of health care services provided and to a lesser extent by reducing administrative costs and profits) and thus to be able to lower their bids. The greater competition relative to the current Medicare program would arise because insurers with lower bids would expect to achieve larger increases in enrollment, because more Medicare beneficiaries would choose plans affirmatively and those beneficiaries would face larger differences in premiums among different plans. The specification adopted for this report that insurers could submit no more than two bids for the basic benefit package per bidding region also would increase competitive pressure to submit lower bids, in CBO's view. (Under the Medicare Advantage program, insurers often submit more than two bids in their service areas.) Given the competitive structure of the two premium support options, CBO expects that restricting insurers to a maximum of two bids would cause insurers to eliminate some of the higher-bidding plans that would exist under the current-law Medicare Advantage program. Another smaller but notable force also would tend to lower private plans' bids: The enrollees in private plans would be healthier (on average, after accounting for characteristics included in the risk adjustment mechanism) than enrollees in the FFS program, and such "favorable selection" would occur to a greater extent in a premium support system than under current law, CBO expects. That relatively greater favorable selection would occur because private plans would face greater pressure under premium support to contain costs (for example, by narrowing provider networks), and as a result, they would be less attractive to beneficiaries who use more health care services than do other beneficiaries with the same risk score.

On the other hand, reductions in the share of Medicare beneficiaries enrolled in the FFS program would cause private insurers participating in a premium support system to pay higher rates to health care providers. Two main mechanisms would be at work. First, although the rates private insurers pay now under the Medicare Advantage program are similar to those for Medicare's FFS program, CBO expects that a lower FFS market share would reduce the importance of the FFS program's rates in determining how much private insurers would pay providers for treating Medicare enrollees. Second, to accommodate an influx of enrollees, some private plans might need to expand their networks to include health care providers who would be more costly, on average. (CBO assumed in this preliminary analysis that all plans would be required to serve all beneficiaries who wished to enroll.) The resulting payment rates negotiated between insurers and health care providers would probably rise toward commercial rates for people under age 65 (which, adjusted for differences in average health status by age, are generally higher than Medicare's rates), especially where the market share of the FFS program declined substantially. However, even in areas where the FFS market share would be very low, CBO expects, the rates private insurers paid providers for their premium support enrollees would be somewhat lower than the rates they would pay for commercial enrollees under current law for several reasons: The FFS provider payment rates would serve as a reference point for negotiations, the competitive structure of a premium support system would tend to constrain rates, and the commercial rates existing alongside a premium support system would be lower because the extent to which relatively low Medicare FFS rates led providers to charge more to treat privately insured enrollees would abate as the FFS market share declined.

Although CBO projects that bids would be similar under the two premium support options, the agency expects that they would be just slightly lower under the second-lowest-bid option than under the average-bid option because private insurers would have a stronger incentive to bid low under the former. However, factors that would tend to increase private plans' bids—the reduced importance of the provider payment rates in the FFS program and the broadening of provider networks—also would be stronger under the second-lowest-bid option than under the average-bid option and would partially offset the stronger incentive to bid low.

Uncertainty in the Estimates. CBO's estimates of the effects on Medicare spending of the two illustrative premium support options depend on numerous parameters and other factors used in predicting the responses of insurers, health care providers, and beneficiaries—all of which are subject to considerable uncertainty. To characterize that uncertainty, the agency specified ranges of values for five key parameters in its analysis and determined the effects of varying those parameters, focusing on estimates for 2020.¹¹ The ranges for the parameters' values were chosen to represent CBO's judgment that, accounting not only for uncertainty about those parameters but for many other sources of uncertainty, there would be about a two-thirds chance that the effect on federal spending would be within the range reported (under an assumption that the premium support system was implemented as specified here).

The results indicate that for the second-lowest-bid option, net federal spending in 2020 on Parts A and B for beneficiaries who would be covered under the premium support system analyzed would probably be reduced by between 9 percent and 14 percent (CBO's central estimate is 11 percent), and for the average-bid option, federal spending would probably be reduced by some amount between 1 percent and 7 percent (the central estimate is 4 percent). (See Table 2.)¹² The range is smaller for the second-lowest-bid option mainly because a higher or lower proportion of beneficiaries enrolled in lower-bidding plans under that option would not directly affect the benchmarks that determined the federal contribution. By contrast, spending under the average-bid option would be directly sensitive to the fraction enrolled in lower-bidding plans, and the range of estimates incorporates the greater uncertainty from that additional factor. (For additional discussion of factors affecting the ranges, see Appendix B.)

Effects After the First Several Years

After the initial years of a premium support system, the percentage savings from either illustrative option would remain roughly constant for about a decade, CBO estimates. At that point, heightened price competition would probably reduce the growth of Medicare spending over the long term relative to that under current law, and that effect would probably be larger under the second-lowest-bid option than under the average-bid option. However, the longer-term effects are even more uncertain than are the short-term effects of a premium support system on Medicare spending. And if other health care or health insurance policies changed as well, the effects of such a system on spending could differ significantly from those presented here.

Effects of the Two Illustrative Options. During the decade following the first several years of implementation, CBO expects that the growth in bids of private plans under either option would be close to the growth in per capita costs in the FFS program under current law, contributing to the roughly constant percentage savings over that period. Over the longer term, CBO expects that the growth in Medicare spending under the options would probably be somewhat less than the growth of Medicare spending under current law.

The increased competition created by either option would tend to restrain growth in Medicare spending by reducing demand for costly new technologies and treatments and by increasing demand for cost-reducing technologies. A crucial factor un-

¹¹ CBO varied the following parameters to construct the ranges: bids of Medicare Advantage plans relative to FFS spending as projected under current law, the amount by which private insurers would reduce their bids relative to Medicare Advantage bids under current law in response to the increased competitive pressure created by the premium support system, the higher rates that private insurers would need to pay providers (with corresponding increases in bids) that CBO projects would result if the market share of the FFS program fell significantly, the responsiveness of beneficiaries to differences in premiums when choosing among plans, and the percentage of beneficiaries who would not actively choose a plan in the first year of premium support and that therefore would be assigned to a plan with a bid at or below the benchmark.

¹² For the second-lowest-bid option, the reported range is not symmetric about the central estimate because of rounding.

derlying the rise in spending for health care in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services.¹³ Although such advances can sometimes reduce costs, in medicine they and the accompanying changes in clinical practice have generally had the opposite effect. By strengthening price-based competition in Medicare, a premium support system could change that dynamic within the program and perhaps in the broader health care system. Moreover, relative to outcomes under current law, the potential for cost savings from managing utilization and limiting provider networks would be greater under a premium support system with a larger share of Medicare beneficiaries enrolled in private plans that have the flexibility to manage care. The magnitude of that effect is highly uncertain, however, and it would take a number of years before it became fully apparent. CBO anticipates that the effect on spending would be larger under the second-lowest-bid option—because of greater competitive pressure—than under the average-bid option.

However, the provisions of current law that will restrain growth in Medicare spending limit the potential for additional savings to result from a premium support system. In particular, CBO anticipates, private insurers would not be able to hold down payments to health care providers to the extent required in the FFS program under the sustainable growth rate mechanism for physicians or under the provisions of the Affordable Care Act that apply to other providers (the consequences of those provisions are discussed below). More generally, current law offers incentives to providers and beneficiaries to help reduce growth in federal spending, and it allows some flexibility for the Centers for Medicare and Medicaid Services in managing the program. Beneficiaries' demand for Medicare services will be constrained as the program's premiums and cost sharing consume a larger portion of their income. For providers, whose updates to Medicare's payment rates are generally scheduled to be smaller than the increases in the costs of inputs, the pressure to adopt cost-reducing procedures and technologies will be significant. Other changes in the structure of Medicare payments to providers—such as financial incentives to reduce hospital-acquired infections and readmissions—also might help to constrain federal spending.¹⁴ The Centers for Medicare and Medicaid Innovation, like many state Medicaid agencies and private insurance companies and providers, is hoping to achieve cost savings by testing promising ideas for modifying rules and payment methods and by expanding the use of ideas that prove effective.¹⁵ Whether any of the several demonstrations currently in process will succeed and be applied more widely is still uncertain.

Another factor limiting the potential for cost savings under a premium support system is that the Medicare program is required by law to cover items and services that are judged to be medically necessary and reasonable. Private insurers participating in the premium support options analyzed for this report would be required to cover the same services as those covered by the FFS program. The options would cause less restraint on the development of costly new technologies than would be the case if private insurers (or the Medicare program as a whole) had the authority to refuse coverage for certain services if, for example, less costly alternatives were available that were at least as effective. Under the options analyzed in this report, however, private insurers would have some flexibility to reduce beneficiaries' use of costly services through tools such as utilization management, higher cost sharing, and exclusion of providers from an insurer's network on the basis of practice style. By contrast, the FFS program does not have the authority to apply such methods to influence beneficiaries' use of services but, rather, must pay for any services that are used as long as they meet Medicare's criteria for coverage. That feature of the FFS program would remain in place under the two premium support options and might limit the extent to which either option could reduce the growth in Medicare spending. (Removing the FFS program as a competitor in the premium support system would tend to push up Medicare spending in other ways, as discussed earlier.)

In quantifying the effects of the illustrative premium support options relative to outcomes under current law, CBO recognized that current law provides for three ap-

¹³ See Congressional Budget Office, *Technological Change and the Growth of Health Care Spending* (January 2008), www.cbo.gov/publication/41665.

¹⁴ For example, see Sarah L. Krein and others, "Preventing Hospital-Acquired Infections: A National Survey of Practices Reported by U.S. Hospitals in 2005 and 2009," *Journal of General Internal Medicine*, vol. 27, no. 7 (July 2012), pp. 773–779, <http://go.usa.gov/DbQC>; and Centers for Medicare and Medicaid Services, "Readmissions Reduction Program," <http://go.usa.gov/DbQW>.

¹⁵ A list of ongoing demonstration projects is available at Centers for Medicare and Medicaid Services, "Innovation Models," <http://go.usa.gov/DbQd>.

proaches to restraining cost growth in Medicare that could be difficult to sustain over the long term: the ongoing reductions in payment updates for most providers in the FFS program, the sustainable growth rate mechanism for payment rates for physicians, and the process associated with the Independent Payment Advisory Board.¹⁶ It is unclear whether the long-term restraint of Medicare spending envisioned to occur through those provisions can be accomplished through greater efficiency in the delivery of health care or whether it would lead to reductions in beneficiaries' access to care or the quality of care they received. Accordingly, CBO's extended baseline reflects the assumption that the growth rate of Medicare spending after 2029 will not be affected by those provisions but that the percentage reduction in Medicare spending in 2029 achieved through those provisions will continue in later years.¹⁷ In the analysis in this report, CBO anticipates that beneficiaries will respond to concerns regarding access and quality in the FFS program by showing some additional preference for private plans relative to the FFS program when payment rates for providers in private plans increase relative to those paid by the FFS system.

Under the assumptions of its extended baseline, CBO anticipates that growth in Medicare spending per beneficiary (after removing the effects of demographic changes on health care spending—in particular, changes in the population's age distribution) would exceed growth in spending per beneficiary for all forms of private health insurance combined because the private sector has more flexibility to respond to the pressures created by rising health care spending than administrators of Medicare have under current law. The growth rate of federal spending for Medicare under the two illustrative premium support options—which involve a mixture of features of Medicare and private health insurance—would probably be lower than that for the existing Medicare program but above that for private health insurance.

Uncertainty in the Estimates. Estimates of the longer-term effects of the premium support options on Medicare spending are subject to the same sources of uncertainty that are described above for the shorter-term effects, but the magnitude of the uncertainty is increased by the longer time horizon. Uncertainty in projecting federal spending for Medicare over the long term under current law adds to the uncertainty of such estimates.

In particular, CBO's assessment—that the growth rate of federal spending for Medicare under the two options would probably be lower than that for the existing Medicare program but above that for private health insurance—is highly uncertain. It is possible, for instance, that over the long term, the bargaining power of health care providers relative to private insurers could increase to such an extent that spending growth under the options would exceed that for the existing Medicare program. Alternatively, private health insurers could be more successful than CBO projects in developing processes for delivering care in ways that would reduce costs, in which case spending growth under the options could be further below that for the existing Medicare program than CBO anticipates.

Effects of Modifying the Illustrative Premium Support Options or of Combining a Premium Support System With Other Changes to Medicare. The longer-term effects of the two illustrative options on Medicare spending could differ significantly from the estimates presented here if either option was modified or if policies for setting payment rates in the FFS program were revised. For example, imposing a cap on federal contributions under a premium support system could have an important effect on federal savings, and changes in the way provider payment rates in the FFS program were set could have complex interactions with a premium support system. Although CBO has not estimated the consequences of such policies, the following observations provide some relevant information.

¹⁶ Before the enactment of the Affordable Care Act, payment updates for most providers (except for physicians, whose payments have been controlled by the sustainable growth rate mechanism since 1998) generally were set to equal the estimated percentage change in the average cost of providers' inputs. Under current law, however, the updates will equal those percentage changes in costs minus the 10-year moving average of growth in productivity in the economy overall—a measure that seeks to capture, for the economy as a whole, how much more output is produced from a given amount of inputs. Under current law, payment rates for physicians' services in Medicare will be reduced by about 25 percent in January 2014 and, CBO projects, will be increased by small amounts in most subsequent years. The Independent Payment Advisory Board will be required to submit a proposal to reduce Medicare spending in certain years if the rate of growth in spending per enrollee is projected to exceed specified targets.

¹⁷ For more discussion, see Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 2012), pp. 56–57, www.cbo.gov/publication/43288.

Effects of a Cap on Federal Contributions. The effects of a cap on federal contributions under a premium support system would depend in part on how the cap was specified. CBO expects that if a premium support system limited the growth rate of federal contributions per beneficiary to match the growth of gross domestic product (GDP) per capita plus, say, 1.5 percentage points per year, in most years such a cap probably would not be binding. Under last year's extended baseline, which largely follows current law and which CBO used for the analysis in this report, the agency projected that the growth rate of Medicare spending per beneficiary between 2020 and 2032 (after adjusting for demographic changes) would be, on average, 0.8 percentage points greater than the growth rate of GDP per capita.¹⁸ As a result of the offsetting factors just described, CBO estimates that the growth rate for Medicare spending during those years under both premium support options would be similar to that under current law.

A cap of per capita GDP plus 1.5 percentage points could be binding regularly, however, if CBO's long-term projection underestimates growth in Medicare spending. And that cap could be binding in some years but not in others even if the projection is generally accurate because of volatility in the growth of health care costs and GDP. Moreover, the prospect of a cap's taking effect could alter the behavior of insurers in any year, thus increasing or decreasing the likelihood that such a cap would take effect. The effects of a cap would also depend on the details of how it was specified and enforced. For the current report, CBO has not attempted to estimate the effects of imposing a cap on federal contributions.

Effects of Alternative Policies for Setting Payment Rates for Providers in Fee-for-Service Medicare. Under CBO's extended alternative fiscal scenario (included in The 2012 Long-Term Budget Outlook), the reduced payment updates would expire and the Independent Payment Advisory Board process would cease to be effective after 2022, and payments to physicians would be maintained at 2012 rates rather than declining as scheduled. Under that scenario, CBO projected, net Medicare spending in 2030 would be about 0.5 percent of GDP higher than it would be under CBO's extended baseline. CBO has not estimated the effects of combining a premium support system with the changes to current law that are assumed under its extended alternative fiscal scenario.

Instead, if current-law policies restraining cost growth were retained through the 2030s or longer, then spending in the existing Medicare program would be below that projected under CBO's extended baseline. CBO has not estimated the long-term effects of a premium support system under such restraints either.

Effects on Beneficiaries' Premiums

The premiums that beneficiaries would pay under the two premium support options would depend on the premiums charged by the plans in their region and on the beneficiaries' choice of plan. Under each option, at least one plan would be available in every region that charged the standard premium or less, and in most regions other plans would be available that charged premiums that were higher or lower than that amount (depending on whether the bid was above or below the benchmark). For each option, CBO estimated the premiums that would be charged by the array of plans offered, and the agency summarized that information by estimating the average premiums charged by three plans—the second-lowest-bidding private plan in the region, the median-bidding private plan (that is, the plan with a bid in the middle of the distribution among private plans), and the FFS program. To arrive at the average premium charged by each plan, CBO computed a weighted average of region-specific premiums, with each region weighted by the proportion of affected beneficiaries.

CBO next estimated the premiums that beneficiaries would pay under each option by estimating their choice of plan, based on the differences in the premiums charged and on beneficiaries' sensitivity to those differences. For that analysis, CBO computed a weighted average of the premiums charged, weighting plans by the number of beneficiaries each one enrolled. CBO compared average premiums charged by plans and average premiums paid by beneficiaries with the Part B premium under current law.

Background on Premium Determination

Under either premium support option analyzed in this report, beneficiaries would pay the standard premium if they chose a plan with a bid that was equal to the

¹⁸ See Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 2012), www.cbo.gov/publication/43288.

regional benchmark. That premium would be the same everywhere in the country and would be determined by the same formula used under current law for the Part B premium: The federal government allocates spending under Medicare Advantage to Parts A and B on the basis of the share of total spending in the FFS program for Part B services and then sets the Part B premium equal to 25 percent of all Part B spending, divided by the number of beneficiaries. In this report, the standard premium equals 25 percent of the estimated amount of total Medicare spending attributable to Part B services under a premium support system.

Under current law, the Part B premium will be \$1,600 in 2020, CBO projects. Because total Medicare spending would be slightly less than it would be under current law under either premium support option, CBO estimates, the standard premium for each would be slightly lower than the Part B premium under current law—\$1,500 per year under either option. (All estimates of annual premiums in this report are rounded to the nearest \$100; although CBO projects that the standard premium under the average-bid option would be higher than that under the second-lowest-bid option, those amounts round to the same number.)

If a beneficiary chose a plan with a bid that differed from the regional benchmark, the premium would depend on the plan chosen. Someone who enrolled in a plan with a bid above the benchmark would pay the standard premium plus the amount by which the plan's bid exceeded the benchmark, and someone who enrolled in a plan with a bid below the benchmark would pay a correspondingly lower premium. CBO expects that, depending on how bidding regions were defined, there might be some sparsely populated regions in which no private plans would participate under either option. In those regions, the FFS program would be the only plan available, and beneficiaries who enrolled in the program would pay the standard premium.

CBO focused on standard premium amounts that did not include income-related adjustments. In addition, the agency analyzed premiums only for the basic package of Medicare benefits, excluding additional amounts that enrollees in private plans might pay for enhanced benefits or that enrollees in the FFS program might pay for supplemental coverage.

Enrollees in private plans under the options would forgo the federal subsidies for supplemental benefits that would be provided by many Medicare Advantage plans under current law. CBO estimates that the annual value of those supplemental benefits (under current law) will be about \$400, on average, per Medicare Advantage enrollee in 2020. The loss of those subsidies would make private plans less attractive under the options, all else being equal. For this analysis, CBO compared premiums for both options with the \$1,600 current-law premium projected for Part B. The agency did not make any adjustment in that analysis for the loss of supplemental benefits under the Medicare Advantage program. Those forgone benefits are included in the analysis presented below concerning the effects of the two options on beneficiaries' total payments.

Premiums by Region. The range of premiums around the standard premium would vary geographically. CBO's analysis focused on four groups of regions—ranked from highest to lowest average FFS spending—with equal numbers of beneficiaries in each group. In regions with high FFS spending, CBO estimates, the bid for the FFS program would be higher than the private plans' bids and higher than the benchmark under either option. Medicare beneficiaries enrolled in the FFS program in such regions tend to use certain health care services at a higher-than-average rate, so private plans would have greater potential to achieve savings relative to the FFS program by reducing that use. In contrast, CBO estimates, the FFS program's bid would be similar to or lower than the bids of private plans in many regions with low FFS spending. People enrolled in the FFS program in those regions tend to use less care, so private plans would have less potential to achieve savings by reducing the quantity of care; savings from reducing the price of care also would be difficult to achieve because of the restraints in provider payment rates that are scheduled for the FFS system under current law. Thus, the range of premiums would be narrower in regions with low FFS spending.

Premiums for Beneficiaries Who Do Not Actively Choose a Plan. CBO projects that many beneficiaries would not actively choose a plan in the first year of a premium support system—perhaps because they were unaware of the new system, did not understand how to enroll, were hampered by a health problem, or for some other reason. Under the options considered for this report, beneficiaries who did not choose a plan would be assigned to a plan with a bid at or below the benchmark. CBO projects that about 15 percent of beneficiaries would not choose a plan in the first year of premium support under the second-lowest-bid option and about

20 percent would not choose a plan in the first year under the average-bid option.¹⁹ Those beneficiaries would pay premiums less than or equal to the standard premium, but there would be no guarantee that the assigned plan would include all of their current providers.

Under an alternative approach, which CBO has not yet analyzed, beneficiaries who did not make a choice would remain in the plan most similar to their current plan (or be transferred to the FFS program if a similar plan was no longer available). In particular, beneficiaries who had been in the FFS program when the premium support system began would remain in that program unless they chose a private plan. In that sort of system, FFS beneficiaries would retain access to their current providers but, depending on the region, their premiums could be substantially higher. In addition, insurers would have less incentive to reduce their bids because they would anticipate that being a lower-bidding plan would result in a smaller gain in enrollment than they would achieve if all beneficiaries were required to affirmatively choose a plan.

Premiums Charged by Plans in 2020

Under either illustrative premium support option, CBO anticipates, beneficiaries would be offered at least one plan at or below the standard premium and most people would have access to at least one other plan with a premium below that amount. In most regions, the plans with premiums at or below the standard amount would be private. Overall, CBO estimates, the premiums charged by plans would generally be lower under the average-bid option than under the second-lowest-bid option because the benchmarks would be higher under the average-bid option, so the federal government would contribute more for each plan.

The Second-Lowest-Bid Option. Under this option, CBO estimates, the average premium for the second-lowest-bidding private plan across all regions would be about \$1,500 per year in 2020, or 6 percent below the Part B premium projected under current law for that year (see Table 4). In regions with low FFS spending, however, the premium for the second-lowest-bidding private plan would tend to be higher than in other regions because of the role of FFS spending in determining the benchmark. Specifically, in some regions with low FFS spending, the bid for the FFS program would be lower than that of the second-lowest-bidding private plan, so the FFS program's bid would become the benchmark, and the premium for the second-lowest-bidding private plan would be above the standard amount. CBO estimates that the average premium for the second-lowest-bidding private plan would be \$1,600 in regions with the lowest FFS spending (see Figure 3).

The average premium for the median-bidding private plan available would be \$1,800 in 2020 under the second-lowest-bid option, CBO estimates. That amount would be 13 percent above the current-law Part B premium.

The average premium for the FFS program under the second-lowest-bid option would be about \$3,100, or almost twice the projected Part B premium under current law, CBO estimates. That increase would occur because, in most regions, the FFS program's bid would be substantially above that of the second-lowest-bidding private plan, and thus the bid for the latter would become the benchmark. The premium for the FFS program would be highest in regions with the highest average FFS spending. CBO estimates that in those regions, the average premium for the FFS program would be \$4,600, or almost triple the projected current-law Part B premium. Even in regions with the lowest FFS spending, the average FFS premium would be \$1,900, or almost 20 percent above the projected current-law Part B premium. (In some regions, the FFS program's bid would be lower than that of the second-lowest-bidding private plan, and the premium would equal the standard premium.)

The Average-Bid Option. Premiums would generally be lower under the average-bid option than under the second-lowest-bid option. For the second-lowest-bidding private plan, the national average premium in 2020 would be \$900 under the average-bid option, CBO estimates—more than 40 percent below the projected current-law Part B premium for that year. That amount would be less than the premium for that plan under the second-lowest-bid option because, in most areas, the benchmark would be higher and the plan's bid would be below the benchmark, which determines the government's contribution. Under the average-bid option, the average

¹⁹CBO expects that some beneficiaries who were assigned to a low-bidding plan in the first year would later switch to the FFS program or to another plan that would have, on average, a higher premium.

premium of the second-lowest-bidding private plan would be the smallest (at \$600) in regions with the highest FFS spending because that plan's bid would be lower relative to the benchmark (which would be influenced by the bids of the FFS program and the higher-bidding private plans). The average premium of the second-lowest-bidding private plan would be substantially greater (at \$1,400) in regions where FFS spending is lowest because, in most of those areas, that plan's bid would be close to the bid of the FFS program.

For the median-bidding private plan, CBO estimates that the average premium would be \$1,200. That amount would be 25 percent below the current-law Part B premium in 2020.

The FFS program's bid under the average-bid option would be above the benchmark in most areas. CBO estimates that the national average premium for the FFS program would be \$2,400, 50 percent higher than the projected current-law Part B premium.

Premiums Paid in 2020

The average premiums that beneficiaries would pay under a premium support system would depend not only on the premiums charged by plans as just discussed, but also on the plans beneficiaries chose to enroll in. Under the second-lowest-bid option, CBO estimates, the average annual premium paid by beneficiaries in 2020 would be \$2,100—about 30 percent higher than the current-law Part B premium for that year (see Figure 4). Under the average-bid option, CBO estimates, the average premium paid by beneficiaries in 2020 would be \$1,500, or 6 percent below the current-law Part B premium.

The Second-Lowest-Bid Option. CBO estimates that about half of the beneficiaries included in the premium support system would enroll in private plans under the second-lowest-bid option and about half would enroll in the FFS program. The average premium paid by beneficiaries for private plans across all regions would be \$1,800 and the average premium paid for the FFS program would be \$2,500. The percentage of household income that beneficiaries would spend on the premium for the FFS program would vary substantially. The premium for the FFS program would amount to less than 2 percent of household income for about one-fourth of enrollees in that plan and to 6 percent or more for about two-fifths of the plan's enrollees. In comparison, under current law that premium would amount to less than 2 percent of household income for about two-fifths of beneficiaries in the FFS program and to 6 percent or more of household income for about one-fifth of beneficiaries in that program. (Those estimates focus on the standard premium and, in the case of premium support, on any reduction or increase in that premium that would result when a beneficiary enrolled in a plan with a bid below or above the benchmark. The estimates do not include amounts paid for the income-related premium.)

Under the second-lowest-bid option, average premiums would vary regionally. Beneficiaries in regions with the highest FFS spending would pay an average of \$2,300 (compared with the nationwide average of \$2,100). The higher average premium estimated for the regions with highest FFS spending is largely a reflection of CBO's estimate that about one-fifth of the beneficiaries would enroll in the FFS program. In those regions, roughly half of all beneficiaries enrolled in the FFS program would spend at least 6 percent of their household income on the FFS premium. Beneficiaries in regions with the lowest FFS spending would pay an average premium of \$1,800, according to CBO's estimates. About 80 percent of beneficiaries in regions with the lowest FFS spending would enroll in the FFS program.

The Average-Bid Option. CBO estimates that slightly fewer than half of all beneficiaries would enroll in private plans under the average-bid option in 2020 and slightly more than half would enroll in the FFS program—proportions that are similar to those CBO projects for the second-lowest-bid option.²⁰ For all regions com-

²⁰Two opposing considerations led CBO to project similar—but not identical—enrollment patterns for the two options. In most regions, the FFS premium would be higher relative to private plans' premiums under the second-lowest-bid option than under the average-bid option. That difference would arise because the second-lowest bid would be lower than the average bid, resulting in a larger gap between the federal contribution and FFS costs under the second-lowest-bid option. As a result, enrollment would tend to be higher in private plans under the second-lowest-bid option. CBO expects, however, that the prospect of paying higher premiums under the second-lowest-bid option would prompt more beneficiaries to choose a plan in the first year of the program. Thus, a smaller proportion of beneficiaries would be assigned to a plan at or

bined, the average premium paid by beneficiaries in the FFS program would be \$2,000 and the average premium paid by enrollees in private plans would be \$1,000, compared with \$2,500 and \$1,800, respectively, under the second-lowest-bid option.

Under the average-bid option, the average premium would be approximately equal for beneficiaries in all four groups of regions classified by FFS spending, CBO estimates. Where FFS spending is highest, the estimated \$1,500 average premium reflects the anticipated choice of some beneficiaries to enroll in private plans with bids below the benchmark (about three-fourths of that group; their average premium would be less than \$1,500) and of others to enroll in the higher-bidding FFS program (about one-fourth; their average premium would be more than \$1,500). In areas with the lowest FFS spending, the \$1,500 average premium reflects much smaller differences between the bids of private plans and the FFS program. In those regions, about three-fourths of beneficiaries would enroll in the FFS program, by CBO's estimate.

Effects on Beneficiaries' Total Payments

CBO has estimated the effects of the two illustrative premium support options on beneficiaries' total payments for covered services. The total consists of premiums and out-of-pocket payments for deductibles, coinsurance, and copayments. In this analysis, out-of-pocket payments include all such obligations for beneficiaries, whether paid directly by beneficiaries or covered by supplemental insurance.²¹ The premiums included in CBO's estimates are the average premiums that beneficiaries would pay as presented above and are based on CBO's projections of the distribution of beneficiaries among plans. Income-related premiums for Part B also were included in the total payments the agency estimates under current law and for both options. In addition, the estimates account for the value of the forgone federally subsidized supplemental benefits that would have been available to enrollees in Medicare Advantage plans under current law but that would not be available under the two options. As discussed below, the estimated effects of the two premium support options on beneficiaries' total payments are subject to considerably greater uncertainty than are the estimated effects on federal spending and the premiums charged by plans.

Effects in 2020

CBO estimates that beneficiaries' total payments in 2020 would be about 11 percent higher, on average, under the second-lowest-bid option than they would be under current law. The premiums paid by beneficiaries would be higher, on average, than under current law, but beneficiaries' out-of-pocket costs would be lower—even though the actuarial value of the Medicare benefit would be unchanged—because of a decline in the total cost of covered services, which would be a result primarily of greater enrollment in lower-bidding private plans.²² (On average, a larger share of beneficiaries' total payments is in out-of-pocket costs than in premiums, so, in the calculations of the change in total payments, the percentage change in out-of-pocket costs receives a greater weight than the corresponding change in premiums.) The projected savings in out-of-pocket costs would offset part, but not all, of the increase in premiums.

CBO's analysis implies that beneficiaries' total payments would be about 6 percent lower, on average, under the average-bid option than under current law. That reduction results from the combination of the lower average premiums paid discussed above and a reduction in average out-of-pocket costs, which would result primarily from higher enrollment in lower-bidding private plans.

below the benchmark, and that would tend to decrease enrollment in private plans under the second-lowest-bid option.

²¹ This report does not provide estimates of the total effects of the premium support options on beneficiaries' payments for Medicare services because the analysis did not include premiums that beneficiaries would pay for supplemental coverage. (CBO has not yet modeled such coverage as part of a premium support system.) However, by including total out-of-pocket costs for Medicare services, whether paid by the beneficiary or by supplemental insurance, the analysis captures, in the aggregate, most of the costs beneficiaries would incur for premiums for supplemental insurance.

²² CBO expects that lower-bidding plans would generally have lower rates of health care utilization. As a result, enrollees would pay less out of pocket than they would with higher-bidding plans. Under the options in this report, the actuarial value of all plans would match the value of current-law Medicare; that is, every plan would cover the same percentage of the total expenses of a given population that is covered by the current Medicare benefit package. For general information on the actuarial value of health plans, see Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Report for Congress R40491 (Congressional Research Service, April 6, 2009).

Under both options, the effect on total payments for particular beneficiaries could differ greatly from the nationwide average and would depend partly on the region and the choice of plan. In particular, beneficiaries who chose to remain in the FFS program would generally face higher premiums and would not experience a reduction in out-of-pocket costs.

Uncertainty in the Estimates

To characterize the uncertainty of the estimated effects of the options on beneficiaries' total payments, CBO applied the same type of analysis reported above for the effects of the premium support options on federal spending. Specifically, it varied the same five parameters, with ranges chosen to generate lower and higher estimates of the effects on beneficiaries' payments for each option. In CBO's judgment, there is a two-thirds chance under the second-lowest-bid option that beneficiaries' total payments in 2020 would, on average, be within a range extending from a reduction of 2 percent to an increase of 24 percent relative to payments under current law (CBO's central estimate is that total payments would increase by 11 percent). For the average-bid option, the corresponding range of likely average effects on beneficiaries' total payments extends from no effect to a reduction of 12 percent (the central estimate is a reduction of 6 percent.) (See Table 2.) The range under the average-bid option is narrower than that under the second-lowest-bid option mainly because the changes in beneficiaries' premiums from varying those parameters are smaller under the average-bid option and because the variation in responsiveness to smaller changes in premiums results in a smaller range of effects on total payments. (For additional discussion of factors affecting the ranges, see Appendix B.)

Beneficiaries' total payments would be unlikely to rise, on average, under the average-bid option relative to those under current law, for two main reasons. First, because use of health care services tends to be higher for enrollees in the FFS program than for those in private plans, out-of-pocket costs would probably be lower under the average-bid option than they would be under current law as long as the percentage of beneficiaries in the FFS program did not increase. According to CBO's central estimates, the share of beneficiaries in private plans would be about 20 percentage points greater than under current law, and a reduction in that share would be unlikely. Second, average premiums paid under the option would be closely tied to the standard premium, which would be set using the same formula as the Part B premium under current law, so those average premiums would not differ greatly from the Part B premium. And even if premiums were slightly higher under the average-bid option than under current law, the effect probably would not offset the decline in out-of-pocket costs.

Effects on Combined Federal Spending and Beneficiaries' Total Payments

The combined payments of the federal government and beneficiaries constitute the total amount paid for health care services covered by Medicare. They consist of the federal government's payments to plans, beneficiaries' premiums, and beneficiaries' out-of-pocket payments. CBO estimates that those payments would be about 5 percent lower under the second-lowest-bid option and about 4 percent lower under the average-bid option than they would be under current law. Those percentages are a combination of the effects on net Medicare spending and on beneficiaries' total payments discussed above.

CBO expects that the decrease in combined payments would probably be slightly larger under the second-lowest-bid option than under the average-bid option mainly because the former would result in lower bids by private plans and a larger share of beneficiaries enrolled in those plans. CBO did not quantify the uncertainty of those estimates but it did reach two conclusions about ranges that would cover two-thirds of the possible outcomes for the two options: First, such ranges would clearly overlap; that is, CBO is not confident that combined payments under the second-lowest-bid option would be lower than combined payments under the average-bid option. Second, based on the separate ranges for federal spending and for beneficiaries' total spending, ranges for combined payments would extend only over reductions in payments; that is, it is likely that either option would result in reductions in combined federal spending and beneficiaries' total payments.

The sum of federal spending and beneficiaries' payments examined here is a significant component of total national spending on health care, and this analysis suggests that total national spending would probably decline under either of the two illustrative premium support options. However, a premium support system would interact with other parts of the health care system in complex ways that CBO has not quantified.

Comparison With CBO's Previous Analyses of a Premium Support System

CBO has previously estimated the budgetary effects of revamping Medicare as a premium support system.²³ But those earlier analyses were limited in at least two key respects: They did not include detailed modeling of beneficiaries' choices among alternative insurance plans, and they did not include detailed modeling of insurers' behavior regarding bids or payments to health care providers. Thus, none of those analyses captured the full effects of a competitive system on federal spending or payments by beneficiaries. The analysis in this report incorporates such modeling. In addition, this report differs from some previous analyses by CBO in considering different illustrative options for a premium support system instead of a specific proposal.

The treatment in this report is substantially different from the rough analysis of a specific premium support proposal published by CBO in April 2011. Not only have there been substantial improvements in CBO's modeling of the behavior of beneficiaries and insurers, but the options examined in this report differ in important ways from that earlier proposal. For example, the earlier proposal included a grandfathering provision, and CBO estimated that only 4 percent of Medicare spending in 2022 would be accounted for by premium support payments under that proposal. The proposal also specified a federal contribution that was initially fixed (rather than determined through bidding) and that would keep pace with the consumer price index for all urban consumers (at a rate that CBO estimated would be substantially slower than the rate of growth in Medicare spending under current law). Moreover, because of the simple formula for determining federal spending in that proposal, CBO projected such spending over a longer period than it does in this report.

CBO's estimates of the total payments by beneficiaries and of combined federal spending and beneficiaries' payments for the 2011 proposal were much higher than the estimates for the two options in this report primarily because CBO projected for that earlier report that health care spending covered by private plans would be much higher initially and would grow faster than the agency currently estimates. The difference arose from two main factors: First, the earlier proposal did not include the Medicare FFS program as a bidding plan in the premium support system. Because that program was not present to put downward pressure on the rates paid to providers by private insurers, CBO projected, the premiums of private plans would be substantially higher than they would be under the premium support options discussed in this report. Second, more recent information has led CBO to make a downward revision in its projections of the future growth rate of private health insurance premiums.²⁴

Implications of Key Specifications and Alternatives

Although policymakers would need to determine many specific characteristics of a premium support system, several choices would be particularly important from a federal budgetary perspective: setting the formula for the government's contributions, determining whether the traditional FFS program would be included as a competing plan, setting rules of eligibility for the system, delineating bidding regions, and designing the program features that would influence beneficiaries' choice of a plan. Policymakers would also need to address many other design and operational issues to implement such a system.

Note again that the illustrative premium support options analyzed here are anchored in basic features of the current Medicare system: Both would guarantee insurance for all beneficiaries; adjust payments to private insurers to account for the health of their enrollees (that is, use risk adjustment); and, under what is called community rating, require that insurers charge everyone in a region the same premium for the same coverage. Changes to those features also could have important consequences for a premium support system.

²³For example, see Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan* (March 2012), www.cbo.gov/publication/43023; *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (attachment to a letter to the Honorable Paul Ryan, April 5, 2011), www.cbo.gov/publication/22085; *Budget Options, Volume 1: Health Care* (December 2008), pp. 120–121, www.cbo.gov/publication/41747; and *Designing a Premium Support System for Medicare* (December 2006), www.cbo.gov/publication/18258.

²⁴See Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (March 2012), www.cbo.gov/publication/43076.

In addition, changes in the broader health care and health financing systems would affect a premium support system and change the way it affected federal spending and beneficiaries' payments. For example, if more people outside of the Medicare market purchased health insurance plans with narrower networks of providers and lower premiums than CBO expects under current law, the willingness of Medicare beneficiaries to purchase similar plans in a premium support system would probably increase—although the opposite could occur if people's experiences with those plans left them dissatisfied. Legislative changes affecting the broader health care market also could have consequences for the effects of a premium support system in Medicare. For instance, repealing the tax exclusion for employment-based health insurance would heighten pressure to restrain the growth of health care costs outside of Medicare. The resulting changes in practice patterns of health care providers would probably decrease private plans' bids under a premium support system, although CBO has no basis for estimating the magnitude of such an effect.

Federal Contributions

In this analysis, CBO focused on two possible approaches to determining federal contributions, but many other methods could be used. For example, capping the growth rate of federal contributions could generate additional federal savings relative to an uncapped proposal, although CBO has not yet estimated the effects of such a cap. In general, federal budgetary savings would increase as federal contributions declined, but beneficiaries' premiums would be higher.

The Fee-for-Service Program

CBO assumed that Medicare's FFS program would continue to be offered within the premium support options analyzed here. If, instead, the FFS program was eliminated, the savings produced for the government under a premium support system would be less (or federal spending could be even more than under current law) because the rates that private insurers would pay health care providers for treating Medicare enrollees would probably be higher than CBO estimates for either premium support option. In general, the rates that private insurers now pay providers for Medicare Advantage enrollees are similar to those Medicare pays under the FFS program but substantially below the rates paid for enrollees who are in commercial plans and are not Medicare beneficiaries.

CBO anticipates that competition from the FFS program within a premium support system would constrain the rates that private insurers paid for premium support enrollees in the same way that the FFS program now appears to constrain the rates that insurers pay for Medicare Advantage enrollees. If a system did not offer the FFS program as a choice, the result probably would be higher payment rates, higher bids, and higher costs for the government. CBO also expects that, under the options analyzed here, in some regions the FFS program would submit the lowest bid, so eliminating the program would directly reduce federal savings by raising the benchmark in those regions.

Eligibility

If fewer people were included in a premium support system, federal savings generally would be lower, all else being equal. For this analysis, CBO assumed that the premium support systems would not include a grandfathering provision (thus including more beneficiaries than if such a provision were part of the system) and would exclude dual-eligible beneficiaries.

A Grandfathering Provision. Under some premium support proposals, all beneficiaries who became eligible for Medicare before the system took effect would remain in the current-law Medicare program and only those who became eligible after that time would enroll in the premium support system. Several important questions would arise about the structure of such a program (see Box 2). Clearly, however, grandfathering some beneficiaries would limit the savings that could be achieved over an extended period because only a subset of the Medicare population would enroll in the new system and (because the grandfathered beneficiaries would be older) the cost of health care for the eligible population would tend to be lower than average.

CBO estimates that if a premium support system implemented in 2018 excluded beneficiaries who entered the program before 2018 and dual-eligible beneficiaries, only about 25 percent of the Medicare population would be covered under the new system after 5 years, and spending for those beneficiaries would represent only about 15 percent of net Medicare spending in total in that year under current law (where such spending includes that for dual-eligible beneficiaries and for Part D). After a decade, approximately 45 percent of the Medicare population would be cov-

ered, and spending for that group would represent about 30 percent of net Medicare spending in total under current law.

Because the share of the Medicare population and the share of Medicare spending covered would rise gradually under a grandfathering provision, federal savings would be substantially smaller over an extended period than would be the case if all beneficiaries entered the new system immediately. A very rough approximation (made on the basis of the estimated share of Medicare spending covered each year) for a system that also excluded dual-eligible beneficiaries suggests that of the total savings achieved if all eligible beneficiaries entered in 2018, federal savings would be about 15 percent as much after 5 years and about 30 percent as much after 10 years.

Moreover, the savings under a grandfathering provision could be slightly smaller than the rough estimates would suggest, for two reasons. First, CBO anticipates that the gradual rise in the proportion of Medicare beneficiaries and Medicare spending covered under such a system would give private insurers less incentive to reduce their bids, over an extended period, than would be the case if all eligible beneficiaries entered the system immediately. Second, the reduction in the growth of Medicare spending likely to occur under a premium support system as a result of changes in the demand for new technologies would be substantially smaller for many years if that system included a grandfathering provision.

Dual-Eligible Beneficiaries. Medicare covers some services for dual-eligible beneficiaries and Medicaid covers others, thus creating conflicting financial incentives for the federal and state governments and for health care providers.²⁵ Recent federal and state efforts have focused on integrating the Medicare and Medicaid funding streams and coordinating the often-complex care of many of those beneficiaries—and including that group in a premium support system would pose substantial additional challenges. For instance, it would be difficult to give dual-eligible beneficiaries incentives to choose low-bidding plans in a premium support system while also minimizing their total payments for medical services. Despite that, excluding such beneficiaries would reduce the potential savings that could be achieved from a premium support system. In addition, that exclusion might create incentives for private plans to encourage lower-income beneficiaries with higher health care costs than predicted by their risk scores to seek Medicaid eligibility and thereby leave the plan.²⁶

Bidding Regions

CBO assumed that bidding regions for both options would reflect health care markets within states. The precise definition of those markets would involve trade-offs. For example, defining regions to include large numbers of beneficiaries would make insurers' projections of average spending within the region more reliable. However, regions that included areas that varied greatly in their spending would make it more difficult for insurers to project spending for their enrollees because those enrollees could be concentrated in certain areas within the region. As another example, because CBO assumed that a premium support system would require any insurer that submitted a bid for a region to serve the entire region, some local and regional insurers might decline to participate if a region included areas they could not serve effectively, thus reducing competition. And in some regions, those firms could be among the insurers offering the lowest-cost health care, the highest-quality health care, or both. However, if regions were small, some insurers might decline to participate even though they would have served those same areas if they had been included in larger regions. That result could occur, say, if the costs to carriers of developing networks of providers in those areas were higher than in nearby areas and if those costs would have been worth incurring to serve a larger region.

Features of a System That Could Influence Enrollment

Features of a premium support system that made beneficiaries more sensitive to differences in plans' premiums would tend to reward plans that bid low with higher enrollment and thus encourage more plans to submit lower bids.

In the illustrative premium support options analyzed here, CBO assumed that differences in bids would be translated dollar for dollar into differences in premiums.

²⁵ See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), www.cbo.gov/publication/44308.

²⁶ Such effects are not included in CBO's estimates in this report.

If, instead, the government retained some of the difference between the benchmark and bids below that amount, two effects would occur: First, the government would reduce its spending by the amount retained, all else being equal. Second, however, by retaining some of the difference between the benchmark and the bids, the government would reduce the incentive for beneficiaries to enroll in low-bidding plans and thus reduce the incentive for plans to submit low bids—which would increase the benchmark and federal spending. The net effect of those two factors on government spending would depend partly on beneficiaries' responsiveness to premiums and partly on the extent to which private insurers raised their bids. Moreover, if the difference between the benchmark and bids below that amount was provided as additional benefits rather than as cash, beneficiaries would tend to have more difficulty comparing plans.

CBO assumed that beneficiaries who did not choose a plan when they entered the premium support system would be assigned to a plan that submitted a bid that was at or below the benchmark (or assigned to one of the four lowest-bidding plans if more than four were at or below the benchmark). If, instead, beneficiaries were automatically placed into their original plan (if they had already been enrolled in Medicare) or into the FFS program, insurers would probably have less incentive to submit low bids, and beneficiaries' total payments would be higher because low-bidding plans would have lower enrollment. Conversely, if those beneficiaries were assigned to plans that had especially low bids (rather than being assigned equally to all plans bidding at or below the benchmark), insurers would probably have a greater incentive to submit low bids, and beneficiaries' total payments would be lower. Alternatively, if beneficiaries were required to choose a plan if they wished to enroll in the premium support system and thus to maintain or obtain Medicare coverage, some would not do so and the fraction of the eligible population not covered by Medicare would increase—particularly in the first few years after implementation.

In this analysis, CBO assumed that the basic packages that plans would be required to offer would consist of health care services and an actuarial value that matched those provided by Medicare's FFS program under Parts A and B—although the plans could vary in other dimensions, such as the breadth of provider networks or the structure of coinsurance. If that basic package was only a minimum requirement and plans could supplement a package in unrestricted ways without offering the basic package itself, comparisons would be more difficult for beneficiaries, enrollment in low-bidding plans would be reduced, and plans' bids would rise. Conversely, if the deductibles and copayments of the basic package were made standard, comparisons would be simpler. The drawback of standardization, however, is that it could dampen the ability of insurers and providers to develop more cost-effective approaches to providing health care and for beneficiaries to choose those approaches rather than more expensive ones.

Appendix A: Basis for CBO's Findings

The preliminary findings presented in this report regarding the effects of two illustrative options for a premium support system for Medicare (one called the second-lowest-bid option and the other called the average-bid option) are based on detailed modeling of the behavior of buyers and sellers of health insurance policies. In its analysis, the Congressional Budget Office (CBO) focused particular effort on estimating private insurers' bids under those options.

CBO reviewed the research literature and consulted a variety of experts who represented a broad span of views about premium support systems. In addition, some insights about the potential responses of beneficiaries and insurers are possible from observing current experience with the Medicare Advantage program (which provides benefits through private insurance), Medicare Part D (the prescription drug program), the Federal Employees Health Benefits program, and various employment-based insurance plans. The usefulness of those systems to inform the analysis of a premium support system is limited, however, because the competitive structure of a premium support system would be quite different from that of Medicare Advantage or the federal employees' program, and the array of health care services covered would be broader than that under Part D. Moreover, information about the small number of employers whose experiences with similar systems have been studied in depth may not be broadly generalizable—particularly to the Medicare population, which is likely to be less responsive than the nonelderly population to dif-

ferences in health insurance premiums. Finally, the changes that are occurring in private health care and in health insurance could affect federal spending on Medicare in complicated and unpredictable ways—either under current law or under a premium support system. And the adoption of a premium support system for Medicare could have spillover effects on private health care and health insurance systems.

The current analysis incorporates a range of significant improvements in the modeling of a premium support system for Medicare compared with CBO's earlier analyses of such systems.²⁷ The agency has devoted considerable time and effort to strengthening its analytical capabilities in this area. Nonetheless, it is extremely difficult to know how beneficiaries or insurers would respond to a premium support system for Medicare, and the actual outcomes would surely differ from the estimates presented in this report—which, according to CBO's current judgment, represent the middle of the distribution of possible outcomes. The agency's modeling effort is not complete; further analysis and additional consultation with outside experts may alter the findings, perhaps in significant ways. One potential area of inquiry that CBO has not analyzed concerns the ways a premium support system might affect the coordination of care or the quality of care that beneficiaries receive; the agency does not currently have the tools necessary to study such effects, nor does it anticipate having them in the near future.

Estimating Private Insurers' Bids

To estimate the bids that private insurers would submit in 2020 under the two illustrative premium support options considered in this report, CBO analyzed insurers' 2012 bids for Medicare Advantage, projected those bids to 2020, and adjusted them to account for the differences in competition that CBO anticipates private insurers would face under the two options as compared with the current Medicare Advantage program.

In adjusting the projected Medicare Advantage bids to develop estimates of what private insurers would bid under a premium support system, CBO concluded that some factors would tend to lower bids and others would tend to raise them (see Figure A-1). The net effect is that the projected bids under the two premium support options considered in this report are lower, by an average of about 4 percent under each option, than those projected for the current-law Medicare Advantage program. (Bids would be slightly lower under the second-lowest-bid option than under the average-bid option, but the differences relative to bids under the Medicare Advantage program are rounded to the nearest percentage point.) The difference between private insurers' bids under the two options and average spending in Medicare's fee-for-service (FFS) program would remain fairly constant in the decade after the first few years of implementation, CBO anticipates.

Projecting Medicare Advantage Bids

Under current law, each Medicare Advantage plan generally can define its service area as consisting of one or more counties.²⁸ CBO based its estimates on the bids submitted by insurers for their service areas, using the county as the unit of analysis. The agency developed simulated distributions of bids for counties based on the view that insurers would participate in a premium support system and would offer insurance plans with a range of prices, just as is the case for the current Medicare Advantage program.

CBO estimated benchmarks for counties under the two premium support options on the basis of the agency's projected distributions of private insurers' bids, which were combined with projected per capita Medicare FFS spending for each county. The use of the county as the unit of analysis simplified the modeling and provides a foundation for subsequent analyses of a system with other types of bidding regions. The results of the analysis could change if different types of regions were specified.

Under current law, Medicare Advantage insurers submit a bid for a beneficiary in average health (defined as a beneficiary with a risk score of 1.0). CBO projects that the average bid from current-law Medicare Advantage plans in 2020 will be 6 per-

²⁷ For examples of earlier analyses, see Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (attachment to a letter to the Honorable Paul Ryan, April 5, 2011), www.cbo.gov/publication/22085, and *Designing a Premium Support System for Medicare* (December 2006), www.cbo.gov/publication/18258.

²⁸ This discussion applies to local Medicare Advantage plans, which account for the bulk of enrollment in the Medicare Advantage program. By contrast, the federal government defines service areas for regional preferred provider organizations—or PPOs—as consisting of one or more states; each PPO must serve one or more of those designated service areas.

cent below the average FFS spending for a beneficiary with the same reported risk score. For the one-quarter of the nation's counties with the highest average FFS spending, CBO estimates, the average Medicare Advantage bid will be 12 percent below that amount.²⁹ For the one-quarter of counties with the lowest average FFS spending, CBO projects that the average Medicare Advantage bid will be 6 percent above that amount.³⁰

CBO expects that Medicare Advantage bids will be higher relative to average FFS spending in the same areas in 2020 than in 2012 because Medicare Advantage plans will be able to achieve some—but not all—of the restraint in provider payment rates that is scheduled for the FFS system under current law. As a result, the agency projects higher growth in the bids of Medicare Advantage plans than it does for growth in per capita spending under the FFS system.

Factors That Would Tend to Reduce Bids

CBO anticipates that two main mechanisms would tend to lower bids under either option relative to Medicare Advantage bids under current law: increased competition that would result from stronger incentives for beneficiaries and insurers to focus on reducing health care costs and the slightly greater favorable selection for private plans than exists under the Medicare Advantage program.

Increased Competition. Differences in the plans' bids under either option would translate directly into differences in beneficiaries' premiums. Under current law, a Medicare Advantage plan with a bid below the benchmark receives a federal payment that equals the bid plus a rebate that is a percentage of the difference between the bid and the benchmark. (Beginning in 2014, the rebate will range from 50 percent to 70 percent, depending on the plan's performance on certain measures of quality.) Plans now return most of that difference in the form of supplemental benefits (rather than as reduced premiums), which consumers generally find harder to evaluate than a cash amount. Under the illustrative premium support options, plans with bids below the benchmark would return the entire difference between the two in the form of lower premiums. Beneficiaries would therefore be more sensitive to differences in plans' bids in deciding on a plan than they would be under the Medicare Advantage program, so the insurers would have more incentive to lower their bids under the two premium support options.

Insurers also would face more competition under both options because of changes in market structure. Under the Medicare Advantage program, the benchmarks are announced before insurers submit their bids. Under the two premium support options, the benchmarks would be determined from the bids themselves. Some evidence suggesting that competition among Medicare Advantage plans is limited under the current approach comes from a study that concluded that a \$1.00 increase in a benchmark, with all other factors (including health care costs) held constant, results in a \$0.49 increase in the average bid.³¹ In a highly competitive system (for example, one in which each dollar that a bid was below the bid of another plan within a region would correspond to a dollar's difference in the premiums between the two plans), the insurers' bids would primarily reflect their costs rather than the benchmarks.

²⁹ For this analysis, CBO divided counties into quartiles on the basis of average FFS spending in the county, with the same number of counties in each quartile. This differs from the approach elsewhere in the report for the analysis of beneficiaries' premiums, which divides groups of regions into quartiles constructed such that the same number of beneficiaries is in each quartile.

³⁰ Those estimates incorporate factors affecting bids that are related to the risk adjustment mechanism, discussed below. For this analysis, CBO excluded three types of Medicare Advantage plans that differ substantially from plans that would probably be offered under a premium support system: private FFS plans, special needs plans, and employment-based group plans. The FFS program's costs used for the comparisons in this report exclude certain types of spending because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. CBO included in its calculations the government's cost of administering the FFS program. The analysis was based on CBO's projections of Medicare expenditures and Medicare Advantage enrollments in March 2012. See Congressional Budget Office, "Medicare—March 2012 Baseline" (March 13, 2012), www.cbo.gov/publication/43060.

³¹ Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *American Journal of Managed Care*, vol. 18, no. 9 (September 2012), pp. 546–552, <http://tinyurl.com/odtwf87>.

Insurers would be expected to respond to increased competition by reducing their costs and lowering their bids.³² The reductions might occur partly as a result of reduced administrative costs or smaller profit margins. But they also could result from cuts in spending for services, perhaps made possible by insurers' combining improvements in management of care with development of more restrictive provider networks, slower adoption of expensive technological advances, faster adoption of methods to compensate providers that demonstrated cost-effective care, or changes in benefit design (for example, tying cost-sharing requirements to evidence of the cost-effectiveness of specific services).

Under the specification of the two options that restricts insurers to submitting a maximum of two bids for the basic benefit package in any bidding region, CBO also expects that insurers would eliminate some of the higher-bidding plans that would exist under the Medicare Advantage program—reducing average bids. (Under the Medicare Advantage program, insurers often submit more than two bids in their service areas.)

Increased Favorable Selection. Under both premium support options, all private insurers in a region would submit bids indicating the payment they would accept to provide Medicare benefits for a beneficiary of average health, and those standardized bids would be used to establish regional benchmarks. Payments to insurers would be adjusted to reflect the health status of their enrollees, using a risk adjustment mechanism that CBO assumed would be comparable to that of the Medicare Advantage program.

It is difficult to adjust payments to reflect health status, and the system used for Medicare Advantage is unavoidably imperfect. Medicare beneficiaries in poor health tend to prefer to enroll in the FFS program because it generally places fewer restrictions on the use of health care services. That tendency is in evidence even among beneficiaries with the same risk scores because risk scores incorporate only limited information about health status. When a beneficiary who enrolls in a private plan is healthier than someone with the same risk score enrolled in the FFS program, the private plan experiences “favorable selection” beyond that captured by risk scores. Some research indicates that current Medicare Advantage enrollees who have a given risk score would have had lower costs, on average, under the FFS program than people enrolled in the FFS program with that same score.³³

CBO expects that, under either premium support option, private plans would experience greater favorable selection (beyond that captured by risk scores) than they will experience under the Medicare Advantage program. That is, people who enrolled in private plans—under either option—would use fewer health care services, on average, than people with the same risk score enrolled in Medicare Advantage. CBO anticipates that outcome because increased competition would prompt insurers to take more aggressive steps to control costs (by enhancing utilization management or using tighter provider networks, for example), thus rendering private insurers less attractive to beneficiaries who would, on average, use more health care services than would other beneficiaries with the same risk score.

Because of the increased favorable selection, costs per enrollee would be lower for private plans under a premium support system than for Medicare Advantage plans under current law if the average risk scores in the two sets of plans were the same.

³² For related research, see Thomas C. Buchmueller, “Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Directed Health Insurance,” *Milbank Quarterly*, vol. 87, no. 4 (December 2009), pp. 820–841, <http://tinyurl.com/nsaff32>, and “Does a Fixed-Dollar Premium Contribution Lower Spending?” *Health Affairs*, vol. 17, no. 6 (November 1998), pp. 228–235, <http://tinyurl.com/puwqjaz>; David M. Cutler and Sarah J. Reber, “Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection,” *Quarterly Journal of Economics*, vol. 113, no. 2 (May 1998), pp. 433–466, <http://tinyurl.com/mycquen>; and Steven C. Hill and Barbara L. Wolfe, “Testing the HMO Competitive Strategy: An Analysis of Its Impact on Medical Care Resources,” *Journal of Health Economics*, vol. 16, no. 3 (June 1997), pp. 261–286, <http://tinyurl.com/nvuz76c>.

³³ Estimates of the difference vary considerably, however. For example, see Joseph P. Newhouse and others, “Steps to Reduce Favorable Risk Selection in Medicare Advantage Large-Ly Succeeded, Boding Well for Health Insurance Exchanges,” *Health Affairs*, vol. 31, no. 12 (December 2012), pp. 2,618–2,628, <http://tinyurl.com/naps2jl>; Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2012), pp. 100–101, <http://go.usa.gov/DXbF>; Gerald F. Riley, “Impact of Continued Biased Disenrollment From the Medicare Advantage Program to Fee-for-Service,” *Medicare and Medicaid Research Review*, vol. 2, no. 4 (2012), pp. E1–E17, <http://go.usa.gov/DXbd>; and Jason Brown and others, *How Does Risk Selection Respond to Risk Adjustment? Evidence From the Medicare Advantage Program*, Working Paper 16977 (National Bureau of Economic Research, April 2011), www.nber.org/papers/w16977.

Reflecting those lower costs, private plans competing for additional enrollees under either option would tend to reduce their bids for a beneficiary of average health relative to those of Medicare Advantage plans, CBO anticipates.

Factors That Would Tend to Raise Bids

CBO estimates that in most counties the percentage of beneficiaries enrolled in the FFS program would decline once either premium support option took effect. In CBO's assessment, the reduced market share of the FFS program would tend to boost the rates that private insurers paid to health care providers and thereby lead them to raise their bids. That reduction in market share, and thus the effect on private insurers' bids, would be greater in areas where average FFS spending was high. (CBO's methodology for estimating the proportion of beneficiaries who would select the FFS program is discussed below.)

Declines in the FFS program's market share would affect payment rates for private insurers through two main mechanisms. First, the importance of payment rates from the FFS program would diminish as a determinant of the amounts private insurers would pay health care providers for treating Medicare enrollees (those FFS payment rates are generally a good deal lower than the rates private insurers pay to providers of health care for people with commercial insurance—that is, employment-based coverage). Second, some private insurers would need to broaden their provider networks to accommodate additional enrollees. Both mechanisms would cause insurers to raise their bids to cover additional costs, CBO projects.

The Reduced Importance of FFS Provider Payment Rates. CBO's assessment of the importance to private plans of FFS payment rates is based on the observation that, on balance, the rates paid for Medicare Advantage enrollees are similar to or slightly above those that Medicare pays for FFS patients' care—even though providers receive substantially higher amounts when they offer the same services to patients in commercial plans focused on the under-65 population.³⁴ The exact cause of the difference is not known, but it appears to arise in part because private insurers that offer Medicare Advantage plans can exclude from their networks any providers who are unwilling to accept Medicare's rates, thus reducing those providers' volume of Medicare patients; those same providers would generally end up being paid the lower rates for treating Medicare patients in the FFS system. Moreover, when Medicare Advantage enrollees go outside their plan's provider network to obtain care that the plan either must cover by law (emergency care, for example) or that it covers as a matter of choice (such as certain highly specialized services), federal law requires providers to accept Medicare's FFS rates as payment in full.³⁵ Thus, a hospital that might anticipate providing a certain amount of emergency care to enrollees in a Medicare Advantage plan would not receive higher commercial rates for treating those patients simply because it refused to join the plan's network.

The relationship between private insurers and providers is much different for plans that serve commercial enrollees. Although there are dominant insurers in many commercial markets, they appear to have less leverage than the Medicare FFS program has with providers—in part, at least, because FFS payment rates are established by law and are not subject to negotiation. If providers are unwilling to accept rates for their commercial enrollees that are similar to Medicare's rates, they can be reasonably confident that other insurers will pay them more—particularly because private insurers typically try to satisfy consumers' desire for broad provider networks. In addition, when enrollees in commercial plans go outside the plan's network to receive care, the providers who treat them generally charge more than they would have charged had they been in the plan's network. Insurers often limit their payments for such care to predetermined amounts, but patients are often responsible for some or all of the differences between those payments and the provider's charges.

In regions where the role of the FFS program diminished under a premium support system, CBO expects, the relationship between private insurers and health care providers would become less similar to the relationship in Medicare Advantage under

³⁴ Information about those rates is based on interviews conducted by CBO staff with industry sources and is consistent with reports in the research literature. See Robert A. Berenson and others, "The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed," *Health Affairs*, vol. 31, no. 5 (May 2012), pp. 973–981, <http://tinyurl.com/nytyudu>.

³⁵ Sections 1866(a)(1)(O) and 1876(i)(1) of the Social Security Act contain the relevant provisions for hospitals and physicians, respectively.

current law and more similar to the relationship in the commercial market for people under age 65.

Broadening of Provider Networks. Another reason bids would increase as the share of beneficiaries in the FFS program fell is that private insurers, on average, would need to expand their networks to accommodate increased enrollment. As a result, private insurers would probably need either to pay higher rates or to contract with providers with higher-cost practice styles. Bids would rise as a result of including higher-cost health care providers that private insurers would tend to have excluded when their networks could be narrower. The expansion would be greater for lower-bidding plans, CBO projects, because those plans would experience greater increases in enrollment.

The Magnitude of the Resulting Adjustments to Bids. CBO did not adjust its projections of private insurers' bids in counties in which it expects that the FFS program would maintain the share that it currently holds (or its nationwide market share, if that is lower). The agency anticipates that, in those counties, the forces that now allow private insurers to obtain payment rates for their Medicare Advantage plans that are similar to those for Medicare's FFS program would continue to prevail under a premium support system.³⁶ However, where the market share of the FFS program is projected to fall below its current level—and where that share would be below the current national market share—CBO expects that private insurers would pay higher rates to providers for their premium support enrollees than they would pay under current law for Medicare Advantage enrollees. CBO adjusted its projections for insurers in those counties, and the adjustment was greater for counties where larger reductions are anticipated in the FFS program's market share. CBO also adjusted the bids upward slightly for plans at or near the bottom of the bid distribution to account for the expected broadening of provider networks.

The size of the adjustment for private plans' bids was made partly on the basis of the agency's assessment of the average difference between the rates paid by Medicare and the rates paid by private insurers to hospitals, physicians, and other providers for enrollees in commercial plans. However, the adjustment was smaller than that average difference as a way to account for four main factors:

- The observed difference in payment rates now is more informative about the rise in rates that might occur under a premium support system in which the FFS program was eliminated; rates would generally rise much less under a system in which the FFS program was a competing plan—particularly in regions where the FFS program retained a significant market share.
- Medicare's FFS payment rates would be used as a reference point in negotiations between private plans and providers for their premium support enrollees, which would tend to keep those rates below commercial rates even in regions where the FFS program had a very low market share.
- The competitive structure of a premium support system would tend to push rates below commercial rates. In particular, current tax-based subsidies to health insurance for commercial enrollees result in less competitive pressure on provider payment rates than would occur under the premium support options analyzed here.
- A reduction in the FFS market share would lower commercial rates, reducing the difference between FFS rates and commercial rates. Because of the reduction in the FFS market share, fewer health care services would be paid for at relatively low Medicare FFS rates. As a result, fewer costs associated with Medicare beneficiaries would probably be shifted to private insurers through higher rates for hospital services, thus reducing commercial rates.

After considering all of those factors, CBO made separate adjustments to its estimates of the bids in each county, depending on the projected changes in the FFS program's market share. The relationship between the FFS market share and private plans' bids is subject to considerable uncertainty, but CBO regards its estimates as being in the middle of the distribution of possible outcomes.

³⁶CBO expects that the rates private insurers will pay providers under Medicare Advantage plans will rise over time relative to Medicare's FFS rates because private insurers are not likely to obtain all of the reductions in payment updates that are scheduled for the FFS program under current law. The adjustments to bids discussed in this section were applied to projected Medicare Advantage bids, developed under the expectation that private insurers' payment rates would be higher relative to Medicare FFS rates than they are now.

Differences Between the Options' Effects on Bids

The combined effects of the factors that would tend to lower bids would be slightly larger under the second-lowest-bid option than under the average-bid option. In 2020, those effects would reduce bids by about 7 percent, on average, under the second-lowest-bid option and by about 6 percent under the average-bid option. In either case, the amount by which bids were reduced would vary considerably from one region to another.

The effects of the factors that tended to increase bids also would be slightly larger under the second-lowest-bid option than under the average-bid option because the increased competition, and the resulting changes in enrollment among the plans, would be greater. In 2020, that effect would boost bids by about 3 percent, on average, under the second-lowest-bid option and by about 2 percent under the average-bid option.

The largest difference in the effects of the two options on bids by private insurers would result from a difference in the degree of competition. That difference would occur for two main reasons.

First, and more important, the benchmark would be lower under the second-lowest-bid option than under the average-bid option in most regions, so the premiums for a plan with a given bid would be higher. In CBO's judgment, insurers would expect those higher premiums to increase beneficiaries' sensitivity to differences in costs because premiums would consume a greater share of enrollees' discretionary income.

Second, bids for plans that wanted to attract automatically assigned beneficiaries would tend to be lower under the second-lowest-bid option than under the average-bid option. Under either option, according to specifications outlined in this report, beneficiaries who made no affirmative choice would be assigned with equal probability to an available plan that had submitted a bid that was at or below the regional benchmark (or to one of the four lowest-bidding plans if more than four met that criterion). Although such beneficiaries would be comparatively less attractive to plans than those who made an active enrollment choice, some plans would nevertheless seek to obtain them through assignment. Because no more than two plans would receive automatically assigned beneficiaries under the second-lowest-bid option in most instances, compared with as many as four under the average-bid option, the plans that wanted to enroll such beneficiaries would have greater incentives to submit lower bids under the second-lowest-bid option.

Changes Over Time in Effects on Bids

Under either option, the combined effects of the factors that tended to reduce bids would increase over time, as would the combined effects of the factors that tended to increase bids. On balance, CBO anticipates, the difference between private insurers' bids under the two options and average FFS costs would remain fairly constant for the decade following the first few years of implementation.

CBO expects that the increased competition in particular would lead insurers to reduce costs even more after 2020 so they could keep their bids as low as possible in subsequent years. However, for three reasons, the incremental reductions would probably be smaller than the initial drop: First, one assumption of this analysis is that the legislation that created a new premium support system would provide private insurers with several years to determine how to reduce their costs before the system was implemented with the result that many changes would probably be undertaken in the first few years. Second, because many beneficiaries would probably remain in the first plan they chose without thoroughly evaluating their options in subsequent years, insurers would have an especially strong incentive to submit low bids in the first year of the new system. Third, insurers would tend to undertake the easier reductions first, and additional reductions would probably involve more difficult actions.

However, CBO also projects that Medicare Advantage bids under current law will rise more rapidly than average spending in the FFS program. As a result, greater cost reduction under the premium support options would be necessary in future years to maintain the percentage savings relative to FFS spending projected for 2020. By CBO's estimate, the additional cost reductions would roughly offset the trends in Medicare Advantage bids projected under current law through the 2020s.

Estimating Federal Spending for Medicare and Beneficiaries' Total Payments

The methods for estimating combined federal spending and beneficiaries' total payments were similar for both options CBO analyzed. CBO projected bids for a given

year as described in the previous section. The agency used those bids (and, for the average-bid option, past enrollment) to estimate benchmarks in each county and premiums for each plan in each county. It then simulated the enrollment of a large sample of beneficiaries in different plans on the basis of premiums and previous patterns of enrollment, calculated federal spending as the sum of the risk-adjusted federal contribution for each beneficiary, and compared total federal spending with the baseline projection. To project beneficiaries' total payments, CBO used claims data to estimate cost-sharing payments by each beneficiary for the services covered by Medicare and combined those estimates with the plans' premiums.

The estimates incorporated data from administrative records for a sample of about 600,000 Medicare beneficiaries, along with county-level projections of the FFS program's bid and the bids of private plans. CBO adjusted the estimates of out-of-pocket spending to match the actuarial value of the plans and current distributions of health spending by age, health risk, and other factors.

The enrollment simulations were based in part on estimates of two especially important aspects of beneficiaries' choices of plans: their sensitivity to premiums and the likelihood that they would actively choose to enroll in a plan. The analysis also incorporated the effects of CBO's expectation that patients who enrolled in private plans would have their diagnoses coded more intensively than would patients in the FFS program. Possible spillover effects on Medicare FFS spending from increased enrollment in private plans were not considered in the estimates.

Sensitivity to Premiums

To develop its projections of the plans that Medicare beneficiaries would choose under different premium support proposals, CBO conducted its own analysis and it examined findings from the research literature concerning beneficiaries' sensitivity to premiums in selecting health plans.³⁷ In the agency's judgment, there are two main reasons that beneficiaries' sensitivity under either option would be greater than is generally reported in the literature for the Medicare population. First, they would face larger differences in premiums under the options than those that have been studied previously. Second, beneficiaries would receive information on the features of available plans—including premiums—in ways that would make comparison among plans simpler than is generally the case under current law. Moreover, CBO anticipates, beneficiaries who are new Medicare enrollees in the future will be more sensitive, on average, than current beneficiaries are to differences in premiums. CBO expects those beneficiaries to be healthier generally (and thus less likely to have strong ties to providers who might not be in some plans' networks) and, because of their experience in the health insurance marketplace, to be more conversant than many current enrollees are with the process of choosing among plans that offer different premiums and packages of benefits.

In most regions, under either option, beneficiaries would be able to choose from several private plans that are likely to be more similar to one another than to the FFS program in terms of the size of provider networks and approaches to utilization management. Therefore, CBO anticipates, beneficiaries would be more sensitive to premiums when choosing among private plans than they would be when choosing between any private plan and the FFS program. Additionally, CBO expects, beneficiaries would become somewhat less sensitive to the cost of premiums after the first few years; once beneficiaries are in a plan, they generally do not seem to switch

³⁷ See, for example, Thomas C. Buchmueller and others, "The Price Sensitivity of Medicare Beneficiaries: A Regression Discontinuity Approach," *Health Economics*, vol. 22, no. 1 (January 2013), pp. 35–51, <http://tinyurl.com/oo2rrk4>; Steven D. Pizer, Austin B. Frakt, and Roger Feldman, "Nothing for Something? Estimating Cost and Value for Beneficiaries From Recent Medicare Spending Increases on HMO Payments and Drug Benefits," *International Journal of Health Care Finance and Economics*, vol. 9, no. 1 (March 2009), pp. 59–81, <http://tinyurl.com/p7sjtvh>; Thomas C. Buchmueller, "Price and the Health Plan Choices of Retirees," *Journal of Health Economics*, vol. 25, no. 1 (January 2006), pp. 81–101, <http://tinyurl.com/m6p93dz>; Adam Atherly, Bryan E. Dowd, and Roger Feldman, "The Effect of Benefits, Premiums, and Health Risk on Health Plan Choice in the Medicare Program," *Health Services Research*, vol. 39, no. 4 (August 2004), pp. 847–864, <http://tinyurl.com/o4w1339>; Bryan E. Dowd, Roger Feldman, and Robert Coulam, "The Effect of Health Plan Characteristics on Medicare+Choice Enrollment," *Health Services Research*, vol. 38, no. 1, part 1 (February 2003), pp. 113–135, <http://tinyurl.com/p34m69r>; Anne Beeson Royalty and Neil Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *Journal of Human Resources*, vol. 34, no. 1 (Winter 1999), pp. 1–41, <http://tinyurl.com/o2m3br7>; David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics*, vol. 113, no. 2 (May 1998), pp. 433–466, <http://tinyurl.com/mycqem>; and Thomas C. Buchmueller, "The Health Plan Choices of Retirees Under Managed Competition," *Health Services Research*, vol. 35, no. 5, part 1 (December 2000), pp. 949–976, <http://tinyurl.com/laixa4w>.

readily.³⁸ Nevertheless, the possibilities of attracting new enrollees each year and of losing existing enrollees to competitors would provide incentives for private plans to continue to keep bids low.

The constraints on Medicare payment rates for providers embodied in current law may result in diminished access to care and in reduced quality of care for beneficiaries in the FFS program, although the timing and extent of such changes are very difficult to predict. In this analysis, CBO anticipates that beneficiaries would respond to the possibility of reduced access or quality by being somewhat more inclined to choose a private plan than to choose the FFS program when the FFS rates for health care providers fell relative to those of private plans.

Active Choice of a Plan

In CBO's assessment, a significant proportion of beneficiaries would not actively choose a plan in the first year that a premium support system was implemented. Under the specifications adopted for this report, beneficiaries who did not make a choice would be assigned randomly to a plan with a bid at or below the benchmark (or to one among the four lowest-bidding plans, if more than four bid at or below the benchmark). To project that share of beneficiaries, CBO analyzed the behavior of Medicare Advantage enrollees whose plans had left the market, and it reviewed research on enrollment in the Part D program.

CBO expects that a higher percentage of beneficiaries would choose a plan under the second-lowest-bid option than under the average-bid option because the higher average premiums would be more likely to impel beneficiaries to learn about the new program and choose a plan. CBO projects that, on average, about 15 percent of beneficiaries would not choose a plan in the first year of premium support under the second-lowest-bid option and about 20 percent would not choose a plan in the first year under the average-bid option. The percentages would be expected to vary according to certain demographic characteristics and health status identified in CBO's analyses and in its review of related research. The agency also projects that most beneficiaries who were assigned to a plan in 2018 would still be in that plan by 2020 (the reference year for the analysis of beneficiaries' premiums) but that some beneficiaries who did not choose a plan in the first year would switch from the low-bidding plan to which they were assigned to a higher-bidding plan later.

More Intensive Diagnostic Coding by Private Insurers

Evidence suggests that private insurers in the Medicare Advantage program record a larger number of diagnoses than FFS providers do, so a given beneficiary would be expected to have a higher risk score in a Medicare Advantage plan than in the FFS program. Because higher risk scores result in larger payments, private insurers have a financial incentive to ensure that every appropriate diagnosis is coded for each enrollee; such an incentive does not generally exist in the FFS sector. Although the Medicare program adjusts the risk scores of Medicare Advantage enrollees downward to attempt to account for the difference—and that adjustment was incorporated in the risk scores used in this analysis—there is recent evidence that the adjustment is probably insufficient.³⁹ CBO expects that under the two options private insurers would code diagnoses more intensively than providers treating FFS

³⁸ For related discussion, see Benjamin R. Handel, "Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts," working paper (University of California at Berkeley, March 2013, <http://emlab.berkeley.edu/bhandel/index.shtml>); Peter J. Cunningham, *Few Americans Switch Employer Health Plans for Better Quality, Lower Costs*, Research Brief'12 (National Institute for Health Care Reform, January 2013), www.nihcr.org/Health-Plan-Switching; Jonathan D. Ketcham and others, "Sinking, Swimming, or Learning to Swim in Medicare Part D," *American Economic Review*, vol. 102, no. 6 (October 2012), pp. 2639–2673, <http://tinyurl.com/ow8l8xu>; Keith M. Marzilli Ericson, *Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange*, Working Paper 18359 (National Bureau of Economic Research, September 2012), www.nber.org/papers/w18359; and Kathleen Nosal, "Estimating Switching Costs for Medicare Advantage Plans," working paper (University of Arizona, June 2012), www.u.arizona.edu/~nosal/research.html.

³⁹ The Centers for Medicare and Medicaid Services has estimated that reported risk scores for Medicare Advantage enrollees are 3.4 percent higher than they would have been in the FFS sector, and the agency adjusts the reported risk scores downward by 3.4 percent when it calculates payments to the plans. Under current law, beginning in 2014 and continuing until 2018, the agency must increase the adjustment until the downward adjustment reaches at least 5.9 percent. The Government Accountability Office has estimated that the difference in coding boosts risk scores for Medicare Advantage enrollees by between 5 percent and 6 percent relative to like-ly scores in the FFS system and that the difference has widened over time. See Government Accountability Office, *Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments*, GAO-13-206 (January 2013), www.gao.gov/products/GAO-13-206.

patients to the same extent that they would do so in the Medicare Advantage program under current law and that the Medicare program would adjust the risk scores of enrollees in private plans to the same extent that is projected for Medicare Advantage under current law. Thus, no adjustments to plans' projected bids in Medicare Advantage were needed to account for those practices.

However, CBO expects that the more intensive coding of diagnoses would affect federal spending under a premium support system even though it would not affect the bids of private plans relative to those under current law. In particular, under both options, a larger fraction of the Medicare population would be covered by private plans, and thus more of the population would be subject to more intensive coding, on average, than is the case under current law. Therefore, CBO accounted for differences in coding in its projections of payments to insurers. CBO expects that beneficiaries who switched from the FFS program to a private plan would end up with higher risk scores and that the Medicare program would adjust for only part of that difference in calculating payment amounts for the insurers. As a result, the federal government would pay more for such beneficiaries under a premium support system, all else being equal, than it would if there was no difference in coding or if the Medicare program adjusted the risk scores of private plans to completely remove the effects of coding differences.

Possible Spillover Effects on Medicare FFS Spending

There is evidence that increases in the proportion of beneficiaries enrolled in Medicare Advantage plans lead to lower federal spending for beneficiaries in the FFS program and in a lower intensity of their treatment.⁴⁰ Such spillover effects could occur through at least two pathways: Increased managed care penetration could change the way physicians treat *all* of their patients, not just those enrolled in managed care plans, and it could influence investment decisions and the adoption of new technology in local markets. For this report, CBO did not incorporate such spillover effects on the FFS program.

In CBO's estimation, such effects would be very small or even negligible in 2020, although the agency will explore the issue more in future analyses. The sustainable growth rate mechanism for physicians and the provisions of the Affordable Care Act that restrain payment updates for most other FFS providers also will restrain federal spending in Medicare's FFS program, suggesting that any additional reductions in Medicare spending on the FFS program that might result from a spillover effect would be smaller than has been estimated in the past.⁴¹

Over the longer term, the size of spillover effects would depend in part on whether the restraints on payment updates in the FFS program specified under current law are maintained. However, as discussed in the section of the text on "Effects After the First Several Years," stronger price-based competition under a premium support system would probably affect the emergence and diffusion of new technology and services in ways that might reduce FFS spending (for a beneficiary of average health, relative to that under current law) in the longer term.

Appendix B: **Analysis of Uncertainty in the Estimates**

To characterize uncertainty in the estimated effects of the two illustrative options for a premium support system (one called the second-lowest-bid option and the other

⁴⁰See Katherine Baicker, Michael Chernew, and Jacob Robbins, *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization*, Working Paper 19070 (National Bureau of Economic Research, May 2013), www.nber.org/papers/w19070; Michael Chernew, Philip DeCicca, and Robert Town, "Managed Care and Medical Expenditures of Medicare Beneficiaries," *Journal of Health Economics*, vol. 27, no. 6 (December 2008), pp. 1,451–1,461, <http://tinyurl.com/gxh4h9>; and Laurence C. Baker, "The Effect of HMOs on Fee-for-Service Health Care Expenditures: Evidence From Medicare," *Journal of Health Economics*, vol. 16, no. 4 (July 1997), pp. 453–481, <http://tinyurl.com/kf28hus>. The study of Baicker and others presented estimates of the effects of Medicare Advantage plans' market share on hospitals' resource costs of treating Medicare beneficiaries, which do not directly determine Medicare's payments for FFS beneficiaries under the prospective payment system. The two other studies estimated the effects of Medicare Advantage plans' market share on Medicare spending for FFS beneficiaries.

⁴¹The Affordable Care Act comprises the Patient Protection and Affordable Care Act and the health care provisions of the Health Care and Education Reconciliation Act of 2010.

called the average-bid option) on federal spending for Medicare and on beneficiaries' total payments, the Congressional Budget Office (CBO) determined ranges of values for five key parameters and estimated the effects of varying those parameters. Those estimates focused on results for 2020, which CBO used as a reference year in the analysis. The ranges for the parameters' values were chosen to represent CBO's judgment that, accounting not only for uncertainty about those parameters but also about most of the sources of uncertainty in the analysis (assuming that a premium support system was implemented as specified here), there would be about a two-thirds chance that CBO's central estimate for the effect on federal spending would be within the range reported.

CBO varied the following parameters to construct the ranges:

- Bids of Medicare Advantage plans relative to Medicare fee-for-service (FFS) spending as projected under current law,
- The amount by which private insurers would reduce their bids relative to Medicare Advantage bids under current law in response to the increased competitive pressure created by the premium support system and other factors,
- The higher rates that private insurers would need to pay providers (with corresponding increases in bids) that CBO projects would result if the market share of the FFS program fell significantly,
- The responsiveness of beneficiaries to differences in premiums when choosing among plans, and
- The percentage of beneficiaries who would not actively choose a plan in the first year of premium support and who therefore would be assigned to a plan with a bid at or below the benchmark.

Effects on Federal Spending

CBO estimated a range of effects on federal spending by simultaneously varying all five key parameters in ways that would result in higher or lower spending under the premium support options. To do so, the agency examined how varying each parameter would affect spending.

Bids by Medicare Advantage Plans Relative to Fee-for-Service Spending

If Medicare Advantage bids under current law were lower than those in CBO's projections and FFS spending was as CBO projects, then federal savings under both options would be greater, according to CBO's estimates, because the benchmarks under the options would be lower than projected. Conversely, if Medicare Advantage bids under current law were higher than those in CBO's projections and FFS spending was as CBO projects, federal savings would be smaller than projected. Although CBO's estimates of the effects of a premium support system are sensitive to changes in the bids of Medicare Advantage plans *relative* to FFS spending, those estimates are not directly sensitive to *equal* percentage changes in Medicare Advantage bids and FFS spending—that is, to an across-the-board increase or decrease in Medicare spending relative to the amounts that CBO projects—because the difference between the benchmarks under the options and federal spending for Medicare under current law would not be affected. However, if such an across-the-board change occurred, it could affect the amount by which private insurers under a premium support system reduced their bids relative to Medicare Advantage bids (as discussed below).

Reduction of Bids of Private Plans in Response to Increased Competitive Pressure and Other Factors

If private insurers responded to increased competitive pressure by reducing their bids by more than the amounts in CBO's central estimates, federal savings would be correspondingly greater under both options because the benchmarks would be lower than estimated. But federal savings would be lower if private insurers reduced their bids by less than the central estimates.

In addition, if FFS and Medicare Advantage costs were higher across the board (because of greater systemwide growth in costs), there might be more opportunity for cost savings, depending on the underlying drivers of that growth, and the amounts by which private insurers reduced their bids under the premium support options would probably be greater than they are in the agency's central estimates. Similarly, if costs were lower across the board, the amounts by which private insurers reduced their bids under the premium support options would probably be smaller than they are in the agency's central estimates.

Rates That Private Insurers Would Pay to Providers

If the decline in the market share of the FFS program under a premium support system resulted in higher payment rates for health care providers and therefore in higher bids from private insurers than in CBO's central estimates, federal savings would be correspondingly smaller because both those bids and the benchmarks would be higher, all else being equal. If that effect was smaller than in the central estimates, however, federal savings would be correspondingly greater.

Beneficiaries' Sensitivity to Premiums

Departures from the central estimates in beneficiaries' responsiveness to differences in premiums would influence federal spending both through the effects on plans' bids and through the effects on the share of beneficiaries enrolled in private plans. If beneficiaries were more responsive to differences in premiums than is predicted in CBO's central estimates, private insurers' bids would be lower than they are in those estimates (because insurers would have a stronger incentive to reduce their bids if such reductions led to larger increases in enrollment); those lower bids would result in greater federal savings. Conversely, if beneficiaries were less responsive to differences in premiums than in the central estimates, the private insurers' bids would be higher and federal savings would be lower. Regarding enrollment shares, if beneficiaries were more responsive to differences in premiums than in the central estimates, a larger proportion would switch to lower-bidding plans under premium support, causing several indirect effects on federal savings (as discussed below). If they were less responsive, the opposite would occur.

Active Choice of a Plan

If a larger percentage of beneficiaries did not actively choose a plan in the first year of premium support than is predicted in CBO's central estimates and if those beneficiaries were assigned to plans with bids at or below the benchmark, a larger percentage of beneficiaries would be enrolled in low-bidding plans, all else being equal. Conversely, if a smaller percentage of beneficiaries did not actively choose a plan, a smaller percentage would be enrolled in low-bidding plans. The implications for federal savings under the two premium support options would be similar to the indirect effects (discussed below) that would occur through changes in the shares of enrollment in private plans when beneficiaries were more, or less, sensitive to differences in premiums than is predicted in the central estimates. (Although one might expect that having a higher share of beneficiaries not actively choosing a plan would have effects similar to beneficiaries' being less sensitive to premiums, that is not the case because the beneficiaries who did not choose a plan would be assigned to a low-bidding plan.)

Effects of Changes in the Proportion of Beneficiaries in Lower-Bidding Plans

A greater responsiveness of beneficiaries to differences in premiums when choosing among plans and a larger percentage of beneficiaries not actively choosing a plan in the first year would both lead to a larger proportion of beneficiaries being enrolled in lower-bidding plans. Similarly, less responsiveness to differences in premiums and a smaller percentage of beneficiaries not actively choosing a plan would lead to a smaller proportion of beneficiaries being enrolled in lower-bidding plans. Those differences in enrollment would have indirect effects on federal savings through three main mechanisms:

- Under the average-bid option, having a greater proportion of beneficiaries in lower-bidding plans would result in lower benchmarks (because benchmarks are constructed by weighting each plan's bid by its enrollment in the prior year) and thus would result in greater federal savings. And if a smaller proportion were enrolled in lower-bidding plans, higher benchmarks and lower federal savings would result. Under the second-lowest-bid option, however, having a higher or lower proportion of beneficiaries enrolled in lower-bidding plans would not directly affect benchmarks.
- In most regions, the lower-bidding plans would be private plans, and higher enrollment in those plans would be accompanied by a lower market share for the FFS program, which would increase bids of private plans for reasons discussed above, all else being equal. Lower enrollment in private plans would have the opposite effect.
- For any given set of bids, CBO expects, greater enrollment in private plans would result in smaller federal savings because diagnostic coding by private insurers would be more intensive than that by FFS providers under a premium support system (as is now the case under the Medicare Advantage program) and federal

payments to private plans would be adjusted to account for only part of that difference in coding. Again, lower enrollment in private plans would have the opposite effect.

Effects on Beneficiaries' Total Payments

CBO estimated a range of effects on beneficiaries' total payments by simultaneously varying all five key parameters in ways that would result in higher and lower payments under the premium support options. In CBO's assessment, the uncertainty of the estimated effects on beneficiaries' total payments is greater than that concerning the estimated effects on federal spending because there are especially broad ranges of plausible values for the two parameters that would affect beneficiaries' payments the most: their sensitivity to premiums and the percentage who would not initially choose a plan. Varying other parameters also affects the estimates.

If beneficiaries were more sensitive to premiums than CBO's central estimates indicate, more of them would enroll in lower-bidding plans, and their total payments would be lower, on average, than the central estimates indicate (because enrollees in low-bidding plans would pay lower premiums and use fewer medical services and therefore pay less out of pocket for services). The opposite also is true: If beneficiaries are less sensitive to premiums, fewer would enroll in lower-bidding plans, and their total payments would be higher, on average.

By the same logic, if the proportion of beneficiaries who did not choose a plan in the first year of a premium support system was larger than that indicated by the central estimates, their total payments would be lower, on average, than predicted (because those who did not choose a plan would be assigned to one with a bid at or below the benchmark). And if the proportion of beneficiaries who did not choose a plan was smaller than in the central estimates, their total payments would be higher, on average.

Beneficiaries' payments under the premium support options also would depend on other factors that contribute to the uncertainty of CBO's estimates. Private plans' bids could differ from the agency's central estimates if the current-law bids for Medicare Advantage were higher or lower than they are in CBO's estimates, if private insurers reduced their bids under a premium support system by more or less than the amounts in those estimates, or if the adjustment to plans' provider payment rates (and thus their bids) reflected a decline in the FFS market share that was smaller or larger than that in the estimates. For example, if the bids of private plans were below the central estimates, then payments would be lower for enrollees in those plans (because of lower premiums and reduced cost sharing) and higher for those who enrolled in the FFS program (because the lower cost of private plans would reduce benchmarks and raise FFS premiums). As a result, beneficiaries would have a greater incentive to switch from the FFS program to private plans, and beneficiaries' total payments would be lower than CBO's central estimates would indicate (assuming that the number of beneficiaries enrolled in the FFS program was not so large that the increase in payments for those beneficiaries outweighed the reduction in payments for enrollees in private plans and the reduction in the standard premium for all beneficiaries as a result of the lower benchmarks). If private plans' bids were higher than predicted by the central estimates, beneficiaries' total payments would rise relative to the central estimates.

About This Document

This Congressional Budget Office (CBO) report was prepared in response to interest expressed by Members of Congress. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

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Douglas W. Elmendorf
Director

September 2013

Table 1.

Change in Net Federal Spending for Medicare Under Illustrative Premium Support Options, Relative to That Under Current Law, 2020

	Second-Lowest-Bid Option	Average-Bid Option
In Billions of Dollars ^a	–45	–15
As a Percentage of Net Federal Spending for Medicare	–6	–2
As a Percentage of Net Federal Spending for Parts A and B for Affected Beneficiaries ^b	–11	–4

Source: Congressional Budget Office.

Note: Although estimates of percentage changes are based on CBO's March 2012 baseline projections (which are the projections underlying the analysis in this report), the dollar savings are based on applying those percentages to CBO's most recent projections (see *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013, www.cbo.gov/publication/44172).

^a Rounded to the nearest \$5 billion.

^b Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid). Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

Table 2.

Change in Net Federal Spending for Medicare and in Beneficiaries' Payments Under Illustrative Premium Support Options, Relative to Amounts Under Current Law, 2020

(Percent)	Second-Lowest-Bid Option	Average-Bid Option
Net Federal Spending for Parts A and B for Affected Beneficiaries ^a		
Central Estimate	–11	–4
Range	–9 to –14	–1 to –7
Total Payments by Affected Beneficiaries ^b		
Central Estimate	11	–6
Range	–2 to 24	0 to –12
Net Federal Spending for Parts A and B for Affected Beneficiaries Plus Total Payments by Affected Beneficiaries ^{a, b, c}		
Central Estimate	–5	–4
Memorandum:		
Premiums Paid by Affected Beneficiaries ^{c, d}		
Central Estimate	31	–6

Source: Congressional Budget Office.

Note: Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid).

^aThe reported range for the second-lowest-bid option is not symmetric around the central estimate because of rounding. Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

^bPayments include premiums and out-of-pocket costs for deductibles, copayments, and coinsurance for services and supplies covered by Part A and Part B. Payments include the standard Part B premium and the income-related premium (applicable for beneficiaries whose income exceeds specified thresholds) but exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage.

^cRange has not yet been estimated.

^dUnder current law and under the options, premiums are for the basic package of Medicare benefits covered under Parts A and B. They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the incomerelated premium.

Figure 1.**Return to Reference****Key Operations Under the Illustrative Second-Lowest-Bid Option for Premium Support**

Operation in each region: The federal government divides the country into regions that reflect health care markets within states. Any insurer that submits a bid for a region would be required to serve the entire region.

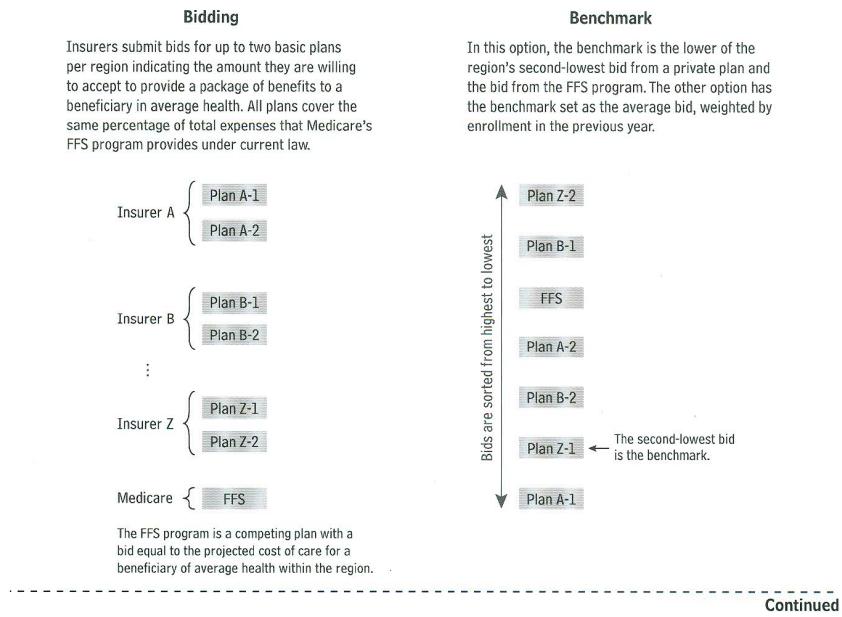
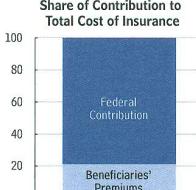
**Continued**

Figure 1.
Key Operations Under the Illustrative Second-Lowest-Bid Option for Premium Support

Participation	Plan Selection and Premiums		Federal Contribution
Dual-eligible beneficiaries (who enroll in Medicare and Medicaid simultaneously) are excluded.	Beneficiaries either select a plan or are assigned to a plan with a bid at or below the benchmark.		The government pays most of the cost of insurance for covered Part A and Part B benefits.
Anyone else enrolled in Medicare when the program takes effect enters the new system.	For all beneficiaries: beneficiary's premium = standard premium + plan's bid - benchmark		For a beneficiary in average health: federal contribution = benchmark - standard premium
Number of Eligible Beneficiaries	Plan	Premium	Share of Contribution to Total Cost of Insurance
 Enrolled in Medicare before 2018 (\$1 million) Newly enrolled in Medicare in 2018 (4 million)	Plan Z-2 Plan B-1 FFS Plan A-2 Plan B-2 Plan Z-1 Plan A-1	Standard + \$\$\$ Standard + \$\$ Standard + \$ Standard + \$ Standard + \$ Standard	The payment to each plan is adjusted up or down for beneficiaries in worse or better health than average.
People who become eligible after 2018 (except dual-eligible beneficiaries) enter the new system when they become eligible.			
			For all plans: total payments received for a beneficiary in average health = bid
			The standard premium is calculated as 25 percent of the national average of the cost per beneficiary for services and supplies covered by Part B.

Source: Congressional Budget Office.

Note: FFS = fee-for-service.

Box 1.

The Medicare Program

In 2013, Medicare will provide federal health insurance for 52 million people who are elderly (age 65 or older) or disabled or who have end-stage renal disease. Of that group, about 85 percent are elderly. Medicare's Part A (Hospital Insurance) primarily covers inpatient hospital, skilled nursing facility, and hospice care. Part B (Medical Insurance) mainly covers services provided by physicians and other practitioners and by hospital outpatient departments. Home health care may be covered by Part A or by Part B. Medicare's Part D is the prescription drug program. Nearly 30 percent of Medicare beneficiaries receive care through the Medicare Advantage program, or Part C, in which private health insurers assume responsibility for, and the financial risk of, providing Medicare benefits. Almost all of the remaining beneficiaries receive care in the traditional fee-for-service (FFS) program. In 2012, gross spending for Medicare was \$557 billion. Net of offsetting receipts (mostly premiums paid by beneficiaries), federal spending for the program was \$472 billion.

Box 1.—Continued**Medicare's Financing**

The various parts of Medicare are financed in different ways. Part A is financed primarily by a payroll tax. Beneficiaries' premiums (including income-related adjustments paid by higher-income beneficiaries) cover just over one-quarter of the outlays for Part B, and general funds from the U.S. Treasury cover nearly all of the rest. The government's payments to Medicare Advantage plans are financed by funds from Parts A and B. For Part D, enrollees' premiums cover about one-quarter of the cost of the basic prescription drug benefit, the federal government receives payments from states for dual-eligible beneficiaries (who are enrolled simultaneously in Medicare and Medicaid), and general funds cover most of the remaining cost. In fiscal year 2012, payroll taxes financed about 37 percent of Medicare outlays, beneficiaries' premiums covered about 13 percent, and most of the rest came from general funds of the Treasury.

Medicare's Traditional Fee-for-Service Program

Enrollees in the traditional FFS program are covered for services delivered by any participating provider, and both the package of benefits and the rates paid to providers are set by law. Medicare beneficiaries share those costs through deductibles and coinsurance, but because cost-sharing liabilities can be substantial (in part because traditional Medicare does not include an annual cap on what beneficiaries spend), about 90 percent of beneficiaries in the FFS program have supplemental insurance that covers most or all of their cost sharing, often through retiree plans offered by former employers or through individual insurance policies (known as medigap plans) or Medicaid.

Medicare Advantage

In most places in the United States, Medicare beneficiaries may choose among competing private insurers—through the Medicare Advantage program—instead of the traditional FFS program. Participating insurance companies submit bids indicating the per capita payment they are willing to accept for providing Part A and B benefits to a beneficiary of average health. (A separate bidding process determines payments for Part D.) The federal payment per enrollee then depends on what the insurance company bids and on how that amount compares with a “benchmark” that is announced by the federal government before those bids are submitted. Under a system set to be fully phased in by 2017, benchmarks will be based on per capita spending in the FFS program at the county level, and they will range from 95 percent of FFS spending per capita in the one-quarter of counties where such spending is highest to 115 percent of FFS spending per capita in the one-quarter of counties where such spending is lowest. Plans with quality ratings above a specified threshold will have bonus amounts added to their benchmarks.

Plans that submit a bid below the benchmark for a service area receive federal payments that equal their bid plus a rebate that is a percentage of the difference between the bid and the benchmark. (Beginning in 2014, the rebate will range from 50 percent to 70 percent, depending on the plan's performance on certain quality measures.) Plans must return the rebate to enrollees in the form of reduced cost sharing for benefits, coverage for items not covered by Medicare, or reduced Part B or Part D premiums. Plans with a bid that equals or exceeds the benchmark receive federal payments that equal the benchmark and must charge enrollees a premium for their Medicare coverage equal to the amount by which their bid exceeds the benchmark. Plans' payments from Medicare are larger or smaller, respectively, for enrollees who are in worse- or better-than-average health.

Table 3.
Examples of Determining Premiums Under Illustrative Premium Support Options, Using Hypothetical Bids and Enrollment

	Region With High Fee-for-Service Spending			Region With Low Fee-for-Service Spending		
	Bid	Annual Premium	Proportion Enrolled	Bid	Annual Premium	Proportion Enrolled
Second-Lowest-Bid Option						
Fee-for-Service Program	14,000	4,300	0.25	9,900	1,900	0.75
Private Plans						
A	11,800	2,100	0.15	10,100	2,100	0.05
B	11,600	1,900	0.15	9,900	1,900	0.05
C	11,400	1,700	0.15	9,700	1,700	0.05

Table 3.—Continued
Examples of Determining Premiums Under Illustrative Premium Support Options, Using Hypothetical Bids and Enrollment

	Region With High Fee-for-Service Spending			Region With Low Fee-for-Service Spending		
	Bid	Annual Premium	Proportion Enrolled	Bid	Annual Premium	Proportion Enrolled
D	11,200	1,500	0.15	9,500	1,500	0.05
E	11,000	1,300	0.15	9,300	1,300	0.05
Benchmark	11,200	n.a.	n.a.	9,500	n.a.	n.a.
Standard Premium	n.a.	1,500	n.a.	n.a.	1,500	n.a.
Average-Bid Option						
Fee-for-Service Program	14,000	3,300	0.25	9,900	1,500	0.75
Private Plans						
A	12,000	1,300	0.15	10,300	1,900	0.05
B	11,800	1,100	0.15	10,100	1,700	0.05
C	11,600	900	0.15	9,900	1,500	0.05
D	11,400	700	0.15	9,700	1,300	0.05
E	11,200	500	0.15	9,500	1,100	0.05
Benchmark	12,200	n.a.	n.a.	9,900	n.a.	n.a.
Standard Premium	n.a.	1,500	n.a.	n.a.	1,500	n.a.
Enrollment-Weighted Average	12,200	1,500	n.a.	9,900	1,500	n.a.

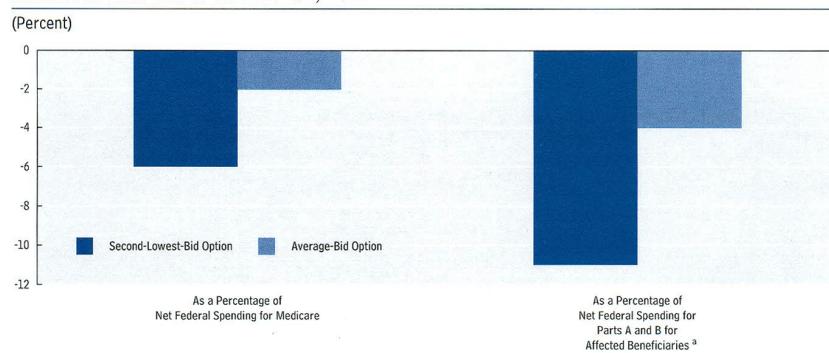
Source: Congressional Budget Office.

Notes: Under the second-lowest-bid option, the benchmark would equal the lower of the second-lowest bid from a private plan and the bid of the fee-for-service program. Under the average-bid option, the benchmark would equal the enrollment-weighted-average bid among all plans, including the fee-for-service program.

Proportion enrolled is for the previous year. Equal proportions among private plans are used to simplify the example. (According to CBO's estimates, enrollment would be higher in low-bidding plans.)

Under both options, premiums would equal the standard premium plus the bid minus the benchmark, and federal contributions for a beneficiary of average health would equal the benchmark minus the standard premium. Those federal contributions would be \$9,700 and \$8,000 under the second-lowest-bid option in regions with high and low fee-for-service spending, respectively, and \$10,700 and \$8,400 under the average-bid option in such regions, respectively.

n.a. = not applicable.

Figure 2.**Return to Reference****Change in Net Federal Spending for Medicare Under Illustrative Premium Support Options, Relative to That Under Current Law, 2020**

Source: Congressional Budget Office.

Note: The second-lowest-bid option would reduce net federal spending for Medicare by about \$45 billion in 2020, and the average-bid option would reduce such spending in that year by about \$15 billion. Although estimates of percentage changes are based on CBO's March 2012 baseline projections (which are the projections underlying the analysis in this report), the dollar savings are based on applying those percentages to CBO's most recent projections (see *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013, www.cbo.gov/publication/44172).

a. Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid). Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

Table 4.**Average Annual Premiums Charged by Plans for Medicare Part A and B Benefits Under Illustrative Premium Support Options, Weighted by Population, 2020**

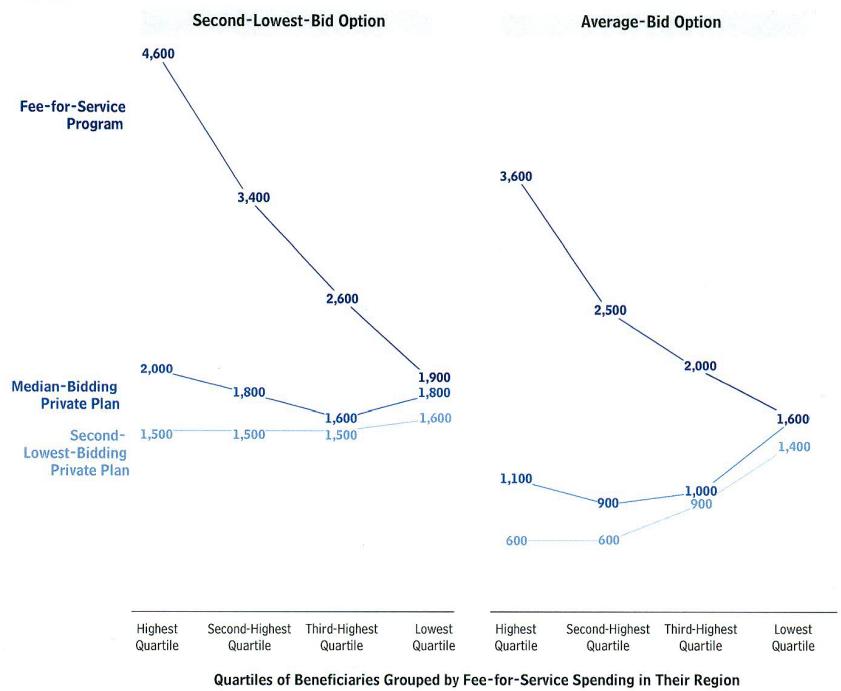
	Second-Lowest-Bid Option		Average-Bid Option	
	Annual Premium (Dollars)	Change From Part B Premium Under Current Law (Percent)	Annual Premium (Dollars)	Change From Part B Premium Under Current Law (Percent)
Second-Lowest-Bidding Private Plan	1,500	-6	900	-44
Median-Bidding Private Plan	1,800	13	1,200	-25
Fee-for-Service Program	3,100	94	2,400	50

Source: Congressional Budget Office.

Note: Premiums charged by plans are averages weighted by the Medicare population in each region. (Those averages differ from the average premiums paid by beneficiaries, which are based on CBO's projections of enrollment in plans.) Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Part A (Hospital Insurance) and Part B (Medical Insurance). They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium (applicable for beneficiaries whose income exceeds specified thresholds). Under current law, for most beneficiaries, Part A will have no premium and the premium for Part B (excluding income-related adjustments) will be \$1,600 in 2020, CBO projects. Amounts are rounded to the nearest \$100.

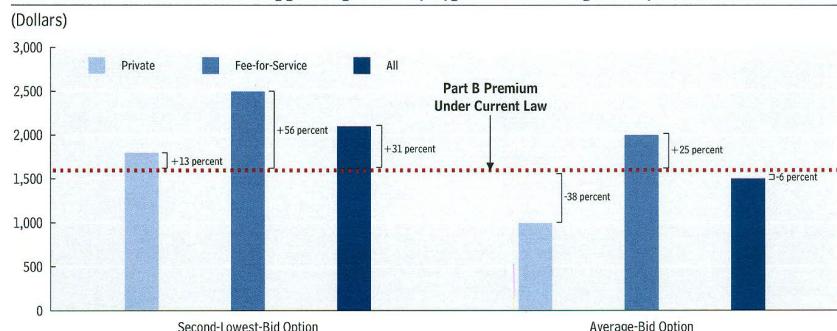
Figure 3.[Return to Reference](#)**Average Annual Premiums Charged by Plans for Medicare Part A and B Benefits Under Illustrative Premium Support Options, by Fee-for-Service Spending in a Region, Weighted by Population, 2020**

(Dollars)



Source: Congressional Budget Office.

Note: Premiums charged by plans are averages weighted by the Medicare population in each region. (Those averages differ from the average premiums paid by beneficiaries, which are based on CBO's projections of enrollment in plans.) Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Part A (Hospital Insurance) and Part B (Medical Insurance). They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium (applicable for beneficiaries whose income exceeds specified thresholds). Under current law, for most beneficiaries, Part A will have no premium and the premium for Part B (excluding income-related adjustments) will be \$1,600 in 2020, CBO projects. Amounts are rounded to the nearest \$100. Quartiles are groups of regions classified by per capita fee-for-service spending; each contains a quarter of the Medicare population.

Figure 4.[Return to Reference](#)**Average Annual Premiums Paid by Beneficiaries for Medicare Part A and B Benefits Under Illustrative Premium Support Options, by Type of Plan, Weighted by Enrollment, 2020**

Source: Congressional Budget Office.

Note: Premiums paid are averages weighted by CBO's projections of enrollment in plans. Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Part A (Hospital Insurance) and Part B (Medical Insurance). They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium (applicable for beneficiaries whose income exceeds specified thresholds). Under current law, for most beneficiaries, Part A will have no premium and the premium for Part B (excluding income-related adjustments) will be \$1,600 in 2020, CBO projects. Amounts are rounded to the nearest \$100. Percentage differences are reported relative to the Part B premium under the current law.

Box 2.**Grandfathering of Beneficiaries Under a Premium Support System**

Under one type of proposal for a premium support system, current beneficiaries and those who became eligible for Medicare before the new system took effect would continue to receive coverage under the existing Medicare program; only those beneficiaries who became newly eligible on or after a specified date would enroll in the premium support system. Such an arrangement would require the federal government to address several important design questions—some are unique to such a system and others are relevant for any premium support system but have added significance if grandfathering is part of the design. Although policymakers might also consider changing the existing Medicare program if it remained in operation, this discussion focuses on design issues specifically related to a grandfathering provision in a premium support system, and it assumes that beneficiaries who remained in the existing system could choose Medicare's fee-for-service (FFS) program or a Medicare Advantage plan and that private insurers could participate in the premium support system, the Medicare Advantage program, or both.

Enrollment in Part B

An important question for any premium support system is whether enrollment in Medicare's Part B (Medical Insurance) would remain voluntary, and if so, how beneficiaries who declined that coverage would be treated by the system. About 8 percent of Medicare beneficiaries are not enrolled in Part B currently, generally because either they or a spouse are still working and have employment-based coverage as primary insurance with Medicare as a secondary insurer.

Among the Medicare population age 65 or older, younger beneficiaries are more likely to decline Part B coverage, and the percentage that does so has increased as more people have stayed in the workforce past age 65. (The late-enrollment penalty for Part B is waived for active workers in larger companies that offer employment-based coverage. If such workers were to enroll, Medicare would be a secondary payer for their health care costs, which would reduce the value of the coverage.) Some 19 percent of 65-year-old Medicare beneficiaries were not enrolled in Part B in 2011, up from 15 percent in 1999. If a premium support program included grandfathering, the question of whether Part B enrollment would remain voluntary would be especially important because the younger segment of the retirement-age population would constitute a substantial fraction of the beneficiaries covered in the first few years.

Box 2.—Continued**Bidding Regions**

Depending on how the regions were defined, in many regions the number of beneficiaries in a premium support system with a grandfathering provision could initially be very small. If dual-eligible beneficiaries also were excluded from the new system, the Congressional Budget Office (CBO) projects, just 5 percent of the Medicare population would be covered by the system after the first year, and only 25 percent would be covered after the fifth year.

Some proposals would have bidding regions correspond to health care markets within states. In that case, grandfathering would result in some regions' enrolling very small numbers of people in the new system in the first few years. Because personal health care expenditures vary widely, the actual costs of enrollees in private plans and the FFS program could differ greatly from those plans' bids for their regions. That uncertainty could make participation less attractive to private insurers, cause them to raise their bids if they chose to participate, and create significant year-to-year variation in the amounts of the bids. In regions with few beneficiaries, private insurers also would have less incentive to modify health care plans to contain costs.

Bids and Risk Adjustment

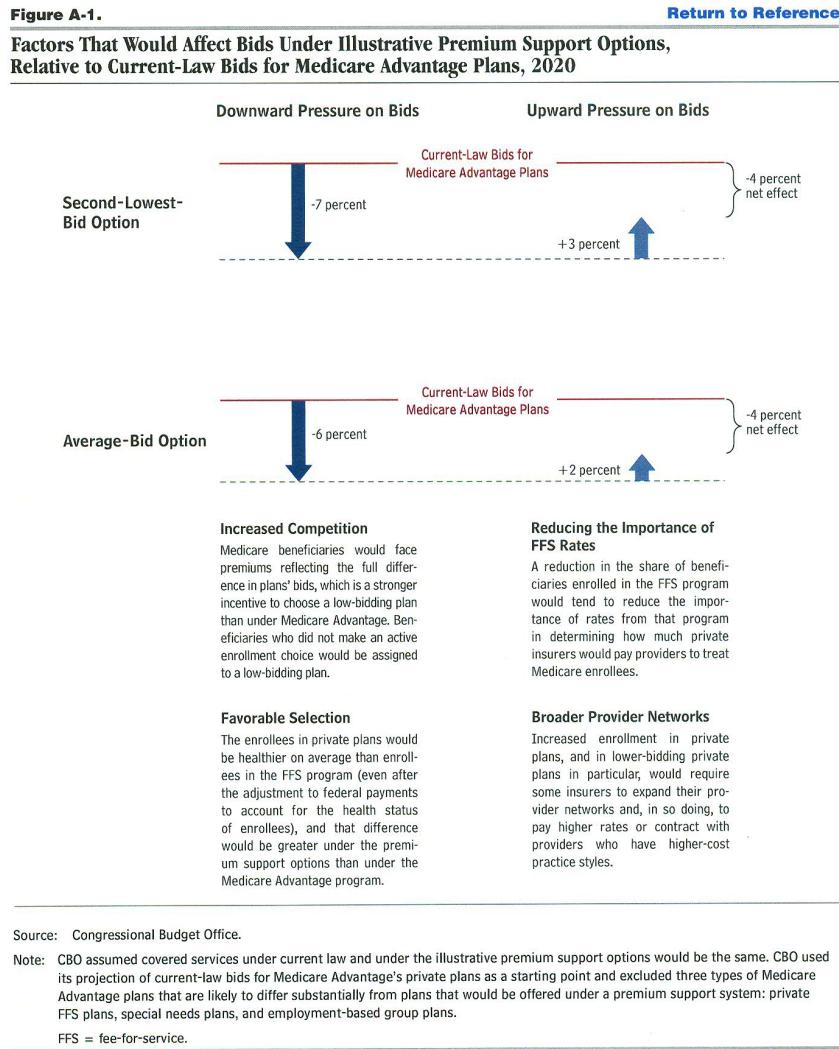
Under the illustrative premium support options analyzed for this report, insurers would submit a bid for a beneficiary with average expected health care costs (that is, a beneficiary with a risk score of 1.0), and federal payments to insurers would be adjusted to account for differences between their enrollees' expected costs and those of the average beneficiary. CBO assumed that the risk adjustment would be comparable to that for the Medicare Advantage program, in which federal payments to insurers are adjusted on the basis of enrollees' medical conditions and demographic characteristics.

In the initial years of a system with grandfathering, a substantial proportion of covered beneficiaries would not have the history of past Medicare claims data necessary to compute a risk score. For those beneficiaries, payments to plans could be adjusted using a version of the risk adjuster based entirely on demographic characteristics. That approach lacks the completeness of the standard risk adjuster, which includes information on medical conditions, so pursuing it would raise questions about the adequacy of risk adjustment in the first few years.

Under a grandfathering provision, the bidding and risk adjustment mechanism could reflect average expected costs for a beneficiary in the premium support system. That approach would necessitate "rescaling" the risk adjustment factors to correspond to the segment of the Medicare population enrolled in the premium support system or reestimating those factors (because particular risks are associated with costs in ways that would differ between that segment and the Medicare population as a whole). If the existing risk adjustment mechanism was used instead, insurers would base their bids on a population that differed from the population served under the premium support system. An analogous set of issues would confront the Medicare Advantage program. Once the premium support system began, the proportion of beneficiaries eligible to enroll in a Medicare Advantage plan would decline each year as new people entered the premium support system.

Beneficiaries' Premiums

For both illustrative options, CBO assumed that beneficiaries who enrolled in a plan with a bid equal to the benchmark would pay a standard premium determined using the same formula used to calculate the Part B premium under current law. With grandfathering, that premium could be determined in various ways. One approach would be to compute a single standard premium for the entire Medicare population that would apply both to beneficiaries in the premium support system and to those who were grandfathered into Medicare in its current-law form. In a second approach, separate computations could be made for a standard premium under the premium support system and for the Part B premium that would apply to the grandfathered population; a standard premium could be computed as one amount, or standard premiums could differ by beneficiaries' age. Each approach would involve a different distribution of health care costs and of potential savings from a premium support system among age groups.



Source: Congressional Budget Office.

Note: CBO assumed covered services under current law and under the illustrative premium support options would be the same. CBO used its projection of current-law bids for Medicare Advantage's private plans as a starting point and excluded three types of Medicare Advantage plans that are likely to differ substantially from plans that would be offered under a premium support system: private FFS plans, special needs plans, and employment-based group plans.

FFS = fee-for-service.

Politico, April 30, 2012

GOP SPLIT ON REFORMING HEALTH CARE

By Jennifer Haberkorn

Ask the 242 House Republicans what kind of health policy they'd like to enact instead of President Barack Obama's health care reform law and you might get 242 different answers.

Even after 3 years of railing against Obama's plan, Republicans have coalesced around only a few basic tenets of health policy—let alone a full replacement plan.

They are even divided over whether some of the popular pieces of Obama's health law are a good idea. For example, most Republicans support the health law's re-

quirement that insurance companies accept all applicants—but the replacement plan put forward by the most prominent Republican ignores that idea.

“It’s a terrible idea,” Rep. Tom Price (R-GA), the sponsor of the plan, told *Politico*. He said Democrats only enacted the provision in order to require exactly what kinds of insurance Americans must have. He would rather expand coverage voluntarily.

The wide range of GOP opinions could make it hard for the party to come together behind a single plan to replace Obama’s health care law if it’s overturned by the Supreme Court this summer.

A ruling against all or part of the legislation has the potential to reopen the health care wars of 2009, putting the differences among Republicans on full display. It’s a divide Democrats would try to exploit as they press Republicans on how they’re going to solve the country’s health care problems.

“If the Supreme Court throws out the president’s plan, we’re going to have to have something on the table,” said Rep. Paul Broun (R-GA), a physician.

House Republicans won’t be the only ones with replacement plans. Gov. Mitt Romney’s health agenda relies more on state-level reforms and private competition than Obama’s law.

On Capitol Hill, there are a handful of pending Republican health bills.

Days before the Supreme Court heard oral arguments over the health law, Broun introduced a plan that allows Americans to deduct all of their health care costs; encourages the use of health savings accounts; converts Medicare to a “premium support” model that subsidizes private coverage; allows consumers to buy insurance across state lines; and encourages the use of association health plans, which allow groups of people or co-workers to buy health care together.

Broun said he’s trying to drum up support among lawmakers and outside groups and already has the backing of FreedomWorks, the conservative group led by Dick Armey.

The plan that’s likely to get the closest look from Republicans is sponsored by Price, an orthopedic surgeon and one of the House’s leading voices on health care. He released a video on Wednesday touting the plan, which he originally introduced in 2009.

PREPARED STATEMENT OF HON. THOMAS PRICE, M.D., NOMINATED TO BE SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you, Chairman Hatch, Ranking Member Wyden, and all the members of this committee, for the opportunity to speak with you today and engage in a discussion about the road ahead for our great Nation. These proceedings, and this entire process, would not be possible without the work of your staff, and so I want to extend my appreciation to them as well for the great service they provide. Thanks so much to Senator Johnny Isakson for his generous introduction. We’ve known each other for nearly 30 years—and I’m so grateful for his friendship and kindness, and our State is blessed to have had his service and leadership. I wish also to especially thank my wife of 33 years, Betty. Her support, encouragement and advice (which is always correct) mean more than I could ever say.

Over the past few weeks, I have had the chance to meet with many of you individually and have gained a real appreciation for the passion you all have about the critical work of the Department of Health and Human Services. Please know that I share that passion. That is why I am here today—and why I’m honored to have been nominated by the President to serve as the next Secretary of HHS.

We all come to public service in our own unique ways that inform who we are and why we serve. My first professional calling was to care for patients. That experience as a physician and later as a legislator has provided a holistic view of the complex interactions that take place every day across our communities and across this country that, when done correctly, are in service to the greater good we seek to achieve. Today, I hope to share with you how my experience has helped shape my understanding of and appreciation for the work of the department and its team, which I hope to lead.

From an early age, I had an interest in medicine. My earliest memories are of a farm in Michigan where my family and I lived before moving to suburban Detroit at the age of five. I spent most of my formative years being raised by a single

mom—and I assumed a lot of responsibility since there were 5 of us. Some of my fondest memories were spending time with my grandfather—a physician—as he made house calls to see patients. Having both a father and grandfather as physicians surely influenced my path toward medicine. And it was very likely that the orthopedist who treated my many broken bones in my youth gave me a particular fascination for fixing things—and not just broken bones.

After graduating with a medical degree from the University of Michigan, I went south to Atlanta, GA—which I’ve called home for nearly 40 years. It’s where I met my wife Betty and where we raised our son. I did my residency at Emory University and Grady Memorial Hospital in downtown Atlanta. I would return to Grady later in my career to serve as Medical Director of the Orthopedic Clinic. Throughout my professional career I treated patients of every age—from all walks of life—including many children. Anyone who has ever treated a child knows how fulfilling it is to look into the eyes of a parent and tell them our team has helped heal their son or daughter—to give them peace of mind. My memories of Grady are filled with the gracious comments from parents and patients for the team of health care specialists with whom I had the privilege of working. I cherished my time there.

After 25 years of school and training, I hung out my shingle to start a solo private orthopedic practice. Over the years, this practice grew and eventually became one of the largest, non-academic orthopedic groups in the country—a group I would eventually serve as Chairman of the Board. Whether as part of that team or on staff at a hospital, it was apparent early on that every person involved in the delivery of care, no matter their role—doctors, nurses, lab techs, orderlies—all had one goal in mind—and that was to get our patients well again, to heal them. It was always a team effort and wherever you fit into that team, you appreciated the value of those working with you.

During 20 years as a practicing physician—both in office and hospital setting—I learned a good bit about not just treating patients but about the broader health care system and where it intersects with government—local, State and Federal. A couple of lessons stand out. One—many patients I knew or treated were never more angry and frustrated than when they realized that there was someone other than themselves and/or their physician making medical decisions on their behalf—when there was someone not involved in the actual delivery of care that was standing between them and their doctor or treatment.

Another lesson came the day I noticed that there were more individuals within our office who were dealing with paperwork, insurance filings, and government regulations than there were individuals actually seeing and treating patients. It was in those moments that it became crystal clear that our health care system was losing focus on the number one priority—the individual patient. Having had no greater joy than taking care of patients, I felt compelled to broaden my role in public service, and help solve the issues harming the delivery of medicine—so I ran for the State Senate in Georgia.

Anyone here who has ever served at the State level knows that State government has a different feel to it—a different pace. In Georgia, I found the State Senate to be a remarkably bipartisan place where collegial relationships were the norm. This is the environment in which I learned to legislate—reaching across the aisle to get the work done—needing the buy-in and the support of more than just one party. I worked with Democrats including then State senator, now-Atlanta Mayor, Kasim Reed. He and I did not see eye to eye on everything, for sure, but we were successful in finding our way together through some really challenging issues for our State.

In Congress, I have been fortunate to have been a part of collaborations that broke through party lines to solve problems including those pertaining to health care. Early in my congressional career, I was privileged to work alongside then-representative, now Senator, Tammy Baldwin to introduce legislation that would have empowered States to come up with new ideas to provide health care coverage to their uninsured populations. Just this past Congress, it was a bipartisan, bicameral effort that actually succeeded in ridding Medicare of a broken physician payment system and which has now begun the creation of a new system that, if implemented properly, will help ensure that seniors have better access to higher quality care.

If confirmed, my obligation will be to carry to the Department of Health and Human Services both an appreciation for bipartisan, team-driven policymaking and what has been a lifetime commitment to work to improve the health and well-being of the American people. That commitment extends to what I call the six principles

of health care—six principles that, if you think about it, all of us hold dear: affordability, accessibility, quality, choices, innovation, and responsiveness. We all want a health care system that's affordable, that's accessible to all, of the highest quality, with the greatest number of choices, driven by world-leading innovations, and responsive to the needs of the individual patient.

But HHS is more than just health care. There are real heroes at this department doing incredible work to keep our food safe, to develop new drugs and treatment options—driven by scientists conducting truly remarkable research. The Centers for Disease Control and Prevention—which we in Atlanta are proud to have headquartered in our city—is the first place the world turns to when there's a health care threat that requires the greatest, most capable minds to solve.

There are heroes among the talented, dedicated men and women working to provide critical social services—helping families and, particularly, children have a higher quality of living and the opportunity to rise up and strive to achieve their American Dream—something we all want for ourselves and our loved ones.

The role of HHS in improving lives means it must carry out its responsibilities with compassion. It also must be efficient, effective and accountable, as well as being willing to partner with those in our communities already doing remarkable work. In every aspect of the department, across the spectrum of issues and services it handles, there is embedded a promise that has been made to the American people. Governor Michael Leavitt, during his confirmation hearing in 2004 to take on this task, spoke of our highly regarded “brands”—the CDC, FDA, NIH, and others—and how they must be preserved and strengthened because they guarantee that those promises are kept.

Today's challenges make it even more important that we strengthen our resolve to keep the promises we, as a society, have made to our senior citizens and to those among us who are most in need of care and support. That means saving, strengthening, and securing Medicare for today's beneficiaries and future generations. It means ensuring that our Nation's Medicaid population has access to quality care. It means maintaining, and expanding, America's leading role in medical innovation and the treatment and eradication of disease.

As I noted at the outset, I share your passion for these issues—having spent my life in service to them. And yet, there's no doubt that we do not all share the same point of view when it comes to addressing each and every one of them. Our approaches to policies may differ, but there surely exists a common commitment to public service and compassion for those we serve. We all hope, by our actions, to help improve the lives of the American people, to help heal individuals and whole communities. With a healthy dose of humility and appreciation for the scope of the challenges before us, with your assistance and with God's will, we can make it happen. I look forward to working with you to do just that.

Thank you very much for the privilege of appearing before you today.

SENATE FINANCE COMMITTEE

STATEMENT OF INFORMATION REQUESTED OF NOMINEE

A. BIOGRAPHICAL INFORMATION

1. Name (include any former names used): Thomas Edmunds Price, M.D.
2. Position to which nominated: Secretary of the Department of Health and Human Services.
3. Date of nomination: January 20, 2017.
4. Address (list current residence, office, and mailing addresses):
5. Date and place of birth: October 8, 1954, Lansing, Michigan.
6. Marital status (include maiden name of wife or husband's name):
7. Names and ages of children:

8. Education (list secondary and higher education institutions, dates attended, degree received, and date degree granted): Dearborn High School, 1969–1972, Diploma; University of Michigan, 1972–1979, Bachelor's Degree and Doctor of Medicine.
9. Employment record (list all jobs held since college, including the title or description of job, name of employer, location of work, and dates of employment): Surgical Intern, Emory University School of Medicine/Grady Health System, Atlanta, GA, 1979–1980; Orthopaedic Surgical Resident, Emory University School of Medicine/Grady Health System, Atlanta, GA, 1980–1984; Orthopaedic Surgeon, solo and group practice (North Fulton Orthopaedic Clinic, Compass Orthopaedics, Resurgens Orthopaedics), Roswell/Atlanta, GA, 1984–2002; Assistant Professor, Orthopaedic Surgery, Emory University School of Medicine/Grady Health System, Atlanta, GA 2002–2004; Georgia State Senator, State of Georgia, Atlanta, GA, 1997–2005; Member of Congress, GA06, House of Representatives, Washington DC, 2006–present.
10. Government experience (list any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments, other than those listed above): See Appendix A.
11. Business relationships (list all positions held as an officer, director, trustee, partner, proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, other business enterprise, or educational or other institution): Founder/owner, North Fulton Orthopaedic Clinic, Roswell, GA; co-founder/president, Compass Orthopaedics, Roswell, GA; Director/chairman of board, Resurgens Orthopaedics, Atlanta/Roswell, GA; managing partner, Chattahoochee Associates, Roswell, GA (owns medical office building); member and co-owner, Diagnostic Ventures of Roswell, LLC, Roswell, GA (owns medical office building); member and co-owner, RMC3, LLC, Roswell, GA (owns stake in Diagnostic Ventures of Roswell, LLC, which owns medical office building); limited partner, Carolina Properties, Ltd., (owns apartment buildings in North Carolina, South Carolina, and Virginia).
12. Memberships (list all memberships and offices held in professional, fraternal, scholarly, civic, business, charitable, and other organizations): Roswell Rotary Club, 1985–present, president 1996–1997; American Academy of Orthopaedic Surgeons; American Medical Association; Medical Association of Georgia; Medical Association of Atlanta; Atlanta Orthopaedic Society; Kelly Orthopaedic Society; Georgia Orthopaedic Society; American College of Surgeons; Chattahoochee Nature Center; Georgia Ensemble Theatre; Georgia Arthritis Foundation.
13. Political affiliations and activities:
 - a. List all public offices for which you have been a candidate.
Georgia State Senate District 56; U.S. House of Representatives GA06.
 - b. List all memberships and offices held in and services rendered to all political parties or election committees during the last 10 years.
Member of Congress, GA06, Republican.
 - c. Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of \$50 or more for the past 10 years.
See Appendix B.
14. Honors and awards (list all scholarships, fellowships, honorary degrees, honorary society memberships, military medals, and any other special recognitions for outstanding service or achievement):
See Appendix C.
15. Published writings (list the titles, publishers, and dates of all books, articles, reports, or other published materials you have written):
Saving the American Miracle: The Destruction and Restoration of American Values. Paperback—self-published, January 20, 2011.
In addition, a listing of all requested Op-Eds authored by Dr. Price has been attached as Appendix D.

16. Speeches (list all formal speeches you have delivered during the past 5 years which are on topics relevant to the position for which you have been nominated):

See Appendix E.

17. Qualifications (state what, in your opinion, qualifies you to serve in the position to which you have been nominated):

My strengths are commitment, passion, and expertise. My entire adult life has been dedicated to service—professionally as an orthopaedic surgeon, politically as a State Senator and member of Congress, and in our community through numerous volunteer and charity activities. As a third-generation physician, I am well aware of the challenges of caring for patients and the societal needs of populations. For over 20 years, I had the privilege of practicing orthopaedic surgery in both private and public settings, training in an urban medical center including service in a veterans hospital, and treating folks of all ages and all walks of life. I founded North Fulton Orthopaedic Clinic and over time co-founded Resurgens Orthopaedics—reputed to be the largest private group practice of orthopaedic surgeons in the country. While serving as a Georgia State Senator, I was responsible for training students, interns, and residents in a large, major urban hospital in Atlanta. Those experiences coupled with being a legislator at both the State and Federal levels has given me a comprehensive understanding of the complex interactions taking place every day between patients and their families, physicians, providers, insurers, as well as local, State, and Federal Governments. It is a perspective that has reinforced my belief that the individual patient must always be at the center of health-care policy decisions. Having examined many systems and collaborated with many individuals and groups to bring improvements to our health-care financing and delivery, my breadth of experience and understanding has uniquely qualified me for this post. I have a deep passion for finding positive solutions to improve the human condition and allowing each member of our society to realize their full potential. I am not daunted by the challenge before us and have confidence in the promise that HHS may bring with its many agencies and broad jurisdiction to assist our communities and citizens. As a student of scientific principles, I have a profound appreciation for the role of basic scientific research, for the development of innovative treatments and cures, and for the imperative that America remains a leader in those pursuits.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, associations, or organizations if you are confirmed by the Senate? If not, provide details.

Yes, any and all necessary.

2. Do you have any plans, commitments, or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, provide details.

No.

3. Has any person or entity made a commitment or agreement to employ your services in any capacity after you leave government service? If so, provide details.

No.

4. If you are confirmed by the Senate, do you expect to serve out your full term or until the next presidential election, whichever is applicable? If not, explain.

Yes.

C. POTENTIAL CONFLICTS OF INTEREST

1. Indicate any investments, obligations, liabilities, or other relationships which could involve potential conflicts of interest in the position to which you have been nominated.

None. The nominee will comply with all Office of Government Ethics recommendations for current and future personal investment holdings.

2. Describe any business relationship, dealing or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.

None. The nominee will comply with all Office of Government Ethics recommendations for personal business relationships, dealings, and financial transactions.

3. Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any legislation or affecting the administration and execution of law or public policy. Activities performed as an employee of the Federal Government need not be listed.

Only as a member of Congress.

4. Explain how you will resolve any potential conflict of interest, including any that may be disclosed by your responses to the above items.

I intend to operate as I always have during all of my years in public service: by making ethical compliance a cornerstone of my public service and operating without reproach. Any personal holdings or positions which could conceivably present a potential conflict of interest have been disclosed to the Office of Government Ethics, and appropriate resolution of any potential conflict of interest will be resolved prior to my confirmation.

5. Two copies of written opinions should be provided directly to the committee by the designated agency ethics officer of the agency to which you have been nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position.

6. The following information is to be provided only by nominees to the positions of United States Trade Representative and Deputy United States Trade Representative:

Have you ever represented, advised, or otherwise aided a foreign government or a foreign political organization with respect to any international trade matter? If so, provide the name of the foreign entity, a description of the work performed (including any work you supervised), the time frame of the work (e.g., March to December 1995), and the number of hours spent on the representation.

N/A.

D. LEGAL AND OTHER MATTERS

1. Have you ever been the subject of a complaint or been investigated, disciplined, or otherwise cited for a breach of ethics for unprofessional conduct before any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, provide details.

The nominee was the subject of an investigation by the Office of Congressional Ethics in 2010 for matters involving fundraising activities associated with his principal campaign committee. Although the matter was referred for further consideration by the House Committee on Standards of Official Conduct, the committee dismissed the matter finding no wrongdoing and recommending that no further action was necessary. The public record associated with this investigation is available at the following link: <https://oce.house.gov/january-26-2011-oce-referral-regarding-rep-tom-price/>.

2. Have you ever been investigated, arrested, charged, or held by any Federal, State, or other law enforcement authority for a violation of any Federal, State, county or municipal law, regulation, or ordinance, other than a minor traffic offense? If so, provide details.

No.

3. Have you ever been involved as a party in interest in any administrative agency proceeding or civil litigation? If so, provide details.

No.

4. Have you ever been convicted (including pleas of guilty or *nolo contendere*) of any criminal violation other than a minor traffic offense? If so, provide details.

No.

5. Please advise the committee of any additional information favorable or unfavorable, which you feel should be considered in connection with your nomination.

N/A.

E. TESTIFYING BEFORE CONGRESS

1. If you are confirmed by the Senate, are you willing to appear and testify before any duly constituted committee of the Congress on such occasions as you may be reasonably requested to do so?

Yes.

2. If you are confirmed by the Senate, are you willing to provide such information as is requested by such committees?

Yes.

APPENDIX A

Leadership Positions and Standing Committee Assignments

1997–1998—Georgia Senate

- Health and Human Services
- Insurance and Labor
- Reapportionment
- Special Judiciary
- Youth, Aging, and Human Ecology

1999–2000—Georgia Senate

- Minority Whip
- Consumer Affairs
- Education
- Health and Human Services
- Reapportionment
- Special Judiciary

2001–2002—Georgia Senate

- Minority Whip
- Education
- Health and Human Services
- Reapportionment
- Rules
- Veterans and Consumer Affairs

2003–2004—Georgia Senate

- Majority Leader
- Appropriations
- Economic Development and Tourism, Vice-chair
- Education, ex-officio
- Ethics
- Health and Human Services
- Insurance and Labor ex-officio
- Reapportionment and Redistricting, Secretary
- Rules, Secretary

2005–2009—U.S. House of Representatives

- Financial Services
- Education and Workforce/Labor

2009–2011—U.S. House of Representatives

- Chair—Republican Study Committee
- Financial Services
- Education and Labor
- Ranking Member—Workforce Protections Subcommittee
- Ranking Member—HELP Subcommittee
- Franking Commission

2011–2013—U.S. House of Representatives

- Chair—Republican Policy Committee
- Ways and Means

- Budget
- Franking Commission

2013–2015—U.S. House of Representatives

- Ways and Means
- Vice-Chair—Budget Committee
- Education and Workforce
- Franking Commission

2015–2017—U.S. House of Representatives

- Chair—Budget Committee
- Ways and Means

APPENDIX B

Contributions Made By Thomas and Elizabeth Price

Contributor Name	Committee Name	Transaction Date	Amount
Clark-Price, Elizabeth	Norwood, Charlie via Norwood for Congress	August 23, 2000	\$250
Clark-Price, Elizabeth	Gingrey, J. Phillip via Gingrey for Senate Inc.	July 27, 2002	\$1,000
Clark-Price, Elizabeth	Isakson, John Hardy via Georgians for Isakson	June 6, 2003	\$200
Price, Elizabeth	Handel, Karen Christine via Handel for Senate Inc.	June 29, 2013	\$1,000
Price, Elizabeth	Handel, Karen Christine via Handel for Senate Inc.	December 18, 2013	\$1,000
Price, Elizabeth	Georgia Republican Party, Inc.	March 21, 2013	\$250
Price, Elizabeth	Georgia Republican Party, Inc.	March 10, 1999	\$200
Price, Elizabeth	Georgia Republican Party, Inc.	June 9, 1997	\$500
Price, Elizabeth	Gingrey, J. Phillip via Gingrey for Senate, Inc.	August 28, 2002	\$1,000
Clark-Price, Elizabeth	Romney, Mitt/Paul D. Ryan via Romney for President, Inc.	June 28, 2012	\$1,000
Price, Thomas E., M.D.	Georgia Republican Party, Inc.	May 4, 1999	\$295
Price, Thomas E., M.D.	Gingrey, J. Phillip via Gingrey for Senate, Inc.	July 27, 2002	\$1,000
Price, Thomas E., M.D.	Gingrey, J. Phillip via Gingrey for Senate, Inc.	August 28, 2002	\$1,000
Price, Thomas E., M.D.	Republican National Committee	October 23, 2000	\$250
Price, Thomas E., M.D.	Bush, George W. via Bush-Cheney '04 (Primary) Inc.	January 22, 2004	\$2,000
Price, Thomas E., Mrs.	Republican National Committee	October 23, 2000	\$250
Price, Thomas E., M.D.	Political Action Committee of the American Association of Orthopaedic Surgeons—PAC of AAO	June 6, 2002	\$250
Price, Thomas E., M.D.	Dole, Elizabeth via Elizabeth Dole for President Exploratory Committee Inc.	August 24, 1999	\$1,000
Price, Thomas E., M.D.	Georgia Republican Party, Inc.	May 24, 2000	\$300
Price, Thomas E., M.D.	Biggert, Judy via Judy Biggert for Congress	September 23, 2012	\$2,000
Price, Thomas E., M.D.	NRCC	December 11, 2008	\$220
Price, Thomas E., M.D.	Gingrich, Newton L., via Friends of Newt Gingrich	January 22, 1998	\$1,000
Price, Thomas E., M.D.	Price, Thomas Edmunds via Price for Congress—Loan, since repaid	July 28, 2004	\$99,000

Contributions Made By Thomas and Elizabeth Price—Continued

Contributor Name	Committee Name	Transaction Date	Amount
Price, Thomas E., M.D.	Price, Thomas Edmunds via Price for Congress—Loan, since repaid	August 6, 2004	\$150,000

Joint Fundraising Contributions

These are contributions to committees who are raising funds to be distributed to other committees.

The breakdown of these contributions to their final recipients may appear below.

Contributor Name	Committee Name	Transaction Date	Amount
Price, Mrs. Elizabeth	Trump Make America Great Again Committee	September 15, 2016	\$1,000

Recipient of Joint Fundraiser Contributions

These are the Final Recipients of Joint Fundraising Contributions.

Contributor Name	Committee Name	Transaction Date	Amount
Price, Mrs. Elizabeth	Trump, Donald J./Michael R. Pence via Donald J. Trump for President, Inc.	September 15, 2016	\$800

Georgia Contributions

Recipient	Contributor's Name	PAC Affiliation/Occupation/Employer	Date Received	Type	Amount
Georgia Republican Party, Inc.	Hon. Thomas E. Price	Physician Self-Employed	April 25, 2006	Monetary General	\$4,863
Georgia Republican Party, Inc.	Hon. Thomas E. Price	Physician Self-Employed	April 25, 2008	Monetary General	\$4,956
Georgia Republican Party, Inc.	Hon. Thomas E. Price	Physician Self-Employed	April 27, 2010	Monetary General	\$5,220
Georgia Republican Party, Inc.	Hon. Thomas E. Price	Physician Self-Employed	January 5, 2010	Monetary General	\$5,220
Karen Handel for Governor, Inc.	Elizabeth Price	Councilwoman, City of Roswell	January 5, 2010	Monetary Primary	\$1,000
Georgia Republican Party, Inc.	Elizabeth Price	Physician Compass Orthopedics	March 21, 2013	Monetary General	\$250
Keep Judge Tom Campbell; Thomas Ralph Campbell Jr.	Elizabeth Price	Physician Compass Orthopedics	April 16, 2014	Monetary General	\$500
Fulton County Republican Party, Inc.	Elizabeth Price	Homemaker N/A	January 22, 2009	Monetary General	\$150
Fulton County Republican Party, Inc.	Elizabeth Price	Homemaker N/A	February 13, 2009	Monetary General	\$50
Fulton County Republican Party, Inc.	Elizabeth Price	Homemaker N/A	April 29, 2010	Monetary General	\$150
Fulton County Republican Party, Inc.	Elizabeth Price	City Councilman, City of Roswell	October 7, 2011	Monetary	\$10
Fulton County Republican Party, Inc.	Elizabeth Price	City Councilman, City of Roswell	October 7, 2011	Monetary	\$180

Georgia Contributions—Continued

Recipient	Contributor's Name	PAC Affiliation/Occupation/ Employer	Date Received	Type	Amount
Friends to Elect Todd Tyson, Inc., Todd Tyson	Thomas E. Price, MD	Congressman United States	October 25, 2013	Monetary Special	\$1,000
Georgia Medical Political Action Committee (GAMPAC)	Thomas E. Price, MD	Physician Self-Employed	December 3, 2014	Monetary Primary	\$250

APPENDIX C**Awards Received by Dr. Thomas Price**

1988 In Appreciation—Chairman, Bylaws Committee—North Fulton Regional Hospital 1988
In Appreciation—American Cancer Society

1990 In Appreciation—Chairman, Department of Surgery—North Fulton Regional Hospital

1993 President's Award—"Rx for Georgia"—Medical Association of Georgia
President's Award—Medical Association of Atlanta—Chairman, Health Care Reform Committee

1994 President's Award—Medical Association of Atlanta—Chairman, Health Systems Reform Committee
President's Award—Medical Association of Atlanta—Chairman, Health Care Reform Committee

1996 Partners in Education—Fulton County Schools
In Appreciation—1st Vice President—Medical Association of Georgia

1997 In Appreciation—Northside Alliance for Mentally Ill
Recognition—Support of Georgia Rotary Student Program—Georgia Rotary Student Endowment
Distinguished Service Award—Medical Association of Atlanta

1998 Rotarian of the Year—Roswell Rotary Club
Outstanding Rotarian—Past Service—Roswell Rotary Club
Legislative Service Award—Association of County Commissioners of Georgia
Certificate of Achievement—Georgia Emergency Management Agency

1999 Outstanding work as a friend of medicine and demonstrating dedication to patients of Georgia—Medical Association of Georgia
In Appreciation—Kiwanis Club of Historic Roswell
Senator of the Year—Georgia Republican Party
Legislative Leadership Award—Georgia Hospital Association
In Appreciation—Honorable and Holy Calling to Public Service—Presbytery of Greater Atlanta

2000 Will Watt Fellow—Rotary International
In Appreciation—Member of Governing Council—Organized Medical Staff Section, American Medical Association
In Appreciation—Medical Team—Roswell High School
Legislative Leadership Award—Georgia Hospital Association

2001 In Appreciation—Georgia Alcohol Policy Partnership
In Appreciation—North Georgia Community Action, Inc.
In Appreciation—Coalition for Hospital Choice
In Appreciation—Friends of Scouting, North Fulton Team
Family Practice Legislator of the Year—Leadership in Health Care—Georgia Academy of Family Physicians

2002 Aven Citizenship Cup—Medical Association of Atlanta
Nathan Davis Award—Outstanding State Senator—American Medical Association
In Appreciation—Keep Roswell Beautiful

2003 President's Award—National Republican Legislators Association

Champion of 2003 Legislative Session—Perimeter Community Improvement Districts
 Cottage School—commencement speaker
 In Appreciation—Northside Baptist Church dedication

2005 NWYC Constituent Communication Award
 Rotary Club of Roswell East
 Civil Air Patrol
 University of Phoenix Award
 Consulate General of Israel—Friend of Israel Award
 New South Energy Award
 Governor's Office of Highway Safety
 National Health Museum Charter Membership Award
 College of American Pathologists Award
 Americans for Tax Reform—2005 Hero of the Taxpayer Award
 Spirit of Enterprise Award—U.S. Chamber of Commerce

2006 U.S. Chamber—Spirit of Enterprise Award
 Tommy Nobis Center—Award Presentation
 Adopt a Road Award
 ATR Hero of the Taxpayer Award
 60 Plus Association of the Guardian of Senior's Rights Award
 Association of Builders and Contractors—Champion of Merit Shop
 JWOD Congressional Champion Award
 Club for Growth Defender of Economic Freedom Award
 National Tax Limitation Committee Tax Fighter Award
 National Museum of Patriotism—Patriotism Award
 All Saints Catholic Church—Community Fellowship Award
 Cobb Chamber Award
 National Society of Sons of the American Revolution
 Armor Troops Foundation, Inc. Award
 National Hemophilia Foundation Award
 National Taxpayers Union—Taxpayers' Friend
 International Foodservice Distributors Association—Thomas Jefferson Award

2007 U.S. Chamber—Spirit of Enterprise Award
 Georgia Ensemble Theater—Legacy Award
 National Taxpayers Union—Taxpayers' Friend
 NAPUS Georgia Chapter Award

2008 North Fulton Chamber of Commerce Pioneer Award
 U.S. Chamber of Commerce Spirit of Enterprise Award
 U.S. English Award
 Medicare Choices Award
 A in English Award
 Americans for Tax Reform Award—Hero of the Taxpayer
 National Association of Mutual Insurance Companies—Benjamin Franklin Public Policy Award
 Club for Growth's Defender of Economic Freedom Award
 American Legion—Certificate of Appreciation
 Oglethorpe Student Body and Phi Delta Epsilon's Thank You Award
 GA Civilian Aide to Secretary of Army—Appreciation Award
 Coalition for Medicare Choices—The Medicare Choices Leadership Award
 IFDA—Thomas Jefferson Award
 National Taxpayers Union Taxpayers' Friend

2009 National Association of Manufacturers—Manufacturing Legislative Excellence
 National Orthopedic Leadership Conference—leadership on musculoskeletal diseases and conditions
 American Conservative Union Defenders of Liberty Award
 National Taxpayers Union—2008 Taxpayers' Friend Award
 60 Plus Association—Ben Franklin Award to thank you for working against the death tax
 AAOS—Congressional Leadership Award
 Club for Growth Defender of Economic Freedom Award
 Weyrich Awards Reception—You are receiving an award
 U.S. Chamber—Spirit of Enterprise Award
 Fulton County Republican Party—Leadership and Service Award
 Cherokee County Volunteer Aging Council Award

FHL Bank—Key to Homeownership Award
 American Academy of Orthopedic Surgeons—Congressional Leadership Award
 Doctors for Patient Freedom—Ed Annis Award for Medical Leadership
 Logisticare Appreciation Award for Presentation to Logisticare Operations

2010 National Taxpayers Union—Friend of the Taxpayer Award
 U.S. Chamber of Commerce Spirit of Enterprise Award
 AAOS Advocacy Communications Award
 National Association of Mutual Insurance Companies—Benjamin Franklin Public Policy Award
 American Conservative Union Defenders of Liberty Award
 U.S. English Award
 ProEnglish—American Unity Award
 GM Executive Retirees Club of GA
 GA GOP 6th District—Ronald Reagan Freedom Fighter Award
 American Academy of Orthopedic Surgeons Advocacy—Communications Award
 International Foodservice Distributors Association—Thomas Jefferson Award
 Club for Growth's Defender of Economic Liberty Award

2011 Institute for e-Health Policy—leadership award on HIT policy issues
 National Association of Manufacturers—Manufacturing Legislative Excellence
 National Taxpayers Union's—Taxpayers' Friend Award
 Emory Board of Trustees—GA Delegation Award
 60 Plus Association's Guardian of Seniors' Rights Award
 American Conservative Union Defender of Liberty Award
 Club for Growth's Defender of Economic Liberty Award
 Health Care Leadership Council—Champion of Healthcare Innovation
 GA Association of Physicians of Indian Heritage Award

2012 Cobb County Republican Women—Trumpet Award
 U.S. Chamber of Commerce Spirit of Enterprise Award
 Rotary International's Polio Eradication Champion Award
 Healthcare Leadership Council—Champion of Healthcare Innovation
 Small Business Council of America's 2012 Congressional Award
 IFDA—Thomas Jefferson Award
 RetireSafe—2012 Standing Up for America's Seniors Award
 Freedomworks Award
 NFIB Guardian of Small Business Award
 Fulton County JROTC's Coin of Excellence Award
 National Society of Daughters of the American Revolution
 NASA-Space Shuttle Discovery GA flag
 American Congress of Obstetricians and Gynecologists—Public Service Award

2013 National Association of Manufacturers—Award for Excellence
 American Conservative Union Foundation Award
 American Congress of Obstetricians and Gynecologists—Public Service Award
 U.S. Chamber of Commerce Spirit of Enterprise Award
 Dearborn High School Hall of Fame
 Senior Connections—Summer 2013 Champion of Senior Award
 America's Essential Hospitals Essential Physician Leader Award
 National Taxpayers Union—2012 Taxpayers' Friend Award
 Doctors for Patient Freedom—Ed Annis Award for Medical Leadership
 Southern Ortho Association's Award
 American Urological Association—Presidential Lecturer Award

2014 U.S. Chamber of Commerce Spirit of Enterprise Award
 America's Essential Hospital Essential Physician Leader Award
 ACU Annual Award
 Association of Builders and Contractors—Champion of Merit Shop
 National Retail Federation—Hero of Main Street Award
 International Foodservice Distributors Association—Thomas Jefferson Award
 Virginians for Quality Healthcare—Healthcare Freedom Guardian Award
 National Association of Manufacturers—Award for Excellence
 National Taxpayer Union—National Taxpayers Union's Taxpayers' Friend Award for 2013
 Association of Mature American Citizens—Friend of AMAC Award
 National Active and Retired Federal Employees Award

	Rx Drug Abuse Summit
	American College of Cardiology—President's Award for Distinguished Public Service Award
	ACC President's Award for Distinguished Public Service
	International Foodservice Distributors Association—Thomas Jefferson Award
2015	FRC Action True Blue Award
	National Association of Manufacturers—Award for Excellence
	American Society of Transplantation—Organ Transplantation and Donation Legislative Leaders of the Year Award
	American Academy of Ophthalmology—Academy's Visionary Award
	American Conservative Union—Award for Conservative Excellence
	60 Plus Association—Member Tax Reform Award
	U.S. Chamber of Commerce Spirit of Enterprise Award
	Alliance for Patient Access and National Association of Nutrition and Aging Services Programs—2015 Medicare Part D Patient Access Champion Award
	ACU Annual Award
	Rotary Club of Dunwoody—Certificate of Appreciation
	GA Ortho Society—James Funk Distinguished Service Award
	GA Association of College Republicans—Order of Reagan
	FRC Action True Blue Award
2016	AMRPA Chairman's Award
	ACU—Award for Congressional Excellence
	American Medical Rehab Providers Association—Chairmen's Award
	American Transaction Processor Coalition—Legislative Champion Award
	ATPC Friend of Industry Award
	U.S. Chamber of Commerce Spirit of Enterprise Award
	Healthcare Leadership Council—Champion of Healthcare Innovation IFDA—Thomas Jefferson Award
	Campaign to Fix the Debt—Fiscal Hero Award
	National Retail Federation—Heroes of Main Street Award
	GA Life Alliance—Advocate for Life Award
	HME—Congressional Leadership Award
	World Harvest Church Award
	Campaign to Fix the Debt Fiscal Hero Award
	National Retail Federation—Heroes of Main Street Award
No Year	Coalition for Medicare Choices—Leadership Award
	SIRPAC
	Alliance for Patient Access Medicare Part D—Patient Access Champion Award
	Veterans Issues—William Cobb VFW of Roswell Award
	Republic of Korea
	Naval Academy—Certificate of Appreciation
	American's Essential Hospital—Essential Physician Leader
	NFIB Guardian of Small Business (111th Congress)
	NFIB Guardian of Small Business (113th Congress)
	NFIB Guardian of Small Business (114th Congress)
	Associated Builders and Contractors Champion of the Merit Shop (111th Congress)
	Theodore Roosevelt American Unity Award (111th Congress)
	Associated Builders and Contractors Champion of the Merit Shop (110th Congress)
	NFIB Guardian of Small Business (112th Congress)
	Associated Builders and Contractors Champion of the Merit Shop (112th Congress)

APPENDIX D

Op-Eds Authored by Dr. Tom Price—May 2011 to the Present

The listing of pertinent Op-Eds begins on the table below and contains website addresses for direct access to the specified publications. In instances where a particular Op-Ed is not available via an internet source, a copy of the actual publication is attached for the committee's reference.

Date	Publication	Title	Link
May 13, 2011	<i>Health Reform Report</i>	Empowering America's Seniors	http://tomprice.house.gov/op-ed/empowering-americas-seniors
May 14, 2011	<i>The Daily Caller</i>	Debt Limit and Spending Reforms are Inextricably Linked	http://tomprice.house.gov/op-ed/debt-limit-and-spending-reforms-are-inextricably-linked
June 28, 2011	<i>TownHall.com</i>	Cutting What Washington Has Yet to Spend and Cannot Afford	http://tomprice.house.gov/op-ed/cutting-what-washington-has-yet-spend-and-cannot-afford
October 10, 2011	<i>Human Events</i>	Empowering Patients First Act: The Solution to Obamacare	http://tomprice.house.gov/op-ed/empowering-patients-first-act-solution-obamacare
November 15, 2011	<i>Cobb Medical Society</i>	H.R. 3000—Empowering Patients Not Government	Attached
November 16, 2011	<i>Big Government</i>	Patient Centered Healthcare is Possible	http://tomprice.house.gov/op-ed/patient-centered-healthcare-possible
November 26, 2011	<i>The Washington Times</i>	PRICE: Preserving the promise to patients	http://tomprice.house.gov/op-ed/price-preserving-promise-patients
December 1, 2011	<i>Reporter Newspapers</i>	Republicans, Democrats see different fixes to fiscal stalemate	http://tomprice.house.gov/op-ed/republicans-democrats-see-different-fixes-fiscal-stalemate
December 12, 2011	<i>Chicago Tribune</i>	Getting America out of deep debt	http://tomprice.house.gov/op-ed/getting-america-out-deep-debt
December 16, 2011	<i>The Oregonian / McClatchy</i>	Medicare pro: Reasonable reforms can provide fair fees for physicians and ensure patients receive quality treatment	http://www.oregonlive.com/opinion/index.ss/2011/12/medicare_pro_reasonable_reform.html
February 15, 2012	<i>The Hill</i>	President obviously doesn't grasp the seriousness of fiscal situation	http://tomprice.house.gov/op-ed/president-obviously-doesn't-grasp-seriousness-fiscal-situation
May 31, 2012	<i>The Daily Caller</i>	Obamacare Medical Device Tax: Hazardous to America's Health	http://tomprice.house.gov/op-ed/obamacare-medical-device-tax-hazardous-america's-health
June 5, 2012	<i>The Hill</i>	IPAB is not the way to lower Medicare costs	http://tomprice.house.gov/op-ed/ipab-not-way-lower-medicare-costs
July 1, 2012	<i>Marietta Daily Journal</i>	Try Principled Solutions to Health Care Fix	http://tomprice.house.gov/op-ed/try-principled-solutions-health-care-fix
July 26, 2012	<i>USA Today</i>	Plenty of Alternatives to Government Health Care	http://tomprice.house.gov/op-ed/plenty-alternatives-government-health-care

Date	Publication	Title	Link
Fall 2012	<i>Jewish Policy Center</i>	A Principled Health Care	https://www.jewishpolicycenter.org/2012/08/31/health-care-empower-patients/
July 30, 2012	<i>The Washington Times</i>	Regulations Are Choking Small Business Engine of Growth	http://tomprice.house.gov/op-ed/regulations-are-choking-small-business-engine-growth
December 6, 2012	<i>AJC</i>	House Republicans Stand by Taxpayers	http://tomprice.house.gov/op-ed/house-republicans-stand-taxpayers
February 6, 2013	<i>Red State</i>	Require A Plan	http://tomprice.house.gov/op-ed/require-plan
March 12, 2013	<i>FoxNews.com</i>	Introducing a responsible, reasonable plan to balance the federal budget	http://tomprice.house.gov/op-ed/introducing-responsible-reasonable-plan-balance-federal-budget
April 19, 2013	<i>The Hill</i>	President's budget ignores the will of the people	http://origin-nyi.thehill.com/blogs/congress-blog/economy-a-budget/295025-presidents-budget-ignores-the-will-of-the-people
May 20, 2013	<i>Real Clear Politics</i>	The Unserious Senate Budget	http://tomprice.house.gov/op-ed/unserious-senate-budget
May 30, 2013	<i>Washington Examiner</i>	President Obama is Responsible for His Administration	http://tomprice.house.gov/op-ed/president-obama-responsible-his-administration
May 31, 2013	<i>AJC</i>	Stop the Obamacare train wreck	http://tomprice.house.gov/op-ed/stop-obamacare-train-wreck
July 17, 2013	<i>The Hill</i>	How to Replace Obamacare	http://tomprice.house.gov/op-ed/how-replace-obamacare
July 31, 2013	<i>The Daily Caller</i>	We can't trust the IRS to enforce Obamacare	http://tomprice.house.gov/op-ed/we-can%28%99t-trust-irs-enforce-obamacare
October 8, 2013	<i>Marietta Daily Journal</i>	All Republicans want is fairness for all Americans, and that's why we fight	http://tomprice.house.gov/op-ed/all-republicans-want-fairness-all-americans-and-thats-why-we-fight
December 5, 2013	<i>National Review</i>	Empowering Patients First	http://tomprice.house.gov/op-ed/empowering-patients-first
February 10, 2014	<i>Conservative-USA.org</i>	Let's Begin Again—Patients First	http://www.conservativeusa.org/uploads/lets-begin-again-patients-first-rep-tom-price-md-ga-06-reptomprice-feb-10-2014
February 19, 2014	<i>Red Alert Politics</i>	A Better Prescription for Millennials	http://tomprice.house.gov/op-ed/better-prescription-millennials
March 7, 2014	<i>Maryland State Medical Journal</i>	There's No Code for Quality Care	Attached
March 20, 2014	<i>AMA SE</i>	New Challenges Mean New Opportunities	Attached

Date	Publication	Title	Link
March 24, 2014	<i>Medical Association of Georgia E-Newsletter</i>	Modernizing Medicare to Protect Seniors	Attached
August 11, 2014	<i>Roll Call</i>	Save Medicare's Home Health Benefit	http://tomprice.house.gov/op-ed/save-medicares-home-health-benefit
January 23, 2015	<i>Real Clear Politics</i>	A Healthy Economy for All	http://tomprice.house.gov/op-ed/healthy-economy-all
March 17, 2015	<i>USA Today</i>	Balance the budget for a prosperous America	http://tomprice.house.gov/op-ed/balance-budget-prosperous-america
April 1, 2015	<i>AMA SE</i>	Prepared to Act on Patient-Centered Reform	Attached
April 6, 2015	<i>SC Times</i>	House budget plan would set U.S. on right fiscal path	http://www.scetimes.com/story/opinion/2015/04/05/house-budget-plan-set-us-right-fiscal-path/25277905/
July 30, 2015	<i>Independent Journal Review</i>	Medicare and Medicaid Turn 50 Today. Let's Keep Them Healthy	http://tomprice.house.gov/op-ed/medicare-and-medicaid-turn-50-today-lets%20keep-them-healthy
February 2, 2016	<i>Medical Association of Georgia E-Newsletter</i>	A Step in the Right Direction	Attached
March 10, 2016	<i>Medical Association of Georgia E-Newsletter</i>	Keep the focus on the patient	Attached
April 5, 2016	<i>AMA SE</i>	Focused on Solutions	Attached
April, 13, 2016	<i>Real Clear Politics</i>	How and Why We Budget	http://tomprice.house.gov/op-ed/how-and-why-we-budget
September 7, 2016	<i>Roll Call</i>	Obamacare Agency Escapes Congressional Oversight	http://tomprice.house.gov/op-ed/obamacare-agency-escapes-congressional-oversight
October 13, 2016	<i>JAMA Forum</i>	Three Congressmen's Views on ACA's Flaws, Alternatives for Health System Reform	http://tomprice.house.gov/op-ed/3-congressmen%20%99s-views-aca%20%99s-flaws-alternatives-health-system-reform
October 17, 2016	<i>FoxNews.com</i>	Reps. Burgess, Price, Roe: Our diagnosis as doctors—ObamaCare is about to collapse	http://www.foxnews.com/opinion/2016/10/17/reps-burgess-price-roes-our-diagnosis-as-doctors-obamacare-is-about-to-collapse.html
November 1, 2016	<i>TownHall.com</i>	Obamacare is failing. Let's try a Better Way	http://tomprice.house.gov/op-ed/obamacare-failing-lets%20try-better-way

A STEP IN THE RIGHT DIRECTION

By Congressman Tom Price, M.D. (GA-06)

On December 28th of last year, President Obama signed into law the Patient Access and Medicare Protection Act (S. 2425)—legislation that included several health-care reforms that had bipartisan support in Congress. Included in that package of reforms was a provision addressing electronic health record (EHR) meaningful use requirements—specifically hardship exceptions for physicians who would be unable to comply with the Centers for Medicare and Medicaid Services’ (CMS) final Stage 2 modification rule. At issue was the fact that CMS released its rule with less than the requisite 90 days left to comply in 2015.

The hardship exceptions provisions in S. 2425 are based on a bill that I had introduced, the Meaningful Use Hardship Relief Act (H.R. 3940), almost 2 months prior. We acted because it was clear that many physicians would likely be unfairly penalized due to CMS’s failure to offer health-care providers adequate time to comply with new requirements pertaining to the electronic health records program. Under the new law, physicians are able to more easily obtain a hardship exception due to insufficient time in the 2015 reporting period. Additionally, CMS is now also able to batch process hardship exception applications for groups of physicians, rather than strictly on a more burdensome individual case-by-case basis.

On January 22nd, CMS released guidance on the updated hardship exception application, and our office is continuing to closely monitor this issue as well as the meaningful use and electronic health records program. We would encourage you to apply for the hardship exemption. You can do so by going to *CMS.gov*. This is a small step but a step nonetheless toward protecting the critical doctor-patient relationship. Patients and physicians face many challenges in today’s health-care system. Anything that can be done to allow physicians to focus more of their time and energy on the practice of medicine ought to be done so that we can further improve the quality and responsiveness of care.

THERE’S NO CODE FOR QUALITY CARE

By Congressman Tom Price, M.D. (GA-06)

Physicians are used to dealing with complex systems—the human body being the most obvious example. They devote their years of education and their craft to finding answers to tough questions, solutions to difficult and—for patients and their families—very personal challenges. The eagerness of physicians, scientists, and other health-care providers to tackle the complex and at times unknown is driven by the knowledge that their time and commitment is in service to the health and well-being of others. Providing the best care for patients is the motivation.

So it is with particular concern and consternation that today physicians are being inundated with a new set of complex problems to solve. The purveyor of these new challenges is, generally speaking, the regulatory state. It’s the folks who are not so much in charge of actually caring for patients but the ones who have taken it upon themselves to be in charge of telling physicians more and more how to care for patients.

Their more widely known mandates and regulations center most recently on the implementation of electronic health records (EHRs) and meaningful use requirements. The sorts of items that can justifiably be applied to improving quality care if physicians have the flexibility, the time and the resources to comply in an orderly fashion. That’s a big “if.”

But then you have the complexities being handed down from high that have at best a tangential relationship to serving the needs of patients. Perhaps none will be more frustrating and costly to the delivery of care than the new ICD-10 diagnosis coding system that American physicians, hospitals, and other health-care providers are being told to adopt.

The ICD-10 system has already earned a reputation as a bridge a bit too far—a sign that the regulatory state has become far too prescriptive to the point of being comical. You’ve likely heard of some of the more humorous new diagnosis codes. ICD-10 applies specific codes to injuries related to burning water skis, injuries sustained through an accident with a military vehicle while riding an animal, or being struck by any number of different animals for example, an orca.

Could those examples and any of the others listed in the ICD-10 system occur? One supposes almost anything is possible. But the “more is better” mentality that sits behind the drafting and implementation of this system portends a very arduous and in many cases financially perilous environment for physicians and their practice.

Resources that might be applied to new innovative technologies, expanded capacity to serve new patients, or even charitable payment scenarios will be diverted to pay for the adoption and implementation of ICD-10. Those most likely to be squeezed are the private practices—particularly those caring for patients in rural or underserved communities—that operate on narrow margins. That shifts the delivery of care to hospitals where the quality can be equal but the costs disproportionately higher.

As an orthopaedic surgeon who practiced medicine for over 20 years in the Metro Atlanta area, I know firsthand about practicing medicine both in a private and hospital setting. There are benefits and drawbacks to both. But what makes our health-care system most beneficial to patients is the flexibility and diversity of care. The regulators are on schedule to continue destroying that flexibility and diversity of care.

We see it in the manner in which the Affordable Care Act (ACA) is defining quality care based on a Washington-centric point of view. And, we see it with the unwillingness on the part of the Centers for Medicare and Medicaid Services (CMS) to consider a delay in the implementation of ICD-10 coding requirements. CMS Director Marilyn Tavenner recently confirmed that Washington would consider no more delays and that it was “time to move on.”

Thankfully, Congress has taken action—albeit in a limited capacity. Legislation recently signed into law included a 1-year delay of the ICD-10 deadline. It pushes back the date at which medical providers must adopt the new coding system from October 1st of this year to October 1, 2015.

So where does that leave physicians trying to practice their profession and care for patients? According to a February 2014 report commissioned by the American Medical Association (AMA), a small medical practice will be on the hook for anywhere between \$56,639 to over \$226,000 in costs associated with the transition. For a medium size practice, AMA estimates pre- and post-implementation costs rising to as high as \$824,735. And, the “typical large practice” can expect to pay anywhere in the range of \$2 million to \$8 million.

Perhaps in Washington that’s not considered a lot of money. But in the real world where the cost of health-care delivery is already rising due to any number of other forces—including innovation and other regulations—adding hundreds of thousands to millions of dollars to the cost of care is incredibly troubling.

It should come as no surprise that an overwhelming majority of physicians were not ready for this year’s October 1st deadline. A survey by the Medical Group Management Association found that slightly fewer than 10 percent of medical practices claim to have made significant progress on implementing the overhaul of the ICD system. In other words, if you were to put aside the argument about whether or not shifting to the new coding system was wise or necessary, folks still are not ready.

In Congress, there’s a broader effort underway to avoid this coming train wreck altogether. H.R. 1701, the Cutting Costly Codes Act of 2013—of which I’m a co-sponsor—would prohibit the Secretary of Health and Human Services from moving forward with the ICD-10 implementation.

What happens if a year passes, no action is taken to prohibit the implementation, and further delays are not forthcoming? If Washington ignores the facts and the frustration shared by many in the medical community? The initial costs associated with adopting ICD-10 will likely seem like a drop in the bucket over the longer term as medical practices struggle to familiarize themselves with the new litany of codes. It is expected that the number of codes will grow from roughly 20,000 to over 150,000.

Any failures to properly apply the right diagnostic label may be met with rejection or withholding of payment for services already rendered. Furthermore, fines and other costly legal proceedings could be incurred by physicians and medical practices whose only crime may be that they had unwittingly failed to comply properly with this complex new system.

Were the new ICD-10 diagnosis codes coming online in otherwise relatively calm waters in the Nation’s health-care system, the disruption could perhaps have been

contained. But that's not the reality physician's face today. With the implementation of the Affordable Care Act, America's health-care system and those participating in it have been thrown one curve ball after another—told to get on board or get out of the way.

Far too often that's how a bureaucracy functions, and it is the strongest argument against endowing regulators with the type of prescriptive power they are now preparing to wield. For the sake of patient access to quality, affordable care, we must continue to search for solutions that will let physicians do what they are trained to do—care for those in need. To be successful, physicians must engage in the public debate.

NEW CHALLENGES MEAN NEW OPPORTUNITIES

By Congressman Tom Price, M.D. (GA-06)

There is no shortage of issues these days competing for our attention. We have turmoil and upheaval around the world. There are long-running disagreements and troubles here at home. And while it can all be a tad overwhelming, it's important to find within these challenges the opportunity to affect positive change. Of note right now are five key areas that do deserve our focus—all of which, coincidentally, have emerged either from action or inaction on the part of your government.

As a physician, I have watched with particular concern the troubled rollout or unraveling of the President's health-care law. Frankly, what we have is the expected outcome of truly disastrous policymaking. The law is not working—at least not as advertised. It is not working for patients, families or physicians. And, its failures are not merely the result of incompetence on the part of the Obama administration. They are the product of a fundamental conflict between the law and those principles of health care we hold dear: affordability, accessibility, choices, innovation, quality, and responsiveness.

Premiums are rising. Provider networks made available through the new exchange plans are smaller. Folks are losing the coverage they had and access to the doctors they trusted. Less access and less affordability mean choices are being taken away from Americans. The law taxes innovation—literally a tax on life-saving medical devices. All of this will contribute to diminished quality of care as the system becomes more responsive to the needs of bureaucrats and less so to the needs of patients, families and doctors.

So what can be done? Anyone who has taken care of patients knows that the status quo that existed prior to the passage of Obamacare was not working either. So no one should pretend we can simply uproot the current law and that will solve everything. We need a set of reforms that serve patients and those who care for them. Patient-centered solutions—like those I've introduced in H.R. 2300, the Empowering Patients First Act—would expand access to more health care choices by making it financially feasible for folks to purchase the coverage they want.

We'd solve the insurance challenges of portability and pre-existing conditions by allowing folks to own their coverage no matter who's paying for it and to pool together and gain the purchasing power of millions. That way we can make sure no one is priced out of the insurance market due to a pre-existing injury or illness.

To go after the rising costs of care in America, H.R. 2300 would enact medical malpractice reforms. Our plan would deter the practice of defensive medicine by giving physicians an affirmative defense in a court of law built on standards agreed upon and established by physicians—not Washington.

Just as we need broader health-care reform, we also need to once and for all rid Medicare of its current payment formula. The sustainable growth rate (SGR) formula is not working for patients or doctors. The effort to repeal and replace it with one that does work has gone on too long. Thankfully, some encouraging steps have been taken in recent weeks.

In the House of Representatives, we have passed a bill to repeal the SGR and modernize the payment system—giving physicians time to adjust to new rules that will hopefully provide the type of certainty and flexibility needed to increase the quality of care. The ball is now in the Senate's court. Our hope is that they will work with us so that there is a credible plan to move forward. We need to get this specific issue resolved in a way that protects seniors and respects American taxpayers.

It is out of respect for American taxpayers that we must also keep our eye on the tremendous fiscal challenges we are facing as a Nation right now. As vice-chairman of the House Budget Committee, I've had the opportunity to work with many of my colleagues on different budget proposals over the years—plans that would balance the Federal Government's books, save and strengthen critical programs like Medicare and Social Security, and enact pro-growth policies like fundamental tax reform to get this economy moving. A budget is a blueprint for the positive direction we can take our Nation if we have the courage to make real, tough decisions on behalf of this generation and the next. Right now the committee is working on the next budget for fiscal year 2015. With the President offering his plan that taxes more in order to spend more, there's a real opportunity and obligation to provide that better, alternative vision.

Another pro-growth area we ought to be focused on is America's ongoing energy revolution. Whether one is talking about the growth in our ability to safely harvest more and more of America's abundant natural resources or the growth in new energy technologies, there are exciting opportunities here that will truly benefit our Nation. A robust energy market means more direct and indirect jobs and economic freedom. Internationally, a lessening of dependence on foreign sources of energy and a growing of America's impact on the global energy markets means we have greater influence in diplomatic and national security affairs.

One doesn't have to look farther than the recent events in Ukraine to see an opportunity to leverage an all of the above energy strategy. With Russia exercising power in that part of the world thanks to their prolific energy production and distribution we can directly undermine their coercive powers by expanding our production and sale of energy resources to allies in the region.

Lastly, what contributes to the disgust many feel watching Russia invade and annex a piece of another country is that this action flies in the face of democratic values we hold sacred here in America. Those values were written into our Constitution and made explicit when our founders declared our rights came from God, not man. Chief among them is the First Amendment's right to freedom of speech.

Unfortunately, that fundamental freedom has been under assault from an overactive regulatory environment in Washington. We know that the IRS unfairly targeted and abused certain Americans whose only crime was attempting to speak up for their beliefs. Now, the IRS is attempting to codify that level of abuse through new regulations affecting groups—including veterans' organizations and those engaged in civic education—that file as nonprofits under the tax code's 501(c)(4) designation.

Under that section of the code, activities by these nonprofits that are for the purposes of "social welfare" are tax exempt. The IRS wants to rewrite the rules after 55 years to essentially force these nonprofits—many of which hold political views in conflict with the current administration—to re-classify under a different section of the code or become subject to taxation. Either way, the end result would be to silence voices and expose more Americans to further abuse and unfair treatment.

All of these issues—whether foreign, domestic or both—impact our lives in some form or another. We should not shy away from these challenges because with them comes opportunity to improve our lives and that of our families, friends, and neighbors. If we can find a way to bridge differences, reinforce time-honored principles, and show leadership, I'm confident we will find positive solutions that build a stronger future for our Nation.

MODERNIZING MEDICARE TO PROTECT SENIORS

By Congressman Tom Price, M.D. (GA-06)

The Medicare program is a vital life-line for millions of American seniors. Unfortunately, the current program is not working as well as it should for either those in retirement or the physicians who care for them. In addition to the real financial challenges the program as a whole faces in the next few years—challenges that ought to be addressed with broader reforms to Medicare—we have an even more immediate concern as it relates to Medicare's current payment formula.

Efforts to address the broken sustainable growth rate formula (SGR) have been underway for years. In the meantime, Congress has acted to avoid the SGR's looming large cuts in physician reimbursements by enacting a series of delays—some longer than others. This has been done to buy time for policymakers to coalesce around

a responsible solution that will repeal the SGR permanently and replace it with a system that makes sense. The cost of those delays has been substantial, but it has also been necessary in order to protect access to care for seniors.

Thankfully, promising steps have been made in the last several months to forge a consensus on a real plan to modernize the Medicare payment system. Introduced in February, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015) enjoys bipartisan, bicameral support. On March 14th the House of Representatives passed the bill and sent it to the Senate for its consideration.

In order to ensure these solutions both protect seniors and respect taxpayers, the legislation endorsed by the House of Representatives included a delay in the Affordable Care Act's individual mandate to offset the costs associated with a repeal of the SGR. The Obama administration has already implemented a *de facto* delay to this provision of the President's health-care law through executive fiat. We thought it better to do so through the normal and constitutional lawmaking process.

The latest projections show cuts to physician reimbursement rates in the range of 24% if nothing is done. Temporary patches will continue to buy more time but in the aggregate over the years they also prove more costly than a full repeal and replace scenario. More importantly, the level of uncertainty and anxiety that will persist so long as this issue remains unresolved exacts its own costs on physicians and seniors that cannot be measured in dollars and cents.

It is rare in Washington these days that you can find an issue that secures both bipartisan support and action. We should not miss this opportunity to enact a positive set of solutions that will modernize Medicare's payment system. Our hope is that the Senate will come to the table with the House of Representatives so we can work together to protect seniors' access to health care.

PREPARED TO ACT ON PATIENT-CENTERED REFORM

By Congressman Tom Price, M.D. (GA-06)

This summer the Supreme Court of the United States will render a verdict in the case of *King v. Burwell*, which could have a lasting impact on whether the Affordable Care Act or "Obamacare" remains the law of the land. The fundamentals of the case are fairly straightforward: should the Obama administration be allowed to offer subsidies to help Americans purchase health-care coverage through Obamacare exchanges established by the Federal Government? The text of the law states that subsidies are to be made available to those who have enrolled in an insurance plan through an exchange established by the State. Since the enactment of Obamacare, 37 States have chosen not to establish their own exchanges or have partnered with the Federal Government in some fashion—meaning millions of Americans have gained health-care coverage with the help of subsidies through a Federal exchange.

If the Court rules in favor of the actual text of the law, which does not explicitly provide financial assistance to those purchasing coverage through the Federal exchange, those millions of Americans who purchased that insurance coverage would lose access to subsidies and face even higher health-care costs. For its part, the Obama administration has claimed it has no strategy in place to handle the aftermath of such a ruling—despite being complicit in the creation of the law itself and its, quite possibly soon to be ruled illegal, interpretation.

Conversely, in March, I introduced the Medical Freedom Act (H.R. 1234)—legislation to allow States the freedom to offer within their jurisdiction health plans, health savings accounts, and other arrangements that are currently restricted under Obamacare, and the Medicare Patient Empowerment Act (H.R. 1650)—allowing patients and physicians to voluntarily contract for a service outside of the dictates from CMS. This type of flexibility within States to regulate their markets and ensuring doctors may practice as they see most appropriate would be strong first steps toward mitigating the fallout from the *King v. Burwell* ruling. At the same time, committees of jurisdiction in the House of Representatives and the Senate have been hard at work putting together policy proposals of their own that would be needed to respond should the court rule that the Federal exchange subsidies are indeed illegal. No matter the makeup of our response, Congress is aiming to be prepared so that the American people are not made to suffer any more than they already have from Obamacare.

Even if the Court rules in favor of the Obama administration's interpretation and keeps the subsidies flowing on the Federal exchanges, there still remains real, fundamental concerns with how this law has been implemented, the impact it is having on the quality and affordability of health care in America, on access to physicians and on innovation.

Those of us who believe we ought to have a health-care system less geared toward Washington and more in the hands of patients, families and physicians have to continue to push our colleagues and Congress and take our case to the American people. We have to keep the conversation going, and make clear that there are positive, patient-centered solutions out there that are far better for the health of our Nation than what Obamacare has to offer.

For several years now, I have introduced legislation each Congress called the Empowering Patients First Act—a set of solutions that would expand access to quality affordable health-care choices and put patients, families and doctors in charge of health-care decisions, not Washington, DC. We have offered patient-centered reforms like Individual Member Associations so folks can pool together for the purpose of purchasing affordable coverage; lawsuit abuse reform to end the practice of defense medicine that adds hundreds of billions of dollars to America's health-care bill each year; health-care tax credits so folks have the financial wherewithal and incentive to purchase the sort of coverage that meets their individual needs.

There are many other aspects of the Empowering Patients First Act that would enhance the quality, affordability and accessibility of care in our country. Indeed, there are a myriad of positive, promising ideas that my colleagues in Congress have put forward and each of those ideas should continue to be a part of an honest and open debate on a broader reform effort.

Depending on its decision, the Supreme Court's ruling later this year may initiate an unraveling of Obamacare or it may have no real impact. Either way, policy-makers need to be prepared to respond. Physicians and other health-care practitioners across the country need to be ready as well to play a constructive role in ensuring that not only in the near term but in the long run, we protect and preserve the sanctity of the doctor-patient relationship.

FOCUSED ON SOLUTIONS

By Congressman Tom Price, M.D. (GA-06)

America's Founding Fathers wisely chose to give Congress—the branch of government closest and most accountable to the people—the power to write laws, determine how many hard-earned tax dollars are necessary to administer those laws, and to ensure the executive branch is faithfully carrying out those laws. For our Nation's experiment in self-government to work, those roles and responsibilities must be respected.

At the Committee on the Budget in the U.S. House of Representatives—on which I am honored to serve as chairman—we have been hard at work doing just that. The House Budget Committee is tasked with putting together an annual budget. We provide lawmakers a blueprint for how Congress can assert the spending and oversight authorities given it under the Constitution and do so in a responsible, responsive manner.

In March, the House Budget Committee introduced and approved our fiscal year 2017 budget resolution which we call *A Balanced Budget for a Stronger America*. This proposal would balance the Federal budget within 10 years without raising anyone's taxes. It keeps the Federal Government's books in balance beyond the coming decade which puts us on a path to pay off the national debt. If the policies we advocate were enacted, we would achieve over \$7 trillion in deficit reduction through a combination of savings and economic growth. Those savings come from common sense reforms we propose to make government more efficient, effective, and accountable.

Some of the more critical reforms are in the area of health care. We put forward a plan to save and strengthen the Medicare program. We advocate for an improved system that enhances quality, gives seniors more choices, and ensures that traditional Medicare is always available to Americans when they reach retirement age.

Under current law, if nothing is done, Medicare will go insolvent in 2030. This will result in a significant reduction in benefits for seniors' health care. We believe this

would be irresponsible. Our plan would prevent this from happening with patient-centered reforms, and ensure this program, which millions have paid into, will be there for them when they need it.

For the brave men and women of our armed forces, for our veterans, and for our military families, our budget encourages additional health-care reforms at both the Department of Veterans Affairs (VA) and the Department of Defense (DoD). Those who protect and defend our Nation must have access to the care they need when they need it.

For those Americans who are struggling to afford health-care coverage, our budget rejects the broken status quo and calls for innovative solutions. We would give States the flexibility to design and implement their Medicaid programs to meet the unique needs of their communities. At the same time, we would get rid of the top-down, Washington-knows-best model that is currently in place in private-sector health care and implement patient-centered solutions to ensure every American has access to the health coverage they want, not the one Washington forces them to buy.

What these solutions ultimately comprise is part of a conversation currently being held in Congress and, specifically, among those of us on the House Task Force on Health Care Reform. We are developing a package of reforms that would create a patient-centered health-care system where Americans have access to quality, affordable choices, the doctor-patient relationship is respected, and real insurance challenges like pre-existing conditions are solved through policies that protect and empower individuals, not government mandates.

The task force is committed to building these solutions from the ground up. However, we do not come to this challenge empty handed. Numerous health care policy ideas—including H.R. 2300, the Empowering Patients First Act which I have introduced for the past several congresses—have been circulating for years, both before and after passage of the President's health-care law.

The Task Force on Health Care Reform is one pillar of a larger effort to advance a positive, proactive agenda. A perfect partner in that effort is the annual budget resolution which is why the House Budget Committee has been committed to bringing this positive proposal forward. We are focused on getting results and solving the numerous challenges facing our country—from the economy to national security—so we have a more secure and more prosperous Nation.

EMPOWERING PATIENTS NOT GOVERNMENT

By Congressman Tom Price, M.D. (GA-06)

While practicing orthopaedic surgery for over 20 years, my focus was, as it should be, on the patients and serving their needs to the best of my ability. Unfortunately, during the early 1990s under then-President Clinton's attempt to overhaul America's health-care system, it became clear that policy decisions were continuing to be made in Washington that would have a profound, and oftentimes, negative impact on the practice of medicine. Many of those decisions were being made by individuals, probably with good intentions, but who knew little to nothing about the practice of medicine—who had never cared for patients or understood what it took to do so.

While President Clinton's efforts were unsuccessful, last year President Obama signed into law a massive health reform law that is destructive and fails to protect and promote the principles of health care we cherish, including affordability, accessibility, quality, responsiveness, innovation, and choices. The challenge to improve our health-care system and make it accessible to more Americans still stands; *i.e.*, the status quo is unacceptable, which makes it incumbent upon those of us who disagree with the overhaul enacted in the previous congress to propose positive solutions in line with health-care principles that protect the rights of patients and doctors.

In order to ensure health-care choices in America, Congress must repeal the President's health-care law first and foremost and then reform the system in a common sense manner. As one of a growing number of physicians in the House of Representatives, we understand that changes must be made. In order to move the debate forward, I recently introduced legislation to repeal and replace the President's health-care law.

The Empowering Patients First Act (H.R. 3000) encourages individuals to obtain health coverage and makes it financially feasible for individuals and families to do so. It addresses the issue of lawsuit abuse and defensive medicine, which was completely ignored in last year's health-care law, and it keeps Washington out of the way of health-care decisions. At its core, it advances patient-centered solutions to the challenges we face.

Many of us in the medical profession have seen firsthand the distortions and disruptions that defensive medicine and excessive bureaucracy have on the practice of medicine. Inserting misguided government controls and regulations will lead to the denial of care and the elimination of health-care choices and personal decision-making. Under current law, there is even an unaccountable, unelected board of 15 bureaucrats—the Independent Payment Advisory Board (IPAB)—that will have the power to deny health care to America's seniors. That is wrong and does not have to happen in order to make our health-care system stronger. It will only weaken the quality of medicine for seniors and all Americans.

Since physicians know the best care for their patients, the Empowering Patients First Act establishes doctor-led quality measures. And we encourage healthier lifestyles by allowing employers more flexibility in offering discounts to their employees through wellness and prevention programs.

The health-care system in America needs to be reformed and improved—there is no doubt about that—but this must be done without handing over greater authority to the Federal Government. As a physician and someone who spent years caring for patients, the damage that can be done to the health of our great Nation by government interference is clear and unacceptable. The current situation demands that we advance a plan not only to halt that interference, but also one to improve access to quality, affordable health care. That solution is H.R. 3000!

KEEP THE FOCUS ON THE PATIENT

By Congressman Tom Price, M.D. (GA-06)

A patient-centered health-care system is built upon six principles: accessibility, affordability, quality choices, responsiveness, and innovation. Today, there are many instances where those principles are being violated—more often than not through rules and regulations handed down from bureaucratic agencies in Washington, DC. For an example, we need only look at how physicians and hospitals have had to go about adopting electronic health records (EHR).

As part of the economic stimulus package that became law in the early days of the Obama administration, there was a concerted effort to help spur adoption of EHR among physicians and hospitals. The law states “the Secretary [of Health and Human Services] shall seek to improve the use of electronic health records and health-care quality over time by requiring more stringent measures of meaningful use.”

From this text was born a complex and burdensome set of requirements known as Meaningful Use (MU) Stage 1, 2, and 3. Although well-intentioned, the MU requirements have chiefly missed the mark by focusing more on data entry and less on patients and their doctors.

Physicians face a number of impediments to meeting the MU requirements, many of which are outside of their control. These include the lack of usability and interoperability among EHR, significant data exchange fees, interference with face-to-face patient care, time-consuming data entry, the degradation of clinical documentation, and in inflexible metrics.

A total of 209,000 physicians will face penalties in 2016 for failing to meet EHR MU criteria. While 80 percent of physicians have adopted EHR in their practices, less than 10 percent of physicians have successfully participated in MU Stage 2 so far. If we want higher quality care, healthier patients, and a more efficient use of time and resources, then the MU program needs to be reevaluated so it moves in the direction of our health-care principles.

This past October, the Centers for Medicare and Medicaid Services (CMS) released its modified Stage 2 rule of the MU program. CMS issued its directive with less than the requisite 90 days remaining in the 2015 program year. That meant it was virtually impossible for doctors to meet the requirement deadlines.

Anticipating this challenge, I introduced H.R. 3940—the Meaningful Use Hardship Relief Act—to provide physicians with much-needed relief by ensuring they would be granted a hardship exception to avoid penalties stemming from the delayed rule-making. Working with colleagues in Congress, physicians and various stakeholders, we were able to get language based on the solutions that we introduced included in a larger package of reforms—S. 2425, the Patient Access and Medicare Protection Act—which was signed into law just prior to the new year.

On January 22, CMS released a hardship application for physicians and hospitals to use when filing an exception to the MU penalty for the 2015 program year. In the past, providers and hospitals had separate application forms. Under the new law, the application is now streamlined and can be used by both. Providers may file as individuals or in groups—while before each individual provider would have had to submit a separate application to be considered by CMS on a case-by-case basis. This new streamlined process also allows CMS to process hardship applications more efficiently in batches.

All physicians are encouraged to go to *CMS.gov* and apply for a hardship exception under the category “EHR Certification/Vendor Issue (CEHRT Issues),” which references “insufficient time” in accordance with CMS’s delayed rulemaking. Applications must be submitted to CMS by March 15.

Sadly physicians know all too well that the work of defending the principles of patient-centered care never ends. While MU penalties affect physicians and hospitals nationwide, here in Georgia our laboratories and physician groups were facing a more unique threat at the beginning of this year. Under a blatantly prejudiced reimbursement policy related to new codes for drug testing, CMS was threatening a 33 percent cut from the national payment rate for Georgia labs and doctors. Thanks to the Medical Association of Georgia and others, we were able to get this serious discrepancy repaired and ensure that Georgia health-care providers were treated fairly.

With solutions to improve our health-care system that adhere to our principles, we can protect the doctor-patient relationship from undue influence and interference, and put patients, families, and doctors in charge.

APPENDIX E

Speeches and Remarks Made by Dr. Tom Price—2012 to the Present

Date	Name	Topic	Location
2016 Speeches and Remarks by Dr. Tom Price			
January 13, 2016	REMARKS: Brookings Event	What, If Anything Congress is Likely to Accomplish in This Election Year	DC
January 23, 2016	REMARKS: Georgia Medical Directors Association Winter Symposium	Washington Update	GA
January 30, 2016	REMARKS: Conservative Policy Leadership Institute	Healthcare Update, Emphasis on H.R. 2300	GA
February 24, 2016	REMARKS: NAHU Meeting	Health Care—ACA replacement	DC
March 1, 2016	REMARKS: AMRPA Leadership Forum	Congressional Update and Gratitude for the AMRPA Chairman’s Award	DC
March 22, 2016	REMARKS: Pete Sessions Medical Professionals Fly-in	General Healthcare Overview	DC
March 24, 2016	REMARKS: Emory College Republicans	The State of the GOP and H.R. 2300	GA
April 11, 2016	REMARKS: Healthcare Symposium with Berry College	Issues of Healthcare Economics and Policy in the U.S.	GA
April 13, 2016	REMARKS: Idea Forum on Healthcare Reform	No topics listed	DC
April 14, 2016	REMARKS: Georgia Society of Ophthalmology Breakfast	Washington Update	DC

Date	Name	Topic	Location
April 19, 2016	REMARKS: NASS Event	General/Broad Update on Healthcare as it Stands in the House and From his Perspective as Chairman of the Budget Committee	DC
May 4, 2016	REMARKS: Emory Science Advocacy Network	Federal Funding for Biomedical Research, Particularly for the National Institutes of Health (NIH) and National Science Foundation (NSF)	GA
June 27, 2016	REMARKS: Roundtable Lunch Event with Market News International Connect	Washington Update With a Focus on Budget Committee Activity and Dr. Price's Work on Health Care	NY
July 13, 2016	REMARKS: Health on Wednesday	Your Perspective as a Leader in the House on Finalizing Health Initiatives in the 2nd Session of Congress; Standard Healthcare Speech	DC
July 21, 2016	REMARKS: Washington Post Panel on Healthcare	Future of Health Care and Health Policy Issues the Next President Will Face	OH
August 7, 2016	REMARKS: GPLA; Perspectives on Physician Leadership Communication	Perspectives on Physician Leadership Communication	GA
August 13, 2016	REMARKS: Concierge Medicine Conference	The Current State of Healthcare and Emerging Entrepreneurial Forms of Healthcare Delivery in America	GA
August 25, 2016	REMARKS: MVP Vets Event With Elektta and AdvaMed	Your Work in Washington and How It's Essential to the Medical Technology Community (Medical Device Tax or Even the Breakthrough Pathways legislation, e.g.)	GA
August 25, 2016	REMARKS: AARP Financial Forum With Senator Isakson	Social Security (Challenges to, the Future of, Possible Solutions) and any Other Financial Initiatives at the Federal Level You Would Like to Highlight	GA
September 10, 2016	REMARKS: AKSM Medical Director Meeting	Washington/Healthcare Update	GA
September 13, 2016	REMARKS: PhRMA Board	CMMI and 2017 Agenda	DC
September 20, 2016	REMARKS: AAMC	Present Information About Mr. Trump's Platform, Especially as it Related to Health Care	DC
September 28, 2016	REMARKS: U.S. Chamber's E8 Committee	Better Way Health Care Plan	DC
October 10, 2016	REMARKS: Emory School of Business's Speaker Series: Medical Technology (Health IT and Medical Devices)	Future of Health, Healthcare, and Congressional Roll	GA
October 17, 2016	REMARKS: Seniors for Trump Conference Call	Senior's Healthcare (Medical and Supplementary Coverage)	Call
October 20, 2016	REMARKS: Eastern Orthopedic Society	Federal Healthcare and How it Affects Orthopaedic Surgeons	LA
November 1, 2016	REMARKS: Healthcare Event With Trump	Healthcare	PA
November 2, 2016	REMARKS: Medtrade Conference	AAHomecare Washington Update	GA
November 12, 2016	REMARKS: RIPON: PANEL 4	National Health Service vs. Obamacare	DC
November 21, 2016	REMARKS: Panel Discussion With U.S. Global Leadership Coalition	Importance of U.S. Global Leadership and to Highlight the Positive Impacts America's Development and Diplomatic Programs Have on Georgia	GA
2015 Speeches and Remarks by Dr. Tom Price			
January 12, 2015	REMARKS: Heritage Action Policy Summit	Vision for the House Budget Committee + Upcoming Fiscal/Economic Deadlines (ex: SGR)	DC

Date	Name	Topic	Location
January 30, 2015	REMARKS: American Society of General Surgeons Conference	Affordable Care Act Update	DC
January 31, 2015	REMARKS: Conservative Policy Leadership Institute	Empowering Patients First Act	GA
February 9, 2015	REMARKS: MASA Conference	SGR, ICD-10 and How the Doctor's Caucus Can Have More Influence in Congress as Far as Medical Issues	DC
February 12, 2015	REMARKS: ASCO Oncology Meeting	SGR Reform and How it is Impacted by the Budget Process	DC
February 18, 2015	REMARKS: Panel Discussion With Senator Isakson: NFIB/GA Small Business Day	Obamacare/Healthcare Reform	GA
February 24, 2015	REMARKS: AMA National Advocacy Conference	Budget, Medicare, etc.	DC
February 28, 2015	REMARKS: CPAC	What Have His Former Colleagues in Medicine Told Him About How Obamacare is Affecting Their Practices, and What Effect Might This Have on Federal Spending?	MD
March 2, 2015	REMARKS: American Academy of Neurology Reception	General Update on Healthcare	DC
April 16, 2015	REMARKS: American Academy of Ophthalmology	Medicare Payment Outlook	DC
April 27, 2015	REMARKS: GNFCC's Healthcare Technology Roundtable	Your Health Care Plan and Obamacare Repeal and Replacement	GA
April 27, 2015	REMARKS: Emergency Department Practice Management Association's Solutions Summit	Repeal of the SGR and Interested in What Will Happen Moving Forward	FL
April 28, 2015	REMARKS: Big Cities Health Coalition Breakfast Briefing With John Lewis	Opening Remarks—Share Your Personal Story	DC
April 30, 2015	REMARKS: Laffar Associates 55th Washington Conference	Discuss What Your View Is as to the Most Important Economic Legislative Agenda Items and Current Events	DC
May 1, 2015	REMARKS: American Association of Orthopaedic Surgeons	What It's Like to Be a Member of Congress and Former Surgeon; Budget Outlook; Healthcare Landscape—Post-SGR	DC
May 6, 2015	REMARKS: Lecture With the Princeton Tory	A Balanced Budget for a Stronger America: Federal Spending, Obamacare, and Other Washington Updates	NJ
May 13, 2015	REMARKS: American Tax Reform Meeting	H.R. 2300	DC
May 19, 2015	REMARKS: National Association of Spine Specialists: (NASS) Capitol Hill Day 2015	Primary Focus: Dr. Price's Patient Shared Billing Legislation—H.R. 1650, Medicare Patient Empowerment Act	DC
June 8, 2015	REMARKS: SE Breakfast at AMA	Healthcare	IL
June 15, 2015	REMARKS: American Society of Actuaries	H.R. 2300	GA
June 23, 2015	REMARKS: Healthcare Leadership Council Luncheon	Brief Overview of Work in the Ways and Means Committee	DC
July 20, 2015	REMARKS: Town Hall Meeting With AMA President Stack	Meaningful Use—Town Hall Is Focused on Electronic Health Records and Looming Regulations	GA
August 1, 2015	REMARKS: Concierge Medicine Conference	Current State of Healthcare and Emerging Entrepreneurial Forms of Healthcare Delivery in America	GA
August 9, 2015	REMARKS: GPLA	Perspectives on Physician Leadership	GA

Date	Name	Topic	Location
August 14, 2015	REMARKS: South Atlantic Region Architecture for Health Annual Conference	Policy and the Impact on Healthcare Delivery	GA
August 17, 2015	REMARKS: UCB Politics and Pizza Luncheon	Healthcare Related Topics—Vision for the U.S. Healthcare System—FDA Reform, etc.	GA
August 21, 2015	REMARKS: WellStar Board Meeting—Reception and Dinner	Healthcare/Budget Update	GA
September 24, 2015	REMARKS: University of Michigan Young Americans for Freedom	Your Specialty in Medicine and Perhaps Touch on Some Important Legislative Issues (Obamacare)	MI
September 28, 2015	REMARKS: Chairman's Council Policy Conference	Health Reform and Budget	DC
October 3, 2015	REMARKS: GOS	No topics listed	GA
November 16, 2015	REMARKS: AMA Southeastern Delegation Breakfast	Personal Experience in Medicine and Transition to Government	GA
December 3, 2015	REMARKS: First Quality Forum	Health Policy and Related Budget Issues	DC
December 9, 2015	REMARKS: AEI Speech	No topics listed	DC
2014 Speeches and Remarks by Dr. Tom Price			
January 15, 2014	REMARKS: Healthcare Policy Briefing	MMP Bill Compleutive Bidding (They May Bring Up SGR, ACA, etc.)	DC
February 10, 2014	REMARKS: Heritage Action Panel	H.R. 2300	DC
February 22, 2014	REMARKS: Tea Party Patriots Healthcare Event	Healthcare Update—H.R. 2300	GA
February 27, 2014	REMARKS: Lone Star Leadership PAC Breakfast	Healthcare Roundtable—E&C, W&M Perspective	DC
February 27, 2014	REMARKS: Galen Institute Health Solutions Conference	Healthcare Reform Proposals	DC
February 28, 2014	REMARKS: AEI Symposium	Healthcare Reform	DC
March 6, 2014	REMARKS: CPAC Panel	The New Medical Realities We All Face: Rationing, Denial of Care, Doctor Shortages and a Loss of Religious Liberty Under Obamacare	MD
March 7, 2014	REMARKS: AEI Panel	The Health of America's Health Policy	DC
March 9, 2014	REMARKS: RJC—Atlanta	Healthcare Update, Emphasis on H.R. 2300	GA
March 12, 2014	REMARKS: The Commonwealth Fund's Harkness Fellows	Affordable Care Act, its Prospects for Expanding Coverage, Transforming the U.S. Health Care System and Containing Costs	DC
March 24, 2014	REMARKS: American Psychiatric Association Advocacy Leadership Conference (annual fly-in)	Current Major Healthcare Issues in Congress	DC
March 27, 2014	REMARKS: American Association of Physicians of Indian Origin (AAPI)	Healthcare: SGR, ACA, etc.	DC
March 27, 2014	REMARKS: NASS Washington Conference	Importance of Physician Advocacy and Visiting Washington, DC, to SGR	DC
April 1, 2014	REMARKS: Obamacare: What to Watch in 2014	Health Care and the Economy Between Now and November	DC
April 3, 2014	REMARKS: Tax Council	Your Thoughts on the Comprehensive Reform Process, SGR, Highways, and Other Items.	DC
April 9, 2014	REMARKS: Las Vegas Metropolitan Chamber of Commerce Conference	Healthcare and the Impact on American Employers Both Large and Small	DC
April 10, 2014	REMARKS: PDMA	Healthcare in 2014 and Beyond	MD

Date	Name	Topic	Location
April 11, 2014	REMARKS: Heritage Conference	If You Like This Session, You Can Keep it—Real Health Care Solutions As Obamacare Unravels	DC
April 14, 2014	REMARKS: Forsyth County Tea Party Tax Day Rally	The Un-Affordable Care Act/Obamacare—“One Giant Tax”	GA
April 23, 2014	REMARKS: National Rx Abuse Summit	Drug-Related Legislation He Has Supported and any Stories He Could Tell About the Epidemic in Georgia	GA
April 23, 2014	REMARKS: St. Louis Orthopaedic Society Dinner	The Future of Health Care Reform: A Physician’s Perspective on Policy Making	MO
April 26, 2014	REMARKS: Alabama Orthopaedic Society Meeting	Navigating the ACA and the Battle for Patient-Centered Solutions	AL
May 8, 2014	REMARKS: Virginians for Quality Healthcare Forum	Concern That is Percolating Among the Republican Base and the Media That the Leadership Actually Has no Intention to “Repeal and Replace”	VA
May 12, 2014	REMARKS: St. Joe’s General Medical Staff Meeting	Healthcare Update	GA
May 17, 2014	REMARKS: Atlanta International Trauma Symposium	Healthcare Update from DC—Emphasis on Reform	GA
June 17, 2014	REMARKS: Government Health Information Technology Conference	Crafting Health Innovation That Works for Patients and Doctors	DC
June 17, 2014	REMARKS: ASCA Dinner	An Update on Healthcare	DC
August 12, 2014	REMARKS: Medical Forum: “Federal Issues Facing the Medical Community in NC’s 3rd Congressional District”	Healthcare Problems Confronting Doctors, Nurses, Administrators, and Patients	NC
August 13, 2014	REMARKS: Roundtable Lunch with Congressman Walter Jones and Special Guest Congressman Tom Price	Federal Issues that Will Affect Eastern NC’s Medical Community	NC
August 17, 2014	REMARKS: Leadership Session—GPLA	Perspectives on Physician Leadership	GA
September 30, 2014	REMARKS: Keynote Speaker, AHIP Medicare and Medicaid Conference	Sustaining Medicare for Future Generations: Views From the Hill	DC
November 20, 2014	REMARKS: Speech/Panel With Benjamin Rush Institute, Georgetown Chapter	General Discussion on How One Goes From Medicine to Congress	DC
2013 Speeches and Remarks by Dr. Tom Price			
January 10, 2013	REMARKS: Florida Healthcare Reception	Update on What is Happening in DC on the Health Care Front Since Election Day—Federal Viewpoint	FL
February 27, 2013	REMARKS: Call With Coalition of State Medical and National Specialty Societies	Reintroduction of the Medicare Patient Empowerment Act. (Dr. Price)—Medicare Patient Empowerment Act in the New Congress and Strategies to Get it Passed	Call
March 4, 2013	REMARKS: AWARD American Congress of Obstetricians and Gynecologists (ACOG) 31st Annual Congressional Leadership Conference	Physician Payments: Cuts, Bumps, and Bruises	DC
March 4, 2013	REMARKS: AAMC Government Relations Conference	Current Climate on Capitol Hill as it Relates to Federal Health Care Spending (Particularly, Medicare, Medicaid, Public Health Service Programs Like the National Health Service Corps, and the NIH)	DC

Date	Name	Topic	Location
March 6, 2013	REMARKS: Meeting With Commonwealth Fund's Fellows	U.S. Health Reform and the Sustainability of Medicare and Medicaid, the Challenge of Improving the Quality of Care and Access to the Latest Technologies and Medications While Containing Spiraling Health Care Costs	DC
March 17, 2013	REMARKS: American Urological Association	Impact of the Affordable Care Act on Physicians	VA
April 7, 2013	REMARKS: Self-Insurance Institute of America, Inc. (SIIA)	Perspectives on Implementation of the ACA and any Future Actions Being Taken by the House Affecting Healthcare Reform	DC
May 3, 2013	REMARKS: National Orthopaedic Leadership Conference (AAOS)	Entitlement Reform: Long-Term Economic Projections and the Outlook for Medicare Reform	DC
May 6, 2013	REMARKS: RADPAC	Specifics on Healthcare and Comments on Radiology Bill—H.R. 846—and H.R. 3269 Last Congress That Had More Than 270 Co-Sponsors	DC
May 15, 2013	REMARKS: PPO Capital Caucus	Impact of Obamacare and the Next Steps as We Look Ahead to 2014	DC
May 22, 2013	REMARKS: American Association for Homecare Washington Legislative Conference	Problems With Medicare's Competitive Bidding Program and Benefits of the Market Pricing Program (MPP) HME Provider Compliance and Audit Issues; Power Mobility Issues; and Efforts to Eliminate Medicare Fraud and Abuse	DC
June 15, 2013	REMARKS: Becker's ASC Review Panel	Orthopaedic, Spine, and Pain Management Practices and ASCs—6 Defining Issues	IL
June 17, 2013	REMARKS: AMA SE Delegation Breakfast	Status of Obamacare	IL
June 24, 2013	REMARKS: National Association of Health Underwriters' Annual Convention	Obamacare and Your Plan on Reducing Costs, From the Provider Side of Business	GA
July 9, 2013	REMARKS: Alliance of Specialty Medicine	Healthcare	DC
July 16, 2013	REMARKS: 2013 Health Care Payments and Policy Conference	What Representative Price Thinks About Emerging Health Reform Issues in the 113th Congress	DC
July 20, 2013	REMARKS: Southern Orthopaedic Association	Obamacare Current Perspective	
August 10, 2013	REMARKS: GA Physicians Leadership Academy	Perspectives on Physician Leadership	GA
August 17, 2013	REMARKS: American Society of General Surgeons	How Will The Affordable Care Act Influence the Practice of Surgery in the Near Future?	MD
August 20, 2013	REMARKS: GNFCC's Healthcare Panel	ACA	GA
September 23, 2013	REMARKS: Elektta Learning and Innovation Center (LINC) Grand Opening/Ribbon Cutting	Importance of Elektta to Georgia and the Health Care Industry	GA
October 9, 2013	SPECIAL GUEST: U.S. Oncology Network PAC Board	Talk About SGR, Government Shutdown, and Thoughts of What Happens Over the Next Couple of Months; Anything Physician Related	DC
October 21, 2013	REMARKS: GA/Cobb Chamber Healthcare Summit	Affordable Care Act—The Story, The Politics and Policy, and the Future	GA
October 24, 2013	REMARKS: CA Lincoln Club Fly-in	Panel of GOP members Who Are Working on a GOP Plan/Alternative to Obamacare—Very Casual/Informal Discussion	

Date	Name	Topic	Location
November 16, 2013	REMARKS: Keynote address Medical Student Section at the AMA-MSS Interim Assembly Meeting	As the Largest Medical Student Organization in the Country the AMA-MSS is Dedicated to Representing Medical Students, Improving Medical Education, Developing Leadership, and Promoting Activism for the Health of America	DC
November 16, 2013	REMARKS: 4th Edward Annis Medical Freedom Awards Dinner/Give Award to Dr. Carson	Current Republican Health Reform Proposals	MD
November 17, 2013	REMARKS: International Medical Graduates Section	Physicians as Leaders and Legislators	MD
November 18, 2013	REMARKS: AMA SE Delegation Breakfast	Developments on ACA and Some on SGR	DC
December 4, 2013	REMARKS: Ripon Society Breakfast	The Health Care Debate: Reform vs. Reality	DC
December 11, 2013	REMARKS: ATR Wednesday Meeting to Roll Out H.R. 2300 Score	H.R. 2300	DC
2012 Speeches and Remarks by Dr. Tom Price			
January 23, 2012	REMARKS: 39th Annual March for Life	March for Life	DC
February 21, 2012	REMARKS: Cushman and Wakefield Healthcare CFO Roundtable	Healthcare Update	GA
February 23, 2012	REMARKS: Southeast Permanente Medical Group Board of Directors Meeting	Healthcare Update, Including the Revolving Status of the ACA Legislation and What SPMG Can Do to Best Position Itself for the Future	GA
February 29, 2012	REMARKS: Luncheon for the American Association of Clinical Endocrinologists	Physician Payment Reform and the Prospects of Passing H.R. 1700 Given the Inability of Congress Thus Far to Enact Permanent Medicare Physician Payment Reform	DC
March 5, 2012	REMARKS: American Urological Association	Perspective on Where Medicine is Going, Implementation of the Health Reform Bill, etc.	DC
March 7, 2012	REMARKS: Academic Health Centers Fly-in	Conference Committee Outcome; What Will the 2012 Election Mean for Teaching Hospitals, Payroll Tax Conference, and SGR?	DC
March 13, 2012	REMARKS: Colorado School of Medicine Benjamin Rush Society	The Nexus of Medicine and Politics . . . Closer Than you Think!	CO
March 16, 2012	REMARKS: RPA Reception	Future of Healthcare	DC
March 22, 2012	REMARKS: Townhall Meeting With Athena Health	Athena's Innovative Approach to Incentivizing Meaningful Health Information Exchange and a Recent OIG Opinion the Company Successfully Obtained That Has the Potential to at Last Unleash the Technological Innovation in the Health Care Sector That Has Eluded Policy Makers for Decades	DC
March 22, 2012	REMARKS: National Association of Chain Drug Stores	Medication Adherence: How Important it Is for Patients to Take Their Medications, and Take Them Correctly; One of the Items in our MTM Bill That We Stress is That Patients in Transition of Care Need Extra Help to Make Sure They Take Their Meds, Take Them Properly, and Continue to Take Them Until the Physician Has Determined They Stop	DC
March 27, 2012	REMARKS: Hands Off My Healthcare Rally	Hands Off My Healthcare	DC

Date	Name	Topic	Location
April 12, 2012	REMARKS: Lunch With AMA Students	Health Care Reform From the Perspective of a Physician in Congress	DC
April 12, 2012	REMARKS: Speaking at the Commons Seminar	Healthcare in America: Where Have We Come From and Where Are We Going?	DC
April 13, 2012	REMARKS: Medical Association for State of Alabama Annual Meeting	Physician Leadership: Critical for Preserving the Profession; Why Physicians Should be More Involved in the Political Process	AL
April 23, 2012	REMARKS: North Fulton Hospital (Semi-Annual Medical Staff Meeting)	A Washington/Healthcare Update	GA
April 26, 2012	REMARKS: National Journal Keynote Interview	Discussion on How Congress Can Act in the Interest of the American Public and the Policy Issues Americans Want Their Elected Officials to Focus on for the Remainder of the 112th Congress	DC
April 26, 2012	REMARKS: American Association of Orthopaedic Surgeons	No Topic Listed	DC
April 30, 2012	REMARKS: To Hilldale Students	A Principled Prescription for America's Health: The Perspective of Doctor-Turned-Lawmaker	
May 8, 2012	REMARKS: College of American Pathologists Breakfast	Outlook in Congress for the Rest of the Year; What's the GOP View on Health Care and Medicare Reform? What Happens Next in Health Care if ACA is Repealed or is Not Repealed?	DC
May 21, 2012	REMARKS: University of Missouri Medical School	Health Care Financing in General and Financing of Graduate Medical Education	MO
May 22, 2012	REMARKS: Richmond County Medical Society	Healthcare Update; Status of Healthcare Reform Legislation	GA
June 3, 2012	REMARKS: GA/SC Radiology Societies Joint Chapter Meeting	Our Bill, H.R. 3269; How We Can Get it Into End of Year Package, etc.; SGR; Your Bill to Repeal and Replace ACA	SC
June 15, 2012	REMARKS: Faith and Freedom Coalition	Panel: Obamacare: Repeal, Replace, and Reform	DC
June 18, 2012	REMARKS: AMA Southeastern Breakfast	No topic listed	IL
June 22, 2012	REMARKS: Stand Up for Religious Liberty Rally	Your/House Perspective on HSS Mandate; Role the Federal Government is Playing to Infringe on the Rights of Religious Organizations; Any Updates From the House on These Issues	GA
June 26, 2012	REMARKS: American Orthopaedic Association	Personal Story of How You Got Involved in Politics	MD
July 10, 2012	REMARKS: American Action Network and Crossroads GPS Healthcare Panel	Repealing and Replacing Obamacare	DC
July 10, 2012	REMARKS: American Association of Neurological Surgeons Fly-in	Price/Boustany Medicare Physician Payment Bill and Private Contracting	DC
July 20, 2012	REMARKS: Smart Girl Politics	Healthcare, Next Steps	VA
July 27, 2012	REMARKS: Lincoln Day Dinner with Ross	Obamacare	FL
July 31, 2012	REMARKS: B26 Romney Breakfast	Healthcare	NC
August 3, 2012	REMARKS: ASCRS/ASOA Retreat (via teleconference)	Medicare Physician Payment Reform, the SGR, IPAB Repeal	Call
August 7, 2012	REMARKS: GAMES Legislative Breakfast	Healthcare: Home Health Care: Medicare Competitive Bidding and the Current Audit Environment	GA

Date	Name	Topic	Location
August 7, 2012	REMARKS: Brunswick Medical Community Event	Healthcare/Washington Update	GA
August 12, 2012	REMARKS: Georgia Physicians Leadership Academy	Perspective on Physician Leadership	GA
August 24, 2012	REMARKS: Strathspey Crown: A New Model for Healthcare	The Opportunity for Reforms to the ACA	CA
August 25, 2012	REMARKS: Government Affairs Panel: Creating a New Era in Healthcare	No topic listed	CA
August 28, 2012	REMARKS: Bipartisan Conversation on Healthcare	Healthcare Panel	FL
August 29, 2012	REMARKS: The Hill Healthcare Panel	No topic listed	FL
September 9, 2012	REMARKS: Docs 4 Patient Care	U.S. Congressional Solutions for Obamacare	VA
September 10, 2012	REMARKS: American Academy of Dermatology	The Outlook for Health Care Legislation and Legislation Impacting Physicians Broadly and, More Specifically, Dermatologists	DC
September 13, 2012	REMARKS: American Congress of Obstetricians and Gynecologists Government Relations Committee	Providing an Assessment of the Post-SCOTUS Health Reform Landscape	Call
September 13, 2012	REMARKS: SC-04 Chambers of Commerce National Issues Fly-in	Healthcare, General Ideas and Thoughts About PPACA, the Supreme Court Ruling on PPACA, and Healthcare Issues in General as it Relates to the Business Community	DC
November 10, 2012	REMARKS: Mount Vernon Towers Retirement Facility	Obamacare's Impact on Seniors	GA
November 11, 2012	REMARKS: Emory Johns Creek Hospital	Healthcare Update; H.R. 3000	GA
November 16, 2012	REMARKS: Medtrade Expo (Power for Funding Welcome Reception)	H.R. 6490—Why That Would be Better Than the Current Competitive Bidding Methodology	GA
November 22, 2012	REMARKS: SCI Solutions Healthcare Meeting	Healthcare Update/Legislative Trends in Healthcare Policy	GA
November 24, 2012	REMARKS: National Association of Spine Specialists	Health Policy Issues Facing Congress	TX

QUESTIONS SUBMITTED FOR THE RECORD TO HON. THOMAS PRICE, M.D.

QUESTIONS SUBMITTED BY HON. RON WYDEN

BROKERAGE ACCOUNT DOCUMENTATION

Question. In the hearing, you were asked to reaffirm that trades in your brokerage accounts were controlled by your stock broker and not by yourself.

Please provide the management and brokerage agreements for *all* accounts that hold individual health-care stocks including but not limited to the Morgan Stanley account labeled Morgan Stanley #1 in your 2015 House of Representatives Financial Disclosure and the Morgan Stanley account labeled Morgan Stanley #2 in your 2015 House of Representatives Financial Disclosure.

Answer. I previously provided the Senate Finance Committee (“SFC”) with substantial information regarding the nature of the brokerage accounts described in this inquiry and have no further information to provide at this time. Additional information regarding Morgan Stanley’s management and brokerage policies is also readily available in the public domain.

MANAGEMENT OF SHARES IN INNATE IMMUNOTHERAPEUTICS

Question. As discussed in the disclosure memo, which was made part of the record of the hearing, you purchased shares in Innate Immunotherapeutics in private placements in 2016.

In what account and in what form were those shares held at the time you filed your financial disclosures, as a nominee, with Federal ethics officials and your response to the committee's questionnaire? In what account and in what form are those shares currently held? If shares were transferred between accounts, when were they transferred and at whose direction?

Answer. I previously provided the SFC with substantial information regarding the issues raised in this question. As the committee is fully aware, the shares of Innate Immunotherapeutics ("Innate") purchased in 2016 through private placement were held with the company in electronic certificate format up until recently. In the process of gathering information to respond to committee questions (posed on January 17, 2017) in the wake of due diligence meetings with committee staff, I learned that these electronic certificate holdings have now been transferred to his Wells Fargo Joint Brokerage Account #1. The desire to transfer this holding from electronic certificate form to a brokerage account was discussed during the due diligence meeting with SFC staff. Both the SFC and OGE were appropriately notified of the transfer upon its completion.

BROKERAGE TRADES

Question. In testimony to the Senate HELP Committee, you stated that you directed your broker to purchase shares in Innate Immunotherapeutics.

During your time in Congress, have you ever directed your broker to make any other transactions in stock of specific companies? If so, please identify the companies, the date, and volume of the transaction.

Answer. To the best of my knowledge, I have not undertaken such actions. Throughout my time as a member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

TRANS-PACIFIC PARTNERSHIP NEGOTIATIONS

Question. Did you or your staff consult with the House Ethics Committee at any time concerning the possibility or appearance of a conflict of interest or other ethics concern arising from your ownership of shares in Innate Immunotherapeutics and your role as a member of the House Ways and Means Committee concerning negotiations related to the Trans-Pacific Partnership, or the receipt of any information that you received in that capacity or as a member of the House concerning such negotiations?

Answer. To the best of my knowledge, neither I nor my staff has had such consultations. Throughout my time as a member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

INNATE IMMUNOTHERAPEUTICS PURCHASES

Question. The nominee owns 461,238 shares of Innate Immunotherapeutics Ltd. ("Innate"), a small Australian biopharmaceutical firm developing a multiple sclerosis therapy. The nominee acquired the stock in four separate purchases on January 8, 9 and 23 of 2015 ("2015 tranche"), and in a pair of private stock placements on August 31, 2016 ("2016 tranche"). Regarding Innate:

Please describe how and when the nominee first learned about Innate.

Answer. I previously answered this question for the SFC. I learned about Innate during the course of a conversation in the fall of 2014 with Representative Chris Collins regarding their respective personal backgrounds. I cannot recall the specific date of that conversation. During that exchange, Representative Collins told me that he sat on a number of public company boards including Innate, which was developing a treatment for multiple sclerosis (MS).

Question. Did the nominee or his staff ever meet or otherwise communicate with current or former employees, directors, consultants, or other officials affiliated with Innate? If so, please describe the communication, including who it involved, the date, subject, place and form (e.g., in person, by phone) of communication.

Answer. I previously answered this question for the SFC.

I communicated with Representative Collins, who is a director of Innate. As noted above, I learned about Innate through a general conversation with him in the fall of 2014. I also communicated with Simon Wilkinson of Innate regarding my interest in participating in the 2016 private placement of company stock. According to Innate's website, Mr. Wilkinson is currently the Managing Director and CEO of Innate.

My congressional staff has not met or otherwise communicated with current or former employees, directors, consultants or other officials affiliated with Innate.

Question. Please describe any communication between the nominee and Congressman Collins regarding Innate Immunotherapy, including the date, subject, place and form.

Answer. I previously answered this question for the SFC.

I had a conversation with Representative Collins in the fall of 2014 that brought Innate, as a company, to my attention. The nature of that conversation did not, however, influence my decision to invest in the company in either 2015 or 2016.

I believe I had subsequent general communications with Representative Collins regarding Innate. I do not have a specific recollection of when those conversations occurred or their substance. Any such communications did not impact my investment decisions, however, because my purchases of Innate stock were based solely on my own research.

Question. The nominee bought 400,316 shares in the 2016 tranche in a private stock sale that included two placements at two prices. Please provide the number of shares bought in each placement, and the price at which the shares were bought.

Answer. I previously answered this question for the SFC. I purchased 250,000 shares of Innate in Private Placement 1 at US\$0.18/share—the same price offered all participants in this private placement. I purchased 150,613 shares of Innate in Private Placement 2 at US\$0.26/share—the same price offered all participants in this private placement.

ZIMMER BIOMET STOCK HOLDING

Question. Did you or your staff meet with Zimmer Biomet employees or representatives, including but not limited to lobbyists, executives, or board members, between July 14, 2015 and April 1, 2016? If so, please describe the communication, including who it involved, the date, subject, place and form (e.g., in person, by phone) of communication.

Answer. To the best of my knowledge, neither I nor any members of my staff met with or attended an event with a lobbyist or representative from Zimmer Biomet during the specified dates.

HOUSE ETHICS COMMITTEE CONSULTATION

Question. House rule 3, clause 1, provides that members of the House “shall vote on each question put, unless having a direct personal or pecuniary interest in the event of such question.” However, the House Ethics Manual (House Ethics Manual, U.S. House of Representatives Committee on Standards of Official Conduct, 110th Cong, 2d Sess. (2008), pp. 233–37) makes a sharp distinction between, on one hand, voting on the House floor, and, on the other, more active advocacy. The House Ethics Manual states:

The provisions of House Rule 3, clause 1, as discussed in this section apply only to members voting on the House floor. They do not apply to other actions that members may normally take on particular matters in connection with their official duties, such as sponsoring legislation, advocating or participating in an action by a House committee, or contacting an executive branch agency. Such actions entail a degree of advocacy above and beyond that involved in voting, and thus a member's decision on whether to take any such action on a matter that may affect his or her personal financial interests requires added circumspection. Moreover, such actions may implicate the rules and standards, discussed above, that prohibit the use of one's official position for personal gain. Whenever a member is considering taking any such action on a matter that may affect his or her personal financial interests, the member should first contact the [Ethics] Committee for guidance.

Before, or any time after, you introduced H.R. 4848, the Healthy Inpatient Procedures Act of 2016 (HIP Act) in the 114th Congress, did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in ZimmerBiomet? If so, when?

Answer. My investment accounts, particularly the Morgan Stanley Portfolio Management Program account wherein the noted stock transaction occurred, were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

Question. Before, or at any time after, you introduced H.R. 4185, the Protecting Access through Competitive-pricing Transition Act of 2015 (the PACT Act) in the 114th Congress, did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in health-care stocks? If so, when?

Answer. My investment accounts, particularly the Morgan Stanley Portfolio Management Program account wherein the noted stock transactions occurred, were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

Question. Before, or at any time after, you introduced H.R. 5400, an Act to amend the Internal Revenue Code of 1986 to make permanent the deduction for income attributable to domestic production activities in Puerto Rico in the 114th Congress, did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in Eli Lilly, Bristol Myers Squibb, and Amgen? If so when?

Answer. My investment accounts, particularly the Morgan Stanley Portfolio Management Program account wherein the noted stock transactions occurred, were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

Question. Before, or at any time after, you introduced H.R. 5210, the Patient Access to Durable Medical Equipment (PADME) Act of 2016 in the 114th Congress, did you consult with the House Ethics Committee concerning the possibility of, or appearance of, a conflict of interest or other ethics concern arising from your ownership of shares in Blackstone, Inc. or any other company that markets or manufacturers durable medical equipment? If so, when?

Answer. My investment accounts were established so as to place trading discretion in the hands of my broker/financial advisor. No conflict of interest existed and no consultation was necessary. Throughout my time as a member of the U.S. House of Representatives, I have abided by and adhered to all ethics and conflict of interest rules applicable to me.

RESURGENS ORTHOPAEDICS

Question. Do you have any financial or business relationship including an equity or ownership stake in Resurgens Orthopaedics, and/or do you derive any financial interest or benefit from the company? If so, please detail the type of financial or business relationship you have, and any income you do or may derive related to Resurgens. In addition, if you answered "yes," please describe your plan to divest your financial interest in the company.

Answer. I have no current financial stake or interest in Resurgens Orthopaedics.

LGBTQ HEALTH CARE

Question. LGBTQ individuals often experience exceptional barriers to care; health disparities associated with gender identity are partially driven by lower rates of insurance. Under the ACA, the LGBTQ population cannot be excluded from health plans due to pre-existing conditions such as HIV. Discrimination based on sex and gender identity is also prohibited for programs receiving Federal funds. Additionally, all insurance plans must offer the same coverage to married same-sex couples as is offered to opposite-sex couples. In terms of national health surveys, the ACA

changed data collection requirements to include sexual orientation and gender identity, which supports future advocacy and research.

Will you maintain health-care protections for the LGBTQ community? Please explain.

Answer. It is essential that health-care services be available to all people with the highest level of quality, affordability, and respect for their human dignity. If confirmed, I will ensure that HHS follows Congress's lead in defining and enforcing nondiscrimination laws, and that HHS will comply with all statutory and judicial requirements in doing so.

MEDICAID AND DISABILITY SERVICES

Question. Medicaid serves as the primary health insurance program for Americans with disabilities, especially those with limited income. A lack of adequate health and long-term care coverage is often cited as a primary barrier to the ability to live in the community and the ability to succeed in employment. Many of the most important Medicaid-funded services for people with disabilities can be the most expensive. States must offer three of these services: inpatient hospital care, home health care, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). State Medicaid programs currently have the option to cover the remaining services important to Americans with disabilities including: many home-and-community based services; prescription drugs; private duty nursing, physical therapy, occupational therapy; speech, hearing, and language therapy; prosthetic devices; intermediate care facilities; and personal care services.

Since the enactment of the Americans with Disabilities Act (ADA) in 1990, there has been a concerted effort at the State, Federal, and community levels to transform the Medicaid program from institutional-care focused financing mechanism into a comprehensive and flexible community-based long-term services and supports program. Examples of such congressional efforts can be seen in the Affordable Care Act, which strengthened and expanded the Money Follows the Person program and created the State Balancing Incentive Program and Community First Choice Option.

How will the administration ensure Medicaid supports the protections of the Americans with Disabilities Act?

Answer. The coordination of two complex laws such as Medicaid and the Americans with Disabilities Act requires the close interaction of those who are expert in each. At some level the protections referred to are best supported by allowing States the flexibility to approach them in a way that makes sense for their program, so long as Federal requirements are met. As to those Federal requirements, there may be a need for close coordination with the Department of Justice or the Equal Employment Opportunity Commission as well as the Department's own Office for Civil Rights.

Question. How will you ensure that Federal dollars are not used in a way that promotes unnecessary institutionalization of individuals with disabilities?

Answer. Community integration, beneficiary autonomy in decision making, and person-centered planning are central tenets articulated in CMS' approach to Home and Community Based Services and the HCBS Settings Rule with a compliance date in March 2019, and I support each of those principles. It is also important to note that many residential, disability-specific settings have long provided a safe and integrated community alternative to institutional placement for individuals with disabilities, and appropriate weight should be given to the preferences of families and individuals with disabilities because they are in the best position to decide what type of setting best meets their individualized needs and circumstances.

Question. How will you work to ensure States have sufficient resources to fund home- and community-based services?

Answer. As with any program or initiative relying on States, the central question for the State is often one of funding. If confirmed, I would work to see that the Department is a helpful resource to the States with respect to these services at least by providing clarity regarding their flexibility, technical assistance and support as needed, and sharing best practices.

Question. Will you direct CMS in its approval of waivers to encourage States to expand home- and community-based services and shift away from waiting lists and institutional care?

Answer. Every State is unique in their specific approach to the provision of services for the population eligible to receive HCBS, and we stand ready to assist States as they develop strategies to meet their particular goals.

MEDICAID EQUAL ACCESS RULE

Question. Congressman Price, as you have previously stated, some providers do not accept Medicaid. Studies show that provider payment rates are a leading reason that some providers choose not to participate in Medicaid.

Recently, the Centers for Medicare and Medicaid Services (CMS) has finalized two major rules to help address this issue—the “equal access” rule and the Medicaid managed care rule.

Congressman Price, given that this is an issue you seem particularly concerned about, will you commit to ensuring successful enforcement of the Medicaid Equal Access rule, the Medicaid managed care rule, and other Federal standards that help ensure States set appropriate payment rates as required under the Medicaid statute’s equal access provision?

Answer. If confirmed as Secretary, I will faithfully implement laws written by Congress and the regulations issued by the Department. This includes enforcement action as appropriate. As a doctor who has actually treated thousands of Medicaid patients, I do care deeply about the Medicaid program and the access of Medicaid patients to actual care, not just a card they can carry with them.

MEDICARE BALANCE BILLING

Question. Congressman Price, you have championed legislation to allow providers participating in Medicare to enter into private contracts with Medicare beneficiaries, meaning that those providers would be permitted to balance bill seniors and other Medicare beneficiaries for the difference between what Medicare pays and what the provider decides to charge—potentially putting seniors and other Medicare beneficiaries on the hook for high medical bills. More than 30 years ago, Congress passed legislation to protect against exactly that situation. One study found that out-of-pocket medical spending declined by 9% in Medicare households as a result of these protections.

Those who want balance billing in Medicare often claim that doctors are fleeing the Medicare program, but evidence demonstrates this is simply not true. Provider participation in Medicare remains strong. In fact, 9 in 10 primary care physicians accept Medicare, and 96 percent of people with Medicare report having regular access to a physician’s care. Allowing balance billing would essentially create two tiers of Medicare beneficiaries—those who can afford to access needed care and those who cannot.

Will you commit to the more than 55 million Americans who rely on Medicare that, if confirmed as HHS Secretary, you will advise the President to veto any legislation that would undermine these decades-old protections and allow providers participating in Medicare to balance bill seniors and other Medicare beneficiaries?

Answer. In considering Medicare, it is important to appreciate that the bipartisan Medicare Trustees have told everyone that Medicare, in less than 10 years, is going to be out of the kind of resources that will allow us as a society to keep the promise to beneficiaries of the Medicare program. My goal, if confirmed, is to work with Congress to make certain that we save and strengthen Medicare. It is irresponsible for us to do anything else. If I am confirmed, my role will be one of carrying out the laws Congress passes and as to that I would convey to the Medicare population that we look forward to assisting them in getting the care they need.

Question. Do you believe low- and middle-income seniors can afford to pay more for Medicare services than they currently do?

Answer. In previous legislation, I have proposed giving our seniors more flexibility within the Medicare Program and providing the opportunity to make decisions with their physicians without interference from Washington. The measure would help ensure that Medicare beneficiaries maintain adequate access to health-care professionals by increasing the number of physicians who will accept Medicare patients and addressing physician shortages by attracting new professionals to the field of medicine. In addition, the bill provides safeguards to Medicare beneficiaries. More importantly, it would allow a provider to see a Medicare patient pro-bono or charge minimal cost (below the standard fee schedule) without prosecution.

RAISING THE MEDICARE ELIGIBILITY AGE

Question. Congressional Republicans support increasing the Medicare eligibility age from 65 to 67 to generate savings for the Federal Government. It is well documented that these savings ultimately shift costs to the American people, States, and employers. According to 2014 estimates, increasing the Medicare eligibility age would result in a \$11.4 billion shift to individuals, States, and employers. The Federal savings would amount to only half of this cost, or \$5.7 billion.

Most Americans retire well before age 67. By age 63, nearly half of the population is no longer working. Advocacy groups argue that increasing the Medicare eligibility age is an across the board benefit cut that undercuts a promise made to working families and seniors more than 50 years ago.

Would you recommend President Trump veto legislation that would increase the Medicare eligibility age?

Answer. In considering Medicare, it is important to appreciate that the bipartisan Medicare Trustees have told everyone that Medicare, in less than 10 years, is going to be out of the kind of resources that will allow us as a society to keep the promise to beneficiaries of the Medicare program. My goal, if confirmed, is to work with Congress to make certain that we save and strengthen Medicare. It is irresponsible for us to do anything else. If am confirmed, my role will be one of carrying out the laws Congress passes and as to that I would convey to the Medicare population that we look forward to assisting them in getting the care they need.

Question. If implemented, would Federal savings from a higher eligibility age be shifted onto Medicare beneficiaries, States, or employers instead?

Answer. If such a change is made and the savings do not accrue to beneficiaries and the Trust Fund, then we may be right back where we started without the change. However, the allocation of savings from such a change, whether to the Medicare Trust Fund or to other budgetary priorities, will be a decision for the Congress.

MENTAL HEALTH

Question. As you must know, mental illness is highly prevalent in the United States. Over 43 million adults, just over 18 percent of the population, had any mental illness in 2014. In the past year, over 68 million Americans, representing 20 percent of the population, experienced a psychiatric or substance use disorder.

Medicaid is the country's primary payer for all mental health services and is an important source of funding for mental health services that would otherwise be out of reach for low-income people. Under Medicaid, children and adults with mental illness receive vital services and supports that are not typically covered by private insurance. Medicaid accounted for 25% of all mental health spending in the United States in 2014.

Thanks to Medicaid expansion under the Affordable Care Act (ACA), an additional 3.8 million Americans have access to mental health coverage. Furthermore, due to consumer protections under the ACA, it is now required that health insurers provide mental health and substance use disorder services as an essential health benefit.

In your 2017 budget and 2015 reconciliation bill, you call for a full-out repeal of the Medicaid expansion; do you still support full repeal?

Answer. This is a matter for the legislative branch to consider. If confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

Question. In 2015 you voted to eliminate important coverage protections for Medicaid beneficiaries in alternative benefit plans so they can access the treatment they need.

Do you still support eliminating these protections?

Answer. This is a matter for the legislative branch. I remain committed to making sure health care is affordable and accessible for all Americans. And if confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

Question. In your Empowering Patients First Act you call for full repeal of the ACA including important protections such as mental health parity that help to en-

sure that a person receives the same level of mental health coverage that they would for any physical illness.

Do you still support repeal of these protections?

Answer. I believe it is important that we as a nation make sure that every American has access to the kind of mental health and substance abuse care that they need. This is a matter for the legislative branch, however, and if confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

Question. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), which will be your principal advisor as HHS Secretary should you be confirmed, reported that in States that didn't expand Medicaid nearly 2 million low-income adults with mental health and substance use disorders are uninsured.

How do you plan to work with States to expand Medicaid coverage to these individuals?

Answer. Every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and Medicaid expansion. That is one of the reasons I devoted so much time working to help identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. If I am confirmed, I will work with CMS and SAMHSA to help the population of uninsured low-income adults with mental health and substance use disorders.

I note that the conversation and focus in these topics has been the question of coverage rather than true access to care. For many Americans, they might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons.

OPIOIDS AND MEDICAID EXPANSION

Question. In November, I released a report describing the consequences of not adequately funding treatment and prevention services for opioid addiction. However, as we both know, the effects of opioid crisis go far beyond mere statistics. People all across the country end up struggling with opioid addiction simply because they got into a car accident, or had a painful surgery. Medicaid expansion has provided millions of Americans an opportunity to get the treatment they need to get back on their feet.

Congressman Price, in your 2017 budget you call for ending the Medicaid expansion, can you confirm whether you still support getting rid of the Medicaid expansion?

Answer. This is a matter for the legislative branch. If confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

Question. In your role as a cabinet Secretary, would you advise the President to veto a bill that repeals the Medicaid expansion?

Answer. I am committed to making sure all Americans have access to affordable health care that is of the highest quality. Every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid. That is one of the reasons I devoted so much time to working with States to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. I would encourage anyone to keep this principle front and center in considering any changes to Medicaid, which themselves might well be part of a greater context that further informs the best approach. In the meantime, I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I will promise you this: Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

Question. Would you advise the President to support ending coverage for the 1.6 million Americans struggling with substance use disorders who gained access to coverage for treatment under the Medicaid expansion?

Answer. It is important that we as a nation make sure that every American has access to the kind of mental health and substance abuse care that they need. If I am confirmed, I am committed to ensure that access is not diminished.

Question. Will you promise that people dealing with opioid addiction will not lose their Medicaid expansion coverage that has provided them with the treatment they need and deserve?

Answer. Opioid addiction has had a severe and devastating impact to communities and families across the country. If I am confirmed, I am committed to ensure that access to treatments is not diminished and will work with CMS and SAMHSA to help low-income adults with mental health and substance use disorders.

NETWORK ADEQUACY RULES FOR SPECIALTY PHARMACIES

Question. Pharmacy Benefit Managers (PBMs) may or may not own the pharmacies in their pharmacy networks. Recently, PBMs have been criticized for using aggressive tactics to restrict access to pharmacies that they do not own. If pharmacy networks are narrowed, then individuals will have limited access to pharmacies and necessary medications.

I have heard from Oregon pharmacies that pharmacy benefit managers (PBMs) are using aggressive tactics to, in the pharmacies' opinion, restrict access to pharmacies not owned by the PBM.

This issue was described in a January 9, 2017 *New York Times* article: (https://mobile.nytimes.com/2017/01/09/business/specialty-pharmacies-say-benefit-managers-are-squeezing-themout.html?_r=0&referrer=https%3A%2F%2Fwww.google.com%2F).

I am concerned that if pharmacy networks are narrowed, access to needed medications will be limited.

Can you explain if practices described in the *New York Times* article are permitted under Medicare Part D and the Exchanges established under the Affordable Care Act (ACA)?

Answer. Part D plans are required to accept any pharmacy willing to participate in the plan under the terms of its standard contract. Qualified health plans do not have such a requirement though State insurance commissioners may consider such practices in their regulatory oversight.

Question. What minimum standards regarding network adequacy for specialty pharmacies exist for both Part D plans and plans offered on the ACA Exchanges?

Question. For Part D plans, network adequacy requirements are set forth in 42 CFR 423.120 and in subregulatory guidance. The requirements vary by the type of drug. For home infusion drugs, they vary by State. See <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Adequate-Access-to-HI-Pharmacies-Rewrite-012610.pdf>.

For Qualified Health Plans, network adequacy requirements are set forth at 45 CFR 156.230, 45 CFR 156.122(e), and QHP application and attestation materials, as well as in State laws.

PREVENTIVE CARE

Question. Countless studies have proven that early detection of disease saves lives and improves quality of life. Early detection, through preventive screenings, can save the health-care system the expense of more costly treatments that may be necessary with a later stage diagnosis. However, early detection of disease is often not possible without preventive screenings, for both acute conditions like cancer and chronic conditions like diabetes. High copays and high deductibles can be a deterrent to patients utilizing these preventive screenings, regardless of socioeconomic status.

The ACA included a provision requiring private health plans to cover recommended preventive services without any co-payments or cost-sharing. It also added coverage of an annual wellness visit and eliminated cost-sharing for recommended preventive services under the Medicare program.

As HHS Secretary, how will you guarantee that Americans will retain their current level of coverage for preventive screenings and ensure early detection screenings are preserved?

Answer. I would convey to the Medicare population that we look forward to assisting them in getting the care they need and the caregivers that they need too.

As we consider what to do with regards to the Affordable Care Act, my hope is to move in a direction where insurers can offer products people want and give them the coverage they want. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans.

SPOUSAL IMPOVERISHMENT PROTECTIONS

Question. In the 1980s, married couples commonly were driven into complete poverty when one spouse developed a need for nursing home care. The couple often had to spend down their joint resources to just a few thousand dollars before Medicaid could provide assistance. Congress addressed this problem in 1988 legislation signed by President Reagan. Beginning in October 1989, the spouse of a nursing home resident has been allowed allocations of income and resources in determining the resident's Medicaid eligibility. These allocations allow the at-home spouse to retain adequate but not lavish amounts of income and savings. To allow for State flexibility, the Federal Government sets a range for these allocations, and indexes those ranges to inflation. Each State sets its own income allocation and resource allocation, as long as the allocation falls within the Federal range.

Spousal impoverishment protections are mandatory for nursing home residents and were optional for people receiving home and community-based services (HCBS). Due to the Affordable Care Act, people receiving HCBS are also entitled to spousal impoverishment protections.

Do you support the requirement for State spousal impoverishment protections?

Answer. I support the flexibility of States to make decisions about eligibility so that they can ensure the broadest set of people get access to the highest quality care on the budget available to the State. Spousal impoverishment protections allow States to delay or prevent the impoverishment of spouses lest they too need to be added to the Medicaid rolls.

Question. Should a person be required to receive long-term care in a nursing home in order to protect a spouse from poverty?

Answer. My hope is that we can move to a system where States can make decisions like this with their population, values, dynamics, and funding in mind.

Question. How will HHS ensure spouses are protected from living in poverty when a loved one reaches a stage of fragility that requires long-term care?

Answer. I have seen that the best solutions to seemingly intractable problems like this rely on States to find the right approach for that State. If confirmed, I look forward to working with Governors (and Congress) to help States chart their course in this regard.

WOMEN'S HEALTH

Question. Congressman Price, in the past, when asked whether birth control should have to be covered, you've stated that not a single woman has been left behind.

Will you reject any proposals that limit a women's access to contraceptive care or make it cost more for her?

Answer. Women should have the health care that they need and want. The system we ought to have in place is one that equips women and men to obtain the health care that they need at an affordable price.

Question. As a cabinet adviser to the President, will you advise the President to veto any bill that reduces guaranteed access to affordable contraceptive coverage?

Answer. As we consider what to do with regards to the Affordable Care Act, my hope is to move in a direction where insurers offer products people want and give them the coverage they want. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans.

Question. In your hearing last week, you were asked about your vote against the DC Council's efforts to protect employees from being fired for taking birth control. Congressman Price, to clarify for the record, do you or do you not think an employer should be able to fire or discriminate against an employee for taking birth control?

Answer. I do not believe so. My vote regarding the DC Council law you mentioned does not relate to this particular issue or question.

Question. Will you advise the President to veto any bill that rips access to care away from hundreds of thousands of women by defunding Planned Parenthood?

Answer. Deciding whether to sign any particular law, particularly one that involves as many different moving parts as one to replace the Affordable Care Act, inevitably involves considering many competing, complementary, or countervailing issues. If Congress passes a law that makes certain that every single American has access to the coverage they want for themselves and ensures the individuals who lost coverage under the Affordable Care Act get or maintain coverage, that is something I would hope would be strongly considered for signature.

Question. You sponsored the 2015 reconciliation bill (H.R. 3762) that would repeal key components of the Affordable Care Act (ACA) and rescind Federal funding for Planned Parenthood for 1 year. Please provide the names of providers other than Planned Parenthood health centers that H.R. 3762 would prohibit from participating in Medicaid?

Answer. H.R. 3762 restricts the availability of Federal funding to a State for payments to any entity that is a 501(c)(3) tax-exempt organization, is an essential community provider primarily engaged in family planning services and reproductive health; provides abortions other than in cases of rape, incest or life of the mother, and receive a total of more than \$350 million under Medicaid in FY 2014.

It should also be noted that H.R. 3762 would increase funding available to the Community Health Center Program (CHC) by \$470 million over 2 years. As I said in my hearing before the Senate Health, Education, Labor, and Pensions (HELP) Committee last week, community health centers are a vital part of the health care delivery system, filling a void in so many areas across the country. We need to do all we can to strengthen them, ensuring they are staffed with the highest quality providers and providing the highest quality care, and look forward to working with you on this if confirmed.

WORK REQUIREMENTS FOR MEDICAID SERVICES

Question. Your Budget Plan for 2017 proposes work requirements for so called “able-bodied” adults in order to qualify for Medicaid coverage. Specifically, these individuals must be actively seeking employment or participating in an education or training program in order to qualify for health-care coverage under Medicaid.

According to independent evaluations of programs that have imposed work requirements, imposition of work requirements found only modest, short-term increases in employment with families living in deep poverty rising under such programs. The evidence also shows that over the long-term, those in programs with work requirements were as likely to find employment as enrollees in Medicaid programs that did not have strict work requirements.

How do you define an “able-bodied” adult?

Do you support work requirements in order for these “able-bodied” adults to qualify for Medicaid?

Given you’re interest in employment, how do you plan on working to support local economies to ensure that those looking for work regardless of income are actually able to obtain jobs?

Answer. One major lesson learned from welfare reform signed into law by President Clinton is that the American people, when given the opportunity, work exceptionally hard. This view is also shared by President Trump and reflected in his commitment to job creation and the dignity of work. Encouraging work allows more families to realize the American dream, earn their success and rise out of poverty. I will faithfully execute any laws passed by Congress to institute work requirements and if given the opportunity to serve I will allow States greater flexibility for determining how to care for their most needy citizens.

AMA RECUSAL

Question. Congressman Price, in your January 11th letter to the Associate General Counsel for Ethics at HHS, you said you would resign from your position as a Delegate of the American Medical Association (AMA) if confirmed as HHS Secretary. You also promised that—for 1 year after your AMA resignation—you would “not participate personally and substantially in any particular matter involving spe-

cific parties in which (you know) the American Medical Association is a party or represents a party, unless (you are) first authorized to participate.”

In 2016 alone, the AMA submitted 21 formal comment letters to HHS and CMS—almost two per month on average—covering a wide range of issues, including, for example, the implementation of the Medicare physician payment reforms in MACRA (the Medicare Access and CHIP Reauthorization Act) and key provisions of last year’s Comprehensive Addiction and Recovery Act (CARA).

In this context, what criteria would you use to determine what constitutes participating “personally and substantially” in a matter?

Answer. I view the term “personally and substantially” in the context of its statutory and regulatory definitions. To the extent necessary, I will seek advice from his designated agency ethics official and other appropriate parties when assessing whether participation in a matter is indeed personal and substantial.

Question. In this context, what criteria would you use to determine whether the level of AMA’s involvement means that it is a party or represents a party in a particular matter?

Answer. I will abide by the actions agreed to in my publicly available ethics agreement with the Office of Government Ethics, and seek advice (when necessary) from the designated agency ethics official and other appropriate persons.

Question. Will you recuse yourself from any matter in which the AMA has submitted formal comments to HHS or CMS?

Answer. This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly available ethics agreement.

Question. For example, will you recuse yourself from any decision-making regarding the implementation of the physician payment reforms in MACRA—given how actively engaged AMA has been with HHS and CMS on that issue?

Answer. This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly available ethics agreement.

Question. Will you also recuse yourself from any matter about which the AMA sent correspondence to HHS or CMS?

Answer. This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly available ethics agreement.

Question. Do you think an HHS Secretary can effectively do his job if he cannot participate in any of the above described matters?

Answer. Adherence to all applicable ethics and conflict of interest obligations under Federal law is an essential component of being an effective HHS Secretary, and in no way limits the ability of an individual to successfully carry out his or her responsibilities within the Department.

AUTOMATIC CUTS TO ENTITLEMENTS

Question. The day after you were nominated for HHS Secretary, you rolled out a set of budget process changes that would force automatic cuts to almost all Federal programs—including Social Security, Medicare, and Medicaid—if the national debt exceeds targets specified by Congress. If the Trump tax plan is signed into law, but Congress cannot agree on how to pay for its cost of more than \$6 trillion over 10 years, your budget process would automatically cut Social Security by \$1.7 trillion and Medicare by \$1.1 trillion over 10 years. This would cut the average Social Security benefit by \$168 per month. President Trump has pledged not to cut Social Security, Medicare, and Medicaid; but your budget process seems to provide a way to cut these programs without President Trump having to sign any specific cuts into law.

If Congress passed your budget changes today, would you recommend he veto that legislation?

Answer. Should the budget pass, I will carefully review the legislation and communicate the health-care implications of that budget to the President.

Question. The sequester, under current law, shields vulnerable populations from across the board cuts. Why do you believe the sequester should be expanded to programs that serve the most vulnerable Americans?

Answer. It is my belief that the Federal Government needs to strengthen mandatory programs if we are going to ensure future generations have access to the programs.

CHILDREN'S HEALTH COVERAGE

Question. Congressman Price, you once remarked that low-income children already have access to all the health care they need. You've publicly said that you, "know of no study that shows these individuals have no access," and that uninsured children are already treated by doctors and hospitals even though they often do not pay for the care they receive.

Do you still believe that all children had adequate access to health care before the ACA?

Answer. Though programs like CHIP have made substantial progress in the availability of health-care coverage to children, there has always been more work to do in this regard. I should add that what is most important in this regard is not just that children have coverage but also actual access to care that is affordable and available to them.

Question. Do you agree that maintaining these coverage gains and not taking a step back on children's health is vitally important?

Answer. With regards to health care for children, our goal is to make certain that every single American has access to the coverage they want for themselves and their children and ensures the individuals and children who lost coverage under the Affordable Care Act get or maintain coverage.

Question. Congressman Price, according to independent reports, repeal of the ACA would mean over 4 million children would become uninsured. As advisor to the President, will you advise the President to veto any bill if the result is fewer children have coverage?

Answer. Deciding whether to sign any particular law, particularly one that involves as many different moving parts as one to replace the Affordable Care Act, inevitably involves considering many competing, complementary, or countervailing issues. I look forward to working with the Congress to ensure that fewer children having coverage is not one of those tradeoffs, but rather that every single American has access to the coverage they want for themselves and their children and ensures the individuals and children who lost coverage under the Affordable Care Act get or maintain coverage.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Question. Today, the bipartisan Children's Health Insurance Program provides 8 million children with access to comprehensive, affordable health care including thousands of children in Oregon's Healthy Kids program. Yet you've publicly referred to CHIP as "government-run socialized medicine" and put forth proposals that would have denied families with access to more affordable care for their children through this successful bipartisan health program.

Congressman Price, in your role as a cabinet Secretary, would you advise the President to support an extension of the Children's Health Insurance Program?

Answer. It is important that every child has access to high-quality health coverage, and CHIP plays an important role in accomplishing this objective.

Question. Will you commit to ensuring that not a single child under Oregon's Healthy Kids program gets left behind under any CHIP extension?

Answer. If confirmed as Secretary, my goal would be to ensure that no child in Oregon or anywhere else is left behind. CHIP plays a major role in this, but there is also a need for coordinated family coverage in the private market and employer plans, and giving States the needed flexibility to accomplish this.

Question. As a cabinet-level advisor to the President, will you advise the President to veto any bill that results in coverage being stripped away from a single child in Oregon benefiting from our Healthy Kids program?

Answer. Deciding whether to sign any particular law inevitably involves considering many competing, complementary, or countervailing issues. I look forward to working with the Congress to ensure that fewer children having coverage is not one of those tradeoffs, but rather that every single child in Oregon and America has access to high-quality care. That means not just having a card, but being able to access the care it covers.

COST SHARING IN MEDICAID

Question. Your 2017 budget used the Healthy Indiana Plan as an example of an innovative State program that is reducing State Medicaid costs. However, the Healthy Indiana Plan has not worked as intended in some important ways and has created access barriers for some. In fact, studies show that the required premiums for many low-income people depress participation and make it harder for people to access the coverage they need. According to an independent evaluation of the program, thousands of individuals in the program were penalized or kicked off and locked out of coverage under the complicated structure.

If these types of complicated structures used in a State's Medicaid program is shown to keep eligible people from getting the health care they need, will you disallow it as not meeting the objectives of the Medicaid statute?

Answer. The Healthy Indiana Plan has long been and continues to be a national model for State-led Medicaid reforms pertaining to the low-income, able-bodied adult population. It is important that Medicaid's design helps its members to transition successfully from the program into commercial health insurance plans, as HIP's consumer-driven approach and underlying incentive structures encourage. HIP members are more engaged with their providers, less reliant on the emergency room, and more satisfied with their coverage than traditional Medicaid members. HIP is achieving Indiana's objective to increase access to consumer-driven coverage as well as the broader objectives of the Medicaid program, and I support the use of HIP's reforms in future 1115 demonstration requests by other States.

DELIVERY SYSTEM REFORM

Question. Congressman Price, you have been an outspoken critic of the delivery system reforms included in the Affordable Care Act (ACA), particularly the Center for Medicare and Medicaid Innovation (CMMI) and the movement away from traditional fee-for-service payments for providers and toward value-based payment models such as bundled payments.

Do you agree that the traditional fee-for-service payment system—in which providers are paid based on volume instead of value—creates incentives for overutilization of health-care services?

Answer. Our health-care system is complex, and we cannot attribute overutilization trends to a single cause. For instance, efforts to curb overutilization in emergency rooms have been unsuccessful. Overutilization is a complex issue that needs to be carefully addressed.

Question. Do you also agree that the successful implementation of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) will require the continued development of value-based payment models?

Answer. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is built on the principle of encouraging providers to develop Alternative Payment Models (APMs) that can ultimately be adopted by CMS and commercial payers.

Question. Will you commit to supporting the continued development of value-based payment models in Medicare and increasing the percentage of provider payments made through those models?

Answer. We share the goal of improving Medicare by empowering providers to be creative and develop payment models that best suit the unique needs of their patients to ultimately improve patient care.

MEDICARE-MEDICAID COORDINATION OFFICE

Question. "Dual eligibles" receive benefits under the Medicare and Medicaid programs. Full benefit dual eligibles suffer from serious health care needs including debilitating physical and mental disabilities, often requiring complicated and expensive long-term services and supports. The ACA created the Medicare-Medicaid Coordination Office, also called the Medicare-Medicaid Coordination Office, to coordi-

nate and address the needs of dual eligibles. The office has led Federal efforts to improve how programs are delivered to this high need, high cost population.

Will the administration continue to support the Medicare-Medicaid Coordination Office?

Answer. If confirmed as Secretary, and if legislation regarding this Office changes, I will work with the CMS Administrator to consider how best to deploy the tremendous resources of CMS against the enormous challenge of ensuring access to the highest quality care for dual beneficiaries. In the meantime, I will implement the law as passed by Congress.

Question. Does the administration plan to continue the financial alignment demonstration currently underway in several States?

Answer. Commenting on specific potential models is premature at this point. These models go through a lengthy development and modeling process, as well as internal review and approval at CMMI and OMB. If confirmed, as HHS Secretary, I plan to work closely with CMS to ensure that CMMI—after appropriate consultation with Congress, the States, health-care stakeholders, and Innovation Center staff—tests innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries.

FEDERAL DATA COLLECTION

Question. The Department of Health and Human Services (HHS) collected valuable data related to the Affordable Care Act (ACA). This includes rate filings, enrollment data, and analytical reports on the efficacy of the law in different sectors of the health system. Additionally, the ACA invested in the implementation of a new health data collection and analysis strategy. Section 4302 of the Affordable Care Act contains provisions requiring all national Federal data collection efforts collect information on race, ethnicity, sex, primary language and disability status. The law also provides HHS the opportunity to collect additional demographic data to further improve our understanding of health-care disparities.

Will health-care data collected by the government continue to be publicly available to promote government transparency?

Answer. If confirmed as Secretary, I would implement the law regarding these topics as written and passed by the Congress.

Question. Will health-care data continue to require the collection of information on race, ethnicity, sex, primary language, and disability status?

Answer. If confirmed as Secretary, I would implement the law regarding these topics as written and passed by the Congress, including with respect to the data points required to be collected.

Question. How does CMS plan to leverage this data to address health disparities?

Answer. Any data that can inform CMS's approach to understanding where people's needs are not being met will help us understand how best to move towards a system where every single American has access to the coverage they want for themselves.

BAN ON HEALTH AGENCY COMMUNICATIONS

Question. News reports on January 24th indicate that Trump administration officials have issued what amounts to a gag order essentially muzzling external communications by employees of the Department of Health and Human Services (HHS) and the National Institutes of Health between now and February 3. This ban on external communications reportedly includes correspondence with public officials including members of Congress as well as press releases and social media posts.

What communications are covered by the Trump administration's restriction of external communications?

Are there any exceptions allowed for releases of information about matters of public health or safety?

If a public health or safety matter arises between now and February 3rd, will the agencies be prevented from communicating with public officials or the general public about these matters?

Under what circumstances would external communications be allowed?

Who within the Department is authorized to allow communications in a public health or safety situation or otherwise? Please provide the criteria that has been developed to determine if and when external communications are permitted.

What impact will this restriction have on whistleblowers who are exercising rights protected by law?

What is the reason for this action?

Is it possible the restriction will be extended beyond February 3rd? Under what circumstances could it be extended?

Does the restriction apply to Federal employees' personal use of social media or only use of official agency accounts?

Will the restriction prevent HHS employees from responding to outstanding questions from members of Congress including letters or other communications awaiting answers? If so, when will such questions be answered?

Will questions submitted by members of the Finance Committee be answered in a timely manner and in any case before February 3rd notwithstanding the restriction on external communications?

Answer. The Acting Secretary Memo to Department of Health and Human Services operating and staff division heads is straightforward and consistent with Chief of Staff Memo issued on behalf of President Trump with regard to regulatory review of new or pending regulations and guidance. As noted in the HHS memo, the purpose of the directive is to ensure "President Trump's appointees and designees have the opportunity to review and approve any new or pending regulations or guidance documents." Furthermore, the Chief of Staff memo provides explicit exceptions for "emergency situations or other urgent circumstances relating to health, safety, financial, or national security matter. . . ." This request is standard for a new administration. With regard to correspondence to public officials, such as members of Congress, the memo outlines a clear and expedited process for adequate review and is by no means intended to impede the agencies or staff divisions from continuing their important work on behalf of the American people, including routine constituent service communications.

COST-SHARING REDUCTIONS

Question. Under the Affordable Care Act, individuals and families with incomes between the Federal poverty level and 250 percent of the poverty level are eligible for cost-sharing reductions (CSRs) if they are eligible for a premium tax credit and purchase a silver plan through the health insurance exchange. The cost-sharing reductions reduce the deductibles, copayments, and other out-of-pocket costs for these lower- and moderate-income Americans.

In *House v. Burwell*, House Republicans challenged the legality of Federal funding of CSR subsidies. In a May 2016 ruling, U.S. District Judge Rosemary Collyer ruled in favor of the House Republicans, although she stayed implementation of the ruling. The previous administration appealed the decision, but the case was stayed until after the 2016 presidential election.

If confirmed as HHS Secretary, will you recommend that the administration continue to reimburse insurers for the cost-sharing reductions that reduce deductibles, copayments and other out-of-pocket costs for lower- and moderate-income Americans?

Answer. The agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

Question. If confirmed as HHS Secretary, will you recommend that the administration protect the Federal Government's authority to make payments for cost-sharing reductions, which was challenged in *House v. Burwell*, and move forward with its appeal of the lower court's ruling?

Answer. The agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

Question. If confirmed as HHS Secretary, will you recommend that the administration seek an appropriation from Congress for the cost-sharing reductions?

Answer. It will be up to the President and Congress to determine the appropriate policy on this issue. My job, if confirmed, would be to faithfully execute that law.

RISK CORRIDOR PAYMENTS

Question. The Affordable Care Act's temporary risk corridor program was intended to promote accurate premiums in the early years of the exchanges (2014 through 2016) by cushioning insurers from extreme gains and losses. It was modeled after the Medicare Part D prescription drug program's successful risk corridor program. The Federal Government currently owes insurers approximately \$8.3 billion under the risk corridor program to offset losses from 2014 and 2015. This is largely due to a rider attached to the 2015 and 2016 appropriations bills requiring the risk corridor program to be revenue neutral, meaning that the Centers for Medicare and Medicaid Services (CMS) can only pay out funds under the program that it collected under the program.

Under the previous administration, HHS and CMS acknowledged that risk corridor payments are an obligation of the government and that full payment must be made to insurers. The Department of Justice defended the lawsuits brought by insurers for the full risk corridor payments, but also expressed a willingness to engage in settlement discussions.

If confirmed as HHS Secretary, will you also acknowledge that risk corridor payments are an obligation of the government and that full payment must be made to insurers?

Answer. The agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

Question. If confirmed as HHS Secretary, will you recommend that the administration engage in settlement discussions with insurers on overdue risk corridor payments?

Answer. The agency is currently involved in litigation related to this matter, and it would be inappropriate for me to comment at this time.

GENDER RATING

Question. Before the Affordable Care Act, insurance companies were able to charge women more for their health insurance compared to men. This practice was widespread, as 92 percent of the best-selling plans on the individual market used gender rating in setting their premiums. This cost women approximately \$1 billion in additional costs each year that men did not have to pay.

Do you believe that insurance companies should be required to charge men and women the same rate for premiums?

Answer. The setting of premiums is something that has historically been a matter of State law and regulation, so that the dynamics of that State and its population and risk pool and consumer behavior can be taken into account. Nevertheless, of course, if confirmed as HHS Secretary, my role would be to implement the law as it is now written.

1332 WAIVERS

Question. The ACA included a provision known as the State Innovation Waiver (SIW), or 1332, that provides States the opportunity to tailor their own health care system in a way that best aligns with the individual State's needs. This waiver was written to give States a chance to implement the ACA better; it was not written as a tool to undermine the law. States may apply to use these waivers beginning January 1, 2017.

As a reminder, a waiver must meet the following requirements:

- Ensure that individuals get insurance coverage that is at least as comprehensive as provided under the ACA.
- Ensure that insurance coverage offered to individuals is at least as affordable as it would be under the ACA.
- Ensure that as many people are covered as would be under the ACA.
- Not increase the Federal deficit.

Please respond to the following questions.

What opportunities do you see for States to use the SIW? Are there particular reforms that you think would enhance access to affordable, quality coverage?

Answer. These waivers present an opportunity for CMS to encourage State innovation and allow for adaptation of national requirements to the needs of individual

States. If confirmed, I would work with CMS to enable States to utilize this—and other—authority provided by Congress to ensure access to high-quality, affordable health insurance.

Question. How do you envision the SIW working in conjunction with Medicaid and any corresponding Medicaid waivers? What checks would you put in place to ensure that those individuals entitled to Medicaid receive the full benefits and protections afforded them under title XIX?

Answer. There is a tremendous opportunity to allow States to innovate with respect to the intersection of their Medicaid programs and qualified health plans and the risk pools within each. State fair hearing processes (as well as the Medicaid waiver process and CMS oversight) provide substantial procedural and other protections that would address concerns regarding Medicaid beneficiaries not getting benefits due to them.

Question. What precautions would you put in place to ensure consumers are protected in States that choose to move forward with a 1332 waiver application?

Answer. The statute itself has protections in place relating to the findings that must be made that would protect consumers in States that move forward with a 1332 waiver application. Furthermore, the democratic process in each State, where government is even closer to the people, provides substantial protection with regards to any 1332 waiver application and its implementation. Such protection may well be even more effective than that available to consumers vis-à-vis the Federal Government.

Question. What steps would you take, as Secretary of HHS, to implement this provision, as intended by congressional drafters, to ensure it is not used to undermine the ACA?

Answer. As part of the ACA, the use of section 1332 to allow States to innovate would not undermine the ACA. In fact, failing to successfully use this important tool to allow States flexibility with regards to the ACA as allowed by the law would undermine the ACA.

RURAL HEALTH

Question. Americans living in rural areas often have difficulty accessing quality care due to physical and economic barriers. The Health Resources and Services Administration estimates that 65 percent of primary care health professional shortage areas are in rural areas. These challenges translate into significant health disparities for rural populations, including higher rates of chronic disease and disability as well as lower life expectancy. Rural Americans have also historically experienced lower rates of insurance. The Affordable Care Act provided new access to coverage for people living in rural areas through the Health Insurance Marketplaces and Medicaid expansions, as well as critical consumer protections.

If confirmed how will you protect access to quality health care in rural areas?

Answer. Too often rural health care is overlooked in the broader discussion of national health-care issues. Significant health disparities exist for rural populations for a variety of reasons, including challenges with access to affordable coverage and health-care services. Rural Americans are acutely aware of the dire need for expanded health insurance options. If confirmed, I will work tirelessly to address the health-care needs of all Americans, rural or urban.

PRE-EXISTING CONDITIONS AND CONTINUOUS COVERAGE REQUIREMENT

Question. The Affordable Care Act prohibits insurers from denying coverage to individuals with pre-existing conditions, charging them higher premiums, or refusing to cover benefits related to a pre-existing conditions.

Your Empowering Patients First Act (H.R. 2300 in the 114th Congress) repeals the Affordable Care Act in its entirety (including the protections for those with pre-existing conditions) and instead puts in place a “continuous coverage requirement,” meaning that individuals with pre-existing conditions must maintain continuous health insurance coverage for at least 18 months in order to qualify for protections against discrimination by insurers. Under your legislation, insurers would once again be allowed to exclude coverage of a pre-existing condition for lengthy periods of time or charge much higher premiums unless individuals had maintained continuous coverage for at least 18 months.

According to a recent report from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), up to 133 million non-elderly Americans may have a pre-existing condition, and nearly one-third (44 million) went uninsured for at least 1 month during the 2-year period beginning in 2013.

If any of these individuals were to face difficult circumstances that resulted in a temporary loss of coverage—such as losing a job or being unable to work due to serious illness—your legislation would allow insurers to refuse to cover services related to the pre-existing condition or charge a much higher premium than many of these individuals would likely be able to afford.

Do you agree that individuals with pre-existing conditions who experience a loss of coverage—for example, due to the loss of a job or being unable to work due to a serious illness—should not be denied coverage for their condition or charged high, unaffordable premiums as a result of that temporary loss of coverage?

Under the continuous coverage requirement included in your Empowering Patients First Act, what would prevent insurers from doing exactly that to any individual with a pre-existing condition who experiences a temporary loss of coverage?

Answer. I believe it is important that we as a nation make sure that every American has access to the kind of mental health care and health coverage that best meets their need. Additionally, it is imperative that all Americans have access to affordable coverage and that no one is priced out of the market due to a bad diagnosis. This is a matter for the legislative branch, however, and if confirmed, I will work to ensure that HHS appropriately implements the statutes within its purview.

HUMAN SERVICES PROGRAMS

Question. In recent years, there has been an increasing focus on using evidence to make policy decisions.

What is your view on this?

Answer. There is no question we must use available evidence when making governmental decisions.

Question. What evidence would you use to decide whether policies or program changes that you have championed are successful?

Answer. When championing policy or program changes, outcomes should always be a top indicator when determining whether or not those changes are successful.

Question. What evidence leads you to believe that TANF was a success?

Answer. Since the passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

Question. The annual data from HHS through the Adoption and Foster Care Analysis Reporting Systems (AFCARS) released in fall 2016 show a third consecutive annual increase in foster care to 427,910 children. This represents an 8-percent increase since 2012. Your home State is no exception. A recent AP story stated that, “the most dramatic increase has been in Georgia, where the foster-care population skyrocketed from about 7,600 in September 2013 to 13,266 last month. The State is struggling to provide enough foster homes for these children and keep caseloads at a manageable level for child-protection workers.”¹ HHS recently indicated that:

A rise in parental substance use is likely a major factor driving up the number of children in foster homes. Citing opioid and methamphetamine use as the most debilitating and prevalent substances used, some State officials expressed concern that the problem of substance use is straining their child welfare agencies.²

Clearly, substance use is having a big impact on children, families, and child welfare systems. I am particularly concerned about the strain the epidemic is placing on grandparents and other relatives who often unexpectedly take on the role of caretaker for children in foster care and at risk of entering foster care. Thankfully, there are programs that work and can even save taxpayer dollars over the long run. For

¹<http://www.bigstory.ap.org/article/12658e69b70148fc8d4743fa631fa9f9/5-states-struggle-surging-numbers-foster-children>.

²<https://www.acf.hhs.gov/media/press/2016-number-of-children-in-foster-care-increases-for-the-third-consecutive-year>.

example, research shows that when parents are able to get into substance use treatment programs that permit them to live with their children, two-thirds of these parents successfully complete the program. That compares with only one-fifth of parents when their children aren't allowed to stay in the treatment facility with them.³ The results achieved by these model programs have saved millions of dollars every year in the costs of keeping kids in foster care.

What will you do to ensure that drug treatment and services will be both maintained and coordinated to target these families that need treatment and whose children could end up in foster care without the appropriate services?

Answer. There needs to be better coordination between Federal departments, State governments, and local governments to ensure we are meeting the challenges of one of the great crises of our times: the opioid epidemic. A top agenda of all levels of government is to ensure innocent children, including those in foster homes, are protected from the scourge of this epidemic. As a strong proponent of the Comprehensive Addiction and Recovery Act of 2016, I will do all I can to effectively administer and implement this law should I be confirmed as Secretary.

Question. How will you help grandparents and other family members receive the supportive services they need in the event that parents cannot safely retain custody of their children?

Answer. Should I be confirmed as HHS Secretary, I will do all within my power, under the laws passed by Congress, to help grandparents and other family members receive supportive services.

Question. Will you pledge to me that, if confirmed, you will work with me to provide Federal support for effective programs, and to ensure that the children and grandparents caught up in the opioid epidemic get support from your Department?

Answer. I absolutely pledge to work with you to ensure support for effective programs and to see that children and grandparents get appropriate support from HHS to deal with the tragic opioid epidemic.

Question. As part of the Comprehensive Addiction and Recovery Act of 2016, Congress required States to have plans of "safe care" for infants born exposed to substances.⁴ This requirement, along with numerous existing requirements, is a condition of State receipt of grants under the Child Abuse Prevention and Treatment Act, or CAPTA. Grants to States under CAPTA total \$26 million per year. Discretionary spending for child welfare services under CAPTA, the Adoption/Kinship Incentives Program, the Promoting Safe and Stable Families Program and Child Welfare Services have all faced significant reductions in appropriations over the past 5 years.

What is your position on proposals that would move mandatory funding to discretionary funding (thus limiting the committee's ability to fund both child welfare and other vital services)?

Answer. This is a legislative matter. Should I be confirmed as HHS Secretary, I will implement the laws passed by Congress.

Question. How will you ensure adequate funding for these services that have suffered significant reductions over the recent past despite a backdrop of increasing foster care numbers?

Answer. Should I be confirmed as HHS Secretary, I will strive to make effective use of all dollars appropriated by Congress in order to provide the most effective services possible.

Question. The United States is the only industrialized country without paid maternity leave.⁵ The President has endorsed such leave for new mothers.

If confirmed, how might you lead the Department to help support this goal? Please be specific about resources and expertise that may be available at HHS, including in such areas as benefit design, eligibility determination, IT systems, and program access.

Answer. If I am so honored as to be confirmed as HHS Secretary, I will implement the laws passed by Congress and support the President's initiatives as they fall

³<https://www.ncbi.nlm.nih.gov/pubmed/11291901> and <https://www.ncbi.nlm.nih.gov/pubmed/11291900>.

⁴<http://www.cwla.org/discussion-on-plans-of-safe-care/>.

⁵http://www.oecd.org/els/family/PF2_5_Trends_in_leave_entitlements_around_childbirth.pdf.

within HHS's authorities. I will do so in a way that is as effective and as efficient as possible, drawing on the expertise and experience of the fine men and women currently working at HHS.

Question. Access to high-quality child care is fundamental to the economic security of families and too many parents cite lack of dependable child care as a key barrier to finding and maintaining employment. The President's child care tax proposals would primarily benefit high-income families through tax deductions, while providing little or no help to low- and middle-income families.⁶ The most significant Federal child care program for families of modest means is the Federal Child Care and Development Block Grant (CCDBG) which provides funds to States to help low-income families afford child care of their choice. Yet the CCDBG serves only one out of seven children eligible for assistance.

If confirmed, under your leadership how might the Department improve access to high quality child care? Please be specific about resources and expertise that may be available at HHS, including in such areas as benefit design, eligibility determination, IT systems, and program access.

Answer. Should I be confirmed as HHS Secretary, I will implement the laws passed by Congress. I will do so in a way that is as effective and as efficient as possible, utilizing the ample and exemplary expertise available by the fine men and women currently working at HHS.

Question. As Budget Chairman, you proposed eliminating funding for the Social Services Block Grant (SSBG), a flexible funding stream for social services programs such as substance use disorder treatment services, child protection, elder protection, services for the elderly like Meals on Wheels, and other critical safety net programs. It also helps fill in financial gaps for overburdened State foster care systems which are facing an increased strain in light of the opioid epidemic.

In light of increased demands on State human services programs brought on by the opioid epidemic, has your position on the SSBG changed?

Answer. During my time in Congress, I have been acutely aware of the need to eliminate duplicative programs and strengthen those programs that work. However, as SSBG continues to be a program authorized by Congress, I will do all I can to effectively administer this law should I be so honored as to be confirmed as HHS Secretary.

Question. If not, where do you suggest States turn to make up for the loss of these flexible SSBG dollars if funding is eliminated? Please be specific in terms of which programs you believe would fill the void left by SSBG.

Answer. Given the nature of our Federal system, there is not a one-size fits all approach to how States might react should there be an elimination of any Federal program.

Question. Can you explain what makes the flexibility in the Social Services Block Grant inherently different and worse than either existing or proposed block grants (such as TANF as it exists or Medicaid as you have proposed)? I'd be especially interested in why you consider SSBG to be a failure while you consider TANF to be a success.

Answer. As a 2011 GAO report pointed out, SSBG is a program of fragmentation, overlap, and duplication. SSBG essentially offers a no-strings-attached approach whereas TANF, while maintaining a great deal of flexibility for the States, has been successful in moving recipients off of welfare and on to work. That being said, SSBG continues to be a program authorized by Congress, I will do all I can to effectively administer this law should I be confirmed as HHS Secretary.

Question. One of the most significant sources of assistance on the human services side of the Department of Health and Human Services is Temporary Assistance for Needy Families, or TANF. During the hearing, in your response to Senator McCaskill, you touted the success of TANF. However, according to HHS data, between 1996—when the welfare reform law was enacted—and 2015, the number of poor families in Georgia receiving support through TANF dropped from 82 per 100 to just 5 families per 100 while the population of poor Georgia families increased by over

⁶https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2842802&download=yes.

50 percent.⁷ While Georgia is one of the most drastic examples, this overall trend is not unique to your home State. Nationally, TANF reached 68 percent of poor families when the 1996 law passed. It now reaches just 23 percent of such families, despite the fact that extreme poverty has more than doubled.⁸ Moreover, TANF has faced effective cuts of over 30 percent since its creation in 1996 and benefit levels have also declined.⁹

Do you believe TANF has been a success both across the Nation and in your home State of Georgia?

Answer. Yes. Since the passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

Question. What metrics do you use in making this determination? Please specifically address time periods beyond 2005 in describing your views.

Answer. I think the best way to measure the success of the law is to see where the Nation was prior to its passage and where we are now. As I've pointed out, since passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

Question. Can you provide a commitment that Medicaid will not see cuts like what you've proposed in your budget and what has happened to TANF?

Answer. I will provide a commitment that if I am honored to be confirmed as HHS Secretary, I will faithfully implement and administer all the laws passed by Congress.

Question. President George H.W. Bush's welfare advisor and one of the conservative architects of the 1996 law, Ron Haskins, has said, "States did not uphold their end of the bargain," and argued that TANF is not a model for other programs, asking "So why do something like this again?"¹⁰ A recent piece published by the conservative think-tank, American Enterprise Institute came to a similar conclusion noting that unfortunately, "some States have abandoned their responsibility to provide support to poor families and help them get jobs," and that enough States have stopped spending money on core services that, "it tarnishes the entire program."¹¹

However, you resisted recent Republican-authored legislation that aimed to ensure States met even the most basic TANF spending obligations.¹² You insisted on changes that essentially would grandfather in practices that let Georgia and other States continue to, to use the AEI publication's words, "abandon their responsibility to provide support to poor families and help get them jobs."

If confirmed, will you continue to oppose efforts to ensure States hold up their end of the bargain with respect to investing their own dollars into the TANF program?

Answer. States should contribute their part in State-Federal human services programs, even if we don't always agree on the method for getting there. I have an open mind and welcome proposals to improve State-Federal human services programs to achieve the goal to reduce low-income families' dependence on government aid through high levels of paid work, especially those that are well supported by evidence. We have a duty to the American taxpayers, and the people these programs were created to help, to find workable solutions to problems within these programs. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President that reform State-Federal human services programs.

⁷ http://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ga.pdf and <http://www.cbpp.org/research/family-income-support/how-states-use-funds-under-the-tanf-block-grant>.

⁸ <http://www.cbpp.org/research/family-income-support/tanf-continues-to-weaken-as-a-safety-net> and <http://poverty.ucdavis.edu/faq/what-deep-poverty>.

⁹ <http://www.cbpp.org/research/family-income-support/tanf-cash-benefits-have-fallen-by-more-than-20-percent-in-most-states> and <https://fas.org/sgp/crs/misc/RL32760.pdf>.

¹⁰ <http://www.cbpp.org/blog/tanfs-worsening-track-record-shows-why-its-not-a-model>.

¹¹ <https://www.aei.org/publication/welfare-reform-progress-states-step-up/>.

¹² <https://waysandmeans.house.gov/event/39841647/> and <http://mlwiseman.com/wp-content/uploads/2016/05/Profiles-in-Courage.052216.pdf>.

Question. Specifically, will you advise the President to oppose legislation, like H.R. 2959 as introduced in the 114th Congress, that would phase out the practice of States being able to count third party spending towards their TANF maintenance of effort requirements?¹³

Answer. The ultimate objective of human services programs is to help people stand on their own again after they have fallen down. Certain interpretations cut against this objective by keeping people down even when they want to stand up. I have a broad and open mind and welcome proposals to improve programs like TANF that would help people stand on their own again, especially those that are well-supported by evidence. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President.

Question. In your testimony and meetings with committee staff, you stressed the need to establish better measures by which to evaluate the effectiveness of Federal human services programs. As you know, timely, accurate and relevant evaluations rely on: modern, efficient and integrated State and Federal data systems; effective data use agreements; and transparent and strong privacy and data security measures. Moreover, system modernization cannot only improve client services but reduce waste, fraud, and abuse. However, much of the funding currently being used to modernize and integrate systems comes through ACA and the OMB A-87 waiver.

Will you commit to working, if confirmed, with Congress and the administration to sustain the current efforts to improve State and Federal health and human services data systems?

Answer. Good data is an essential element for ensuring that we have accurate information and are able to effectively manage the programs under our charge. While funding decisions ultimately rest with Congress, if I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President to modernize State and Federal human services data systems.

Question. The Maternal, Infant, and Early Childhood Visitation program (MIECHV) is a program that members on both sides of the aisle have championed due to the demonstrated success of its models in improving the health and well-being mothers and children. MIECHV's innovative model has well-established goals, outcomes and metrics.

MIECHV is due for reauthorization this year. At current funding levels (\$400M/year), the Department of Health and Human Services (HHS) estimates that only 3% of the eligible population receives MIECHV services. To me, reauthorization represents an opportunity to increase access to the program and improve the life course of children born into low-income households, while also reducing preventable government spending in the short and long term.

In your home State of Georgia, the Great Start Georgia program receives MIECHV funds. The program's aim is to provide evidence-based home visiting services to those families who are most in need of support and has met all 6 program benchmarks, including maternal and newborn health, family economic self-sufficiency, improving at-risk students' school readiness, and reducing crime and domestic violence.

If confirmed, how do you plan on continuing the successful MIECHV program?

Answer. I share your goal of increasing access to affordable, quality health coverage. While I cannot comment specifically on legislation that would reauthorize MIECHV, I look forward to working with you on examining this program's funding and working on ways to improve rural and child health using evidence-based approaches.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. Your health proposal would remove protections for individuals with pre-existing conditions, allowing insurers to charge them higher premiums or denying them coverage altogether, unless an individual has maintained coverage for 18 months. Your bill would expand high-risk pools as an option to individuals with pre-existing conditions. In Florida, more than 7.8 million people have pre-existing conditions.

¹³ <https://www.gpo.gov/fdsys/pkg/BILLS-114hr2959ih/pdf/BILLS-114hr2959ih.pdf>.

Please explain how you believe high-risk pools will provide quality coverage to the 7.8 million people in my State who have pre-existing conditions.

Answer. Pooling mechanisms that allow individuals to come together for the purchase of coverage, like the traditional Blue Cross Blue Shield Plan, have been successful in bringing down the cost of insurance for Americans. I believe this same concept could be successful in pooling the risk among those Americans with pre-existing conditions.

Question. Have high-risk pools been successful in providing adequate and affordable coverage in populous, high-cost States like New York or Florida?

Answer. If confirmed, I look forward to working with you to implement common-sense solutions that prioritize flexibility for States like New York and Florida to design and operate their own high-risk pools or other risk-mitigation programs that suit their citizens' unique needs.

Question. You introduced the 2015 reconciliation bill, which would have repealed key parts of the Affordable Care Act, had it not been vetoed. The nonpartisan Congressional Budget Office released a report on the effects of your bill, including increased numbers of uninsured Americans and increased premiums.

Last week, President Trump said the Republican replacement plan is "coming down to the final strokes." He said that as soon as the HHS Secretary is confirmed, a repeal and replace plan will be submitted, "essentially simultaneously."

Is there a nearly fully formed replacement plan?

If yes, what's in the replacement plan?

Does it provide insurance coverage for everyone as President Trump said?

Does it protect individuals with pre-existing conditions from paying higher premiums or being denied coverage altogether?

Does it allow children to stay on their parents' insurance until age 26?

Does it ensure that individuals struggling with substance use disorders or diagnosed with behavioral health conditions have adequate access to quality treatment?

Answer. Plans for real health-care reform are a work in progress, but the President and I share the same goal: to provide relief to all Americans from Obamacare. Obamacare has raised premiums and deductibles, narrowed doctor networks, reduced choices of plans, limited Americans' liberty, and undermined the doctor patient relationship. The goal is to make certain that every single American has access to the coverage they want for themselves.

Question. What will you do to provide coverage to the more than 800,000 Floridians that could have been covered by Medicaid expansion?

Answer. I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I will promise you this: Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fit the needs of their States.

Question. Can you explain how, under a Medicaid block grant program, States like Florida would cover the unforeseen costs associated with public health crises, like Zika virus, or high cost prescription drugs, or unexpected sudden changes in demographics without harming another population?

Answer. My work in the Congress has been focused on how to improve Medicaid and provide additional flexibility. If I have the privilege of being confirmed as Secretary, I would look forward to the opportunity to work with States and Congress using the tools and authorities given by Congress in legislation. The mechanics of any new Medicaid program along the lines described would be a legislative decision that would need to account for how to encourage States to save for such eventualities or how the Federal and State governments do so together.

Question. Florida is currently in the process of renegotiating its section 1115 Medicaid managed care waiver.

What safeguards and beneficiary protections do you believe HHS should keep in place when reviewing Medicaid waivers?

Answer. The 1115 waivers are an important tool for States to innovate within the Medicaid program, as they have for many years prior to the ACA becoming law. The statute itself has requirements for certain procedures. Furthermore, the democratic process in each State, where government is even closer to the people, provides substantial protection with regards to any 1115 waiver application and its implementation.

Question. You introduced a bill to allow practitioners to enter into private contracts with their Medicare patients and charge higher fees than what is currently allowed under the Medicare program. Currently, when seniors in Medicare see their doctors, they are responsible for a set amount of costs and don't encounter any surprise bills. Under current law, physicians who choose to participate in Medicare are not allowed to bill their patients for any costs that remain once Medicare pays their share of the bill, a practice that is commonly known as balance billing.

Did you know that half of all Medicare beneficiaries had incomes of less than about \$24,000 and savings below \$63,350 in 2014? Is this the population that your bill targets?

Answer. The Medicare Patient Empowerment Act is one approach to giving our seniors more flexibility within the Medicare Program and providing the opportunity to make decisions with their physicians without interference from Washington. The measure would help ensure that Medicare beneficiaries maintain adequate access to health-care professionals by increasing the number of physicians who will accept Medicare patients and addressing physician shortages by attracting new professionals to the field of medicine. In addition, the bill provides safeguards to Medicare beneficiaries. More importantly, my legislation would allow a provider to see a Medicare patient pro-bono or charge minimal cost (below the standard fee schedule) without prosecution. Without this legislation, a physician can be charged with fraud for failure to attempt to collect the full coinsurance amount under Medicare.

Question. The Medicare Advantage program provides quality care to over 1.6 million Floridians and over 18 million seniors across the United States.

Do you have any ideas about how to strengthen and build upon this vital and proven part of the Medicare program? In your role as Secretary of HHS, will you commit to supporting Medicare Advantage and protecting the Nation's seniors as they age?

Answer. Medicare Advantage provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. If confirmed as Secretary, I would seek to ensure Medicare Advantage remains a stable option for beneficiaries and that Medicare Advantage plans are afforded the flexibility to design plans that beneficiaries want and give them the coverage they want.

Question. Today, I joined a bipartisan group of Senators in reintroducing the Public Health Emergency Response and Accountability Act, which would fund the nearly empty Public Health Emergency Fund through mandatory appropriations designated as emergency spending, a proposal modeled after FEMA's disaster relief fund.

As HHS Secretary, would you work with me to protect my constituents from the Zika virus and other public health emergencies? Do you support the creation of an emergency health fund to provide mandatory appropriations to fight Zika and other infectious diseases?

Answer. If confirmed as HHS Secretary, I give you my word I will do all within my power to protect your constituents, and the constituents of every Senator, from the Zika virus and other public health emergencies. Should Congress create a new program or alter an existing program, I will work to ensure the program is as effective as it can be in fighting Zika and other infectious diseases.

Question. The increased use of generic drugs results in real savings due to their lower costs as compared to brand name drugs. Senator Collins and I asked GAO to examine the factors behind recent spikes in some generic drugs. GAO found that Part D generic drug prices declined overall since 2010—they fell about 59 percent. Additionally, GAO found that 300 of the more than 1,400 established generic drugs analyzed had at least one price increase of 100 percent or more between 2010 and 2015.

What do you believe should be done to keep generic drugs affordable?

Answer. I appreciate that generic drugs play an important role in meeting many American's health-care needs. If confirmed, I look forward to focusing on how we

can make health care more affordable, including prescription drugs, and build on policies that have helped to empower patients in meeting their health-care needs.

Question. Amyotrophic lateral sclerosis (ALS) usually strikes people between the ages of 40 and 70, and for unknown reasons, military veterans are approximately twice as likely to be diagnosed with ALS. There is currently one FDA approved drug that modestly slows the progression of ALS in some people. While there is no cure or treatment that halts or reverses ALS, scientists have made significant progress in learning more about this disease.

The Centers for Disease Control and Prevention operate a National ALS Registry, which is a critical resource for (1) providing data to researchers focused on developing treatments and prevention strategies; and (2) matching patients to potential clinical trials.

Please advise how the administration will support this work in fiscal year 2018 and work with Congress to make the registry even more effective at confronting ALS.

Answer. ALS is a devastating disease with far-reaching consequences for both those afflicted and their families, and as a physician I understand the hardships these individuals must endure. If confirmed, I plan to work to advance patient-focused health care, which will support efforts to better serve those suffering from ALS.

Question. The ACA reauthorized the Minority Centers of Excellence (COE) program, housed within the Department of Health and Human Services. The Florida Agricultural and Mechanical University (FAMU) Pharmacy, located in Florida, is a grantee. COE supports curriculum-based initiatives for increasing minority and underrepresented individuals to become health professionals.

Do you support preserving important programs like COE, Health Careers Opportunities Program, and Area Health Education Centers?

Answer. As a physician, I understand the critical importance of diversity among health-care practitioners in order to meet the varied health-care needs of the American people. If confirmed, I look forward to working with you and others to ensure that we are supporting efforts to increase diversity within our Nation's health-care workforce as part of advancing patient-focused health care.

Question. CT colonography (CTC), also known as virtual colonoscopy, are diagnostic medical tests, which produce detailed images of the colon by using a combination of 2-dimensional x-rays and a 3-dimensional computer views. They have the ability to identify lesions and tumors on the kidneys and other organs and blockages in the coronary arteries.

Currently, Tricare and private payers in 21 States and the District of Columbia cover virtual colonoscopies for colorectal cancer screening, but Medicare does not.

Will you use your authority as Secretary to consider the addition of virtual colonoscopies as a colon cancer screening option for Medicare beneficiaries?

Answer. As you know, CMS has a detailed process for making determinations regarding whether items and services are reasonable and necessary, if they can be considered eligible for Medicare coverage given other restrictions and prohibitions. I understand CMS's decision to cover CT colonography only for diagnostic testing but not screening was based on the state of the technology at the time and the possible need for a confirmation colonoscopy in so many cases. If confirmed as Secretary, I would look forward to working with you to understand if revisiting this issue is appropriate and warranted.

Question. On July 16, 2015, Proposed/Draft Local Coverage Determination for Lower Limb Prostheses (DL33787) (Draft LCD) was published by the four Durable Medical Equipment Medicare Administrators ("DME MACS"). Last year, the Coverage and Analysis Group, headed by CMS, was created to review the DME MAC recommendations. That Group continues to deliberate.

Can you speak to what actions as an administrator you would take on finalizing this Draft LCD?

Answer. Medicare coverage for prostheses can be a particularly challenging topic given the role this durable medical equipment plays in the lives of many Medicare beneficiaries. I understand CMS has stated it is committed to providing high quality care to Medicare beneficiaries in need of a prosthesis, that it has committed to a Workgroup the task of making recommendations concerning the best and most rel-

event measures in this realm, and that CMS will ensure there is opportunity for public comment and engagement. If confirmed as Secretary, I would be pleased to work with you to look into the timing of this matter and see what can be done to either expedite it or further support the work so there is assurance of its comprehensiveness and objectivity.

Question. Representative Price, I know you are very familiar with the Centers for Medicare and Medicaid Service's (CMS) Home Health pilot program known as the "Pre-Claim Review Demonstration (PCRD)" which affects five States, including Florida. I am concerned that the PCRD may restrict beneficiary access to timely services, divert clinical resources to paperwork management, and incur high administrative costs. These concerns were amplified after hearing what the State of Illinois had been dealing with when PCRD began there in August 2016.

In response to my concerns, CMS delayed PCRD in Florida until April 2017. While I understand the concern, CMS has with needing to tackle the improper payment rates, PCRD may not get to the root of the problem.

As Secretary, how do you plan to tackle the problem of improper payments? Do I have your commitment that you will work with me to alleviate the concerns raised by the PCRD?

Answer. The topic of improper payments is one of concern in the Medicare program—both overpayments and in some cases underpayments. Tackling them requires close support for the payment integrity team within CMS and close cooperation with the Office of the Inspector General and the Department of Justice. But it also involves a definition of scope and a prioritization—which improper payments are ones that reflect services not rendered and which involve a missing signature on a form. With that prioritization in mind, I am hopeful we can align resources to those areas of highest risk.

As to the Pre-Claim Review Demonstration (PCRD), if confirmed, I would be pleased to work with you to address your concerns. For example, we may want to explore the experience of the Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport demonstration to understand if there are applicable lessons for PCRD or vice-versa.

Question. During the public comment period for the FDA's tobacco deeming rule, the Small Business Administration's Office of Advocacy filed concerns that the economic impact analysis conducted by FDA was "deficient" and should be recalculated. Small business premium cigar retailers and manufacturers in my State have expressed the same concern to me. Unfortunately, FDA took no action to address these concerns.

Do you believe additional review of the costs of this regulation should be conducted before any additional implementation?

Answer. Whenever the Federal Government implements its regulatory responsibilities, it is important to consider the costs, especially those imposed on small businesses. Any time economic impact analyses are conducted, I believe they must be fact-based. If I am confirmed, I would seek to better understand the SBA's views of the regulation in question, which is consistent with the President's commitment to reduce the overall regulatory burden on American businesses.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. The number one concern I hear from my constituents about health care is affordability. I was pleased to hear the President say that under his plan, health insurance will be better and less expensive for all Americans. Americans cannot afford to pay more for their health care. Even supporters of the President value the health benefits they have gained through the Affordable Care Act and could not bear the higher deductibles and decreased benefits that your earlier plans have called for.

Can you ensure that under the President's health-care plans, health insurance premiums, deductibles, and co-pays will decrease for all Americans? How exactly will you do this?

Answer. President Trump and I have the same goals for health-care reform and the same general approach to meeting those goals. Neither one of us is wedded to a particular plan to the exclusion of all others. We see eye-to-eye on this, and are looking forward to giving the American people what they've been longing for, for 7

long years: real health-care reform. But they have never wanted Obamacare. It has raised premiums and deductibles, narrowed doctor networks, reduced choices of plans, limited Americans' liberty, and undermined the doctor patient relationship.

Question. The Congressional Budget Office (CBO) has found that repealing the ACA will cause more than 30 million Americans to lose their insurance and increase premiums by more than 20 percent.

Do you agree that the President's executive order to begin repealing the Affordable Care Act while there is no alternative plan creates instability and uncertainty that will only drive up costs in our health-care system?

Answer. The insurers are deciding right now as they come forward in March and April what the premium levels will be for 2018. What they need to hear from us is a level of support and stability in the market, the kinds of things that are able to provide stability. There are counties in the State where there is only one provider. We must, as policymakers, ask what is going on. Where are the problems out there? The President's Executive order is directed towards exactly that—reducing costs and the other burdens on the American people imposed by Obamacare. The initial reactions to the order from plans and others indicate this is something they anticipated based on the President's promises and that the recent and current discussions regarding how to address the issue of costs have been productive. In fact, it is the costs of inaction which are not acceptable.

Question. Do you believe that all Americans, regardless of income, should have health insurance and does the President share your views on this? Have you told the President that repealing the ACA without a replacement means 32 million Americans will lose their health insurance and add \$9 trillion to our national debt? Have you had direct discussions with members of the Transition Team or the President's current health-care advisers since your nomination? Would you insist that Congress hold multiple bipartisan hearings on the President's health care proposal? Will you commit to, should you be confirmed, to answer our questions when such a proposal is sent to Congress and evaluated by the non-partisan, independent Congressional Budget Office?

Answer. I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons. And so when we talk about coverage we ought to make clear what we really mean and want to have happen. In any case, the President has made clear his hope and plan for a replacement to Obamacare. The goal is to make certain that every single American has access to the coverage they want for themselves.

Question. Sixty percent of the children born outside of marriage are from unplanned pregnancies. This is a major public health challenge, as children born from unintended pregnancies and raised in single parent households have a higher rate of mental health problems, a lower rate of high school graduation, earn less income than their peers, and cost more to taxpayers. Because of the Affordable Care Act, millions of American women can now afford contraception, without co-pay or cost-sharing, and the rate of unplanned pregnancies has dropped.

Will the President's plan to replace the ACA ensure these women will not have to pay more for contraception and put birth control out of reach for millions of young women and families?

Answer. Women should have the health care that they need and want. The system we ought to have in place is one that equips women and men to obtain the health care that they need at an affordable price.

Question. Health-care experts have found that obesity, smoking, and mental health challenges are the "root causes" of our country's most persistent public health challenges. Together, tobacco, obesity, and mental health lead to more than a million deaths and cost us more than half a trillion dollars each year. It's critical that all health insurance plans fully cover the treatment for these conditions. If the ACA is repealed, Americans would lose access to treatment for mental health care, smoking cessation, and obesity treatment.

Under the bills and proposals you have championed, would the treatment and cost of insurance coverage for obesity, smoking cessation, and mental health care remain the same or decrease?

Answer. It has been the goal, for any legislation I have championed, for the treatment and cost of insurance coverage for all Americans to decrease.

Question. The obesity epidemic has had a devastating impact on our health-care system, increasing the prevalence of nearly every major chronic condition, including heart disease, hypertension, diabetes, and cancer, and costing our country hundreds of billions of dollars every year to treat the variety of conditions attributable to this increasingly prevalent disease. A critical step in combating obesity was the decision by the AMA in 2013 to designate obesity as a disease. This designation is an important step towards ensuring the best medical care is provided to those suffering from this disease.

Will you, as Secretary of Health and Human Services, follow the leading medical association and declare obesity as a disease and will you assist us in maximizing the use of all the medical interventions currently available to combat this crisis?

Answer. Obesity is a chronic condition that takes its toll over many years and in many quiet ways. I agree it is an important priority for all involved in the health-care system to address this toll. This is particularly the case because obesity is generally a preventable condition and can be controlled through changes in behavior. Fundamental to that is the relationship between patient and doctor which our current system has undermined in many ways. I can tell you that I will consider the legal framework within which any decision regarding the formal designation of any disease ought to take place and come to any decision with these considerations in mind.

Question. Have you ever been a member of the Association of American Physicians and Surgeons? This group has said that the government poses a greater threat to patients than tobacco use, drug addiction, and excessive alcohol intake, and that patients should seek doctors who do not participate with Medicare, Medicaid, and private health insurers. When you were a member of this group, did you agree with this position? Do you agree with this position now? This group has also compared the use of advance directives—the process by which patients and their health-care providers plan for end of life care decisions in advance and when they are of sound mind and body—as “population control.” Do you agree with this comparison?

Answer. My work has been focused on making sure that physicians and patients are ones making medical decisions, rather than the government. Once that relationship is undermined and patients do not trust their doctors or doctors do not think first about their patients then no other medical or public health goal can be achieved. This is important when it comes to chronic disease, preventive care and healthy choices, and life and death decision-making. For all these reasons, I have fought alongside many to ensure patients have these choices to make for themselves and with their doctors.

Question. As you know, the Affordable Care Act prohibits health insurance companies from limiting coverage to individuals on the basis of sexual orientation and gender identity. But a number of your previous statements regarding lesbian, gay, bisexual, and transgender people indicate that you don’t support these consumer protections.

As HHS Secretary would you support reversing these protections and jeopardizing the LGBT population’s access to health care? As Secretary of Health and Human Services, would you uphold the department’s efforts to ensure that health insurance companies do not deny or limit health-care coverage to LGBT people?

Answer. If confirmed, my efforts and work as Secretary will be to seek the availability of the highest quality care for all Americans. The goal is to make certain that every single American has access to the coverage they want for themselves. Of course, consumer protections at Federal and State levels ought to be available to all consumers, not just certain ones who meet certain criteria.

Question. Data has shown repeatedly that Federal resources devoted to fighting health-care fraud is well worth the investment. The Health and Human Services Department has found that for every dollar that is invested to fight fraud, the government recovers \$5. On January 23, 2017, the President announced a hiring freeze on government workers, which would include a freeze on hiring investigators and attorneys devoted to protecting Medicare and Medicaid from criminals. The GAO has repeatedly listed Medicare and Medicaid as two of the Federal Government programs most vulnerable to fraud, waste, and improper payments. Unfortunately, this freeze only leaves Medicare and Medicaid more vulnerable to fraud.

Do you agree with these concerns and if confirmed, will you recommend to the President that the hiring freeze should be lifted for Federal workers fighting criminal activity, waste, and fraud in Medicare and Medicaid?

Answer. The President's memorandum is not for time immemorial. It provides that within 90 days of its issuance, the Director of OMB, in consultation with the Director of OPM, shall recommend a long-term plan to reduce the size of the Federal Government's workforce through attrition and that the "freeze" will expire upon implementation of the OMB plan. If confirmed as Secretary, I will take into account in weighing in with OMB and OPM the clearly important role our fraud fighters play which you outline.

Question. During your time in Congress, you have supported proposals that would block grant Medicaid or put a per capita cap on Medicaid spending. The Congressional Budget Office has found that reversing the Medicaid expansion under the Affordable Care Act would lead to the loss of health care for millions of Americans and would lead to State funding shortfalls of \$1 to \$2 trillion.

Do you support proposals to block grant or cap Medicaid? Do you agree that block granting or capping Medicaid would save the Federal Government as much as \$1 to \$2 trillion?

Answer. Every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid. That is one of the reasons I devoted so much time to working with States to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. Of course, the specifics of any particular proposal to provide more flexibility to States will determine its budgetary consequence.

Question. The American Association of Actuaries has pointed to risk corridors and other risk mitigation programs as important mechanisms for stabilizing our insurance markets. These programs were also included in the Medicare Part D program and remain in place today. Please just give us a yes or no answer to the following questions.

Do you support the use of these programs in Medicare Part D? Did you support these programs as a part of the State insurance marketplaces created by the Affordable Care Act? Do you think these types of programs should be included in any plan to improve on the ACA or to replace the ACA?

Answer. Risk adjustment is used to adjust payments to health plans based on the relative risk of plan participants. Reinsurance has been used to reimburse insurers for the cost of individuals who have unusually high claims. And risk corridors are used to mitigate the pricing risk that insurers face when they lack data on health spending for potential enrollees. Part D has successfully deployed these mechanisms consistent with the underlying direction of Congress. The issue with any of these programs is often in the way they are implemented and the direction Congress gives with respect to them. In any current or future legislation, it would be important to consider these issues closely.

Question. You have expressed concerns with delivery system reforms and in particular, bundled payments.

Please talk about your recommendations for how we can move away from fee for service reimbursement to a health care payment system that rewards better health outcomes and reduced costs.

Answer. For certain populations, bundled payments make a lot of sense. And they can often lead to both better health outcomes and reduced costs. But it is important we not get fixated on one of those two outcomes. That is, I support making certain that we deliver care in a cost-effective manner but we absolutely must not do things that harm the quality of care being provided to patients. What we ought to do is allow for all sorts of innovation. Not just in this area. There are things that haven't been thought up yet that would actually improve health-care delivery in our country and we ought to be incentivizing that kind of innovation. And in finding our way to those innovations, we ought to remember we are not talking about science experiments in a lab or a computer simulation, but about experiments involving real patients' lives.

Question. During your time in Congress, how have you worked to strengthen and improve community health centers in your district and in the country? Do you think we should increase the presence of community health centers to increase Americans' access to health care?

Answer. Community health centers are a vital part of our medical infrastructure. They fill a void in so many States and are often times the entry point if not the main source of health care. I have sought to support them to make sure they can provide the highest quality care and will continue to do so if confirmed.

Question. I have always felt that we can't manage what we can't measure. You point to having good metrics as an important tool for ensuring we've made good progress. I agree with you wholeheartedly.

With your wealth of experience as a physician, a State legislator, a Congressman, and the chairman of a major House committee writing major legislation, please share with me the metrics we should use to measure our progress towards a more just and equal health-care system that ensures affordable and high quality health care for all Americans. If you cannot name any specific metrics, can you outline the process by which we should determine what metrics we should use to measure progress towards increasing access to health care?

Answer. The fundamental metric for knowing that our system is on the right track is the centrality of the patient in the system and their ability to make choices about their care in consultation with their doctor. Without that, the most impressive facilities and technology are not serving our people's needs, nor is the most efficient system doing what is most important. With the patient at the center of the system as a foundation, all else is possible and achievable.

Question. During the debate over the Affordable Care Act, Congress held more than 100 bipartisan hearings, roundtable discussions, and negotiations, which were predominantly open and transparent to the public. The legislation was open to amendment by both parties in lengthy committee markups and by the full Senate, completely evaluated by the Congressional Budget Office, and reported on extensively by the news media before Congress voted on final passage. I understand that you place a high premium on transparency and honesty.

Will you commit to having the same level of bipartisan discussion, transparency, and honesty in putting together the President's proposal for reforming our country's health-care system and ensuring that all Americans will have affordable and high quality health care?

Answer. The President has made clear his hope and plan for a replacement to Obamacare. At the same time, many in Congress have their own ideas. And the conversation about how those will play out is ongoing. That is the nature of our democracy. I certainly hope we will have bipartisan support for any approach to fixing the current system, which we must all agree is broken. If confirmed, I look forward to working with anyone in Congress willing to work with me and the administration generally to come up with the best replacement plan under the procedures and involving the processes the Congress considers appropriate so as to make available the highest quality care to all Americans.

Question. Do you agree with the President that the sale of health insurance over State lines will increase competition and lower the cost of health insurance? Section 1333 of the Affordable Care Act already allows States to form interstate compacts to allow for the sale of health insurance over States lines? The States of Georgia, Maine, Kentucky, and Wyoming allow for out-of-state insurance sales, but virtually no out-of-state insurers have tried to sell insurance in these States. How would you increase the sale of insurance over State lines while maintaining consumer protections such as insurance coverage for contraception, preventive screenings, maternity care, and mental health treatment?

Answer. The idea of allowing interstate sale of insurance may take many different forms. I agree with the President that it is an important option to increase competition and lower the cost of insurance. While the details of any such proposal would have to consider the extent to which benefit design varies among States, it is important that individuals be able to purchase the coverage that they want and there has to be a floor of creditable coverage.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. As someone who is being considered to lead the Department of Health and Human Services, and as a physician, do you have any doubts about safety and effectiveness of vaccines?

Answer. I understand the significant impact vaccines have had on our Nation's public health, as well as the importance of patients having confidence in the therapies they receive as part of their care.

Question. As a physician would you recommend that families follow the recommended vaccine schedule that has been established by experts and is constantly reviewed?

Answer. As a physician, I encourage individuals and families to consult with their physician on the most appropriate care for them and their loved ones.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

CLAMPDOWN ON COMMUNICATIONS WITH THE PUBLIC AND CONGRESS

Question. Shortly after your hearing concluded, press reports came out that a memo was issued to employees of the Department of Health and Human Services and the National Institutes of Health prohibiting any external communication throughout the entire Department. Specifically, the press accounts quote the memo as stating “[f]or your additional awareness, please note that (HHS employees) have been directed not to send any correspondence to public officials (to include Members of Congress and State and local officials) between now and February 3, unless specifically authorized by the Department[.]”

I find this to be an unconscionable clampdown of information and a rejection of basic transparency and accountability standards that should seriously concern all Americans. This is made all the more concerning given the health-care, public safety, research, and biodefense programs that operate within HHS.

Do you support this directive or any other department-wide order to suppress the flow of information between the Department of Health and Human Services, the public and Congress?

If confirmed, do you commit to never imposing such restrictions on any agency, office, or employee at HHS that limits their ability to communicate with the public and Congress?

During your hearing today you agreed “to provide a prompt response in writing to any questions that may be submitted to you or addressed to you by any Senator or this committee[.]” Do you believe this directive prohibits you from fulfilling that commitment to the committee?

Were you aware this directive was going to be issued prior to the time of your hearing on January 24, 2017?

Answer. The Acting Secretary Memo to Department of Health and Human Services operating and staff division heads is straightforward and consistent with the Chief of Staff Memo issued on behalf of President Trump with regard to regulatory review of new or pending regulations and guidance. As noted in the HHS memo, the purpose of the directive is to ensure “President Trump’s appointees and designees have the opportunity to review and approve any new or pending regulations or guidance documents.” Furthermore, the Chief of Staff memo provides explicit exceptions for “emergency situations or other urgent circumstances relating to health, safety, financial, or national security matters. . . .” This request is standard for a new administration. With regard to correspondence to public officials, such as members of Congress, the memo outlines a clear and expedited process for adequate review and is by no means intended to impede the agencies or staff divisions from continuing their important work on behalf of the American people, including routine constituent service communications.

FIDELITY TO SCIENCE AND TO DEBUNKING DANGEROUS FALSEHOODS

Question. During the hearing I raised a series of debunked and fake health and science claims, all of which have been perpetrated and advanced by the Association of American Physicians and Surgeons, a group to which you currently, or previously, have been a member. These debunked and factually inaccurate claims include linking undocumented immigrants to a spike in leprosy, connecting abortions to breast cancer, and claiming that the HIV virus doesn’t lead to AIDS. This group has also promoted widely debunked and untrue claims that vaccinations lead to the development of autism spectrum disorder. These are dangerous claims made all the more toxic for being promoted by a group comprised of medical professionals. What’s even

more dangerous is that the President himself has a long history of promoting falsehoods linking vaccinations to autism.

Will you state unequivocally that vaccines do not have any link to the development of an autism spectrum disorder and confirm that such all claims are fraudulent and have been widely debunked?

Answer. General scientific consensus at this time is that vaccines do not lead to autism spectrum disorder. As always, this is an area where patients and the parents of patients should consult with their doctor.

Question. Will you, if confirmed to be the Nation's highest ranking health care official, actively work to debunk these types of false health-care and scientific claims?

Answer. If confirmed, I will work to hold HHS to the highest scientific standards.

Question. Do you ensure that no political appointed within any agency, department or office in the Department of Health and Human Services believes in, or has promoted, demonstrably false statements about health-care practices or debunked scientific claims?

Answer. As a physician, I understand the importance of patients having confidence in the therapies they receive as part of their care. When confirmed, I commit to conducting the due diligence HHS must to ensure that factual, science-based information is clearly communicated to the American people.

Question. Will you advise that the President not appoint anyone to the staff of the Executive Office of the President who believes in, or has promoted, demonstrably false statements about health-care practices or debunked scientific claims?

Answer. As a physician, I understand the importance of patients having confidence in the therapies they receive as part of their care. When confirmed, I commit to conducting the due diligence HHS must to ensure that factual, science-based information is clearly communicated to the American people.

AUTISM POLICY

Question. Since I first learned that New Jersey has the highest incidence of autism in the country, I have been Congress's leading advocate for advancing Federal policy to help individuals and families with autism and other developmental disabilities. Recently, the CDC released updated numbers showing that 1 in just 41 children in New Jersey are diagnosed with an autism spectrum disorder by the age of 8. This is the highest rate in the Nation.

In 2014, I authored the Autism Collaboration, Accountability, Research, Education, and Support Act of 2014, known as Autism CARES. Among the several key policies included in this law was the continuation of the Interagency Autism Coordinating Committee and the elevation of a senior Health and Human Service official to serve as the HHS Autism Coordinator.

Do you commit to ensuring individuals appointed to these key positions maintain a fidelity to science, and will you ensure that they will have the ability and freedom to debunk false claims linking autism to vaccines (or any other similar demonstrable falsehoods) without fear of retribution from you or the White House?

Do you commit to promoting, through your capacity as Secretary and through the President's annual budget, increased funding for autism research and supports and services programs?

What specific steps will you take as Secretary to promote and support a robust environment throughout the Department that focuses on research into diagnosis, treatments, supports and services, specifically those targeting adolescents and adults with autism and other developmental disabilities?

The Centers for Disease Control and Prevention report that a child with an autism spectrum disorder can be diagnosed as early as age 2, yet children are frequently much older at the time of diagnosis. List the specific steps will you take to promote early diagnosis and early intervention?

Answer. As a physician, I understand the importance of patients having confidence in the therapies they receive as part of their care. If confirmed, I commit to conducting the due diligence HHS must to ensure that factual, science-based information is clearly communicated to the American people. HHS is involved in a number of autism-related initiatives with the important goal of helping the individ-

uals and families living with autism. When confirmed, I look forward to continuing this important work on behalf of these individuals and families.

Question. The Affordable Care Act, as part of the Essential Health Benefit Package for plans sold on the Marketplace, requires that all carriers provide coverage for behavioral health-care services, including those for autism. This was an amendment that I had included into the ACA, and it has provided families across the Nation with assurances that their children's coverage will provide them with the care they need.

Do you commit to maintaining nationwide access to behavioral health care by preserving the Essential Health Benefits package?

Answer. My hope is to move in a direction where insurers offer products people want and give them the coverage they want. And in so doing, we want to not lose sight of our shared objective of the best and highest quality care being available to every American. I refer to care because ultimately, having maternity or other coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off. So we must work towards both coverage and care.

Question. Do you strongly disavow any attempt to weaken this coverage standard or any attempt at the Federal level to preempt States, like New Jersey, that have a long-standing State requirement that insurance provides benefits that cover services for autism?

Answer. I am respectful of the role of States and, if confirmed as Secretary, will work to provide States with flexibility along the lines described and consistent with President Trump's Executive order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.

Question. Medicaid is a literal lifeline to those with autism and other developmental disabilities. Every year, 50,000 of these individuals age out of school-based services and need access to home and community-based care to ensure they live as active and integrated a life as possible. This is largely accomplished through Medicaid.

List the specific policies will you promote as Secretary to expand access to home and community-based services for individuals with autism and other developmental disabilities?

Answer. Every State is unique in their specific approach to the provision of services for the population eligible to receive HCBS, and we stand ready to assist States as they develop strategies to meet their particular goals.

Question. List the specific steps will you take to improve outcomes for transitioning youth and ensure that they maintain access to services and supports?

Answer. If confirmed, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue approaches that fit the needs of their States.

Question. The Autism CARES Act of 2014 requires the Secretary of Health and Human Services to submit to this committee a report concerning young adults with autism and the challenges related to the transition from existing school-based services to those services available during adulthood. This report is long overdue.

When will this report be finalized? Will you prioritize the finalization and submission of this report to Congress before March 31, 2017?

Answer. If confirmed, I would be pleased to work with you on the status and finalization of this report.

COMMUNITY HEALTH CENTERS

Question. Federally Qualified Health Centers (FQHCs) are the health-care home for more than 25 million patients nationwide with 494,912 Community Health Center patients in New Jersey. In New Jersey, FQHCs save the State and hospitals millions of dollars when patients are seen at health centers rather than in emergency rooms. FQHCs cost of care is substantially lower than other types of providers, even though they provide a wide range of ancillary services not offered in other health-care settings. As an example, FQHCs in New Jersey have a lower average per-episode cost than health centers nationally, and almost half that of hospitals.

Further, community health centers are essentially one-stop shops for health care, providing medical, oral health, mental health, substance abuse, and other critical services at the same location. The 23 New Jersey Community Health Centers make up the largest primary care network in the State, providing care to almost half a million patients in over 131 sites of care including in schools, homeless centers, and public housing. Beyond just providing health care, our State's FQHCs employ more than 180,000 individuals, and generate over \$26 billion annually in economic impact to some of the Nation's most distressed communities.

What is the specific dollar amount that Community Health Centers stand to lose as a result of ACA repeal and the repeal of Medicaid expansion funding?

Answer. I am not aware of the specific dollar amount.

Question. How many fewer patients will not get health-care services at Community Health Centers as a result of ACA repeal and the repeal of Medicaid expansion funding?

Answer. I do not have this figure.

Question. What will be the impact on any ongoing Community Health Center expansion project that will be halted as a result of ACA repeal and the repeal of Medicaid expansion funding?

Answer. We are committed to supporting Community Health Centers, providing increased access to care for patients across the Nation.

Question. Please provide an economic impact, including lost jobs and diminished economic impact, that will occur as a result of ACA repeal and the repeal of Medicaid expansion funding?

Answer. To my knowledge, repeal of the ACA is projected to have a positive impact on the labor market and the economy.

Question. If the ACA is repealed, list the specific steps you will take to further promote the importance of seeking preventative care rather than policies which encourage patients to wait until they have to go to the emergency room?

Answer. Our goal is to ensure that all Americans have access to affordable coverage that best meets the needs of them and their families so that they can receive preventative care from the doctor of their choice in a primary care setting.

Question. Do you commit to maintaining current funding levels for Community Health Centers, not only in the Department's annual budget submission to Congress, but in ongoing operations that will be financially damaged by the repeal of the Affordable Care Act?

Answer. I support Community Health Centers, however, funding levels are determined by Congress. If confirmed, I will uphold the law as passed by Congress and signed by the President.

INTERSTATE SALE OF HEALTH INSURANCE

Question. One of the policies that you and President Trump often refer to in your talks about an ACA "replace" plan is to allow insurance to be sold across State lines. As you must be aware, the ACA already allows for this, and several States—including your home State of Georgia—have passed State laws to allow for it too.

In the 5 years since Georgia started allowing out-of-state insurance to be sold, how many insurance companies have started selling out-of-state plans?

How has allowing out-of-state plans impacted consumer choice in available health insurance plans, what has been the impact on insurance costs, and what has been the impact on access to care in Georgia?

How many States have indicated they want to form a compact to allow out-of-state plans, under the current law?

How would this lack of interest on the part of States and insurance companies change under the plan you've previously proposed (e.g., title III of H.R. 3200, the Empowering Patients Act)?

As a former physician who had to negotiate with insurance companies to be in their networks, wouldn't you prefer to work with an insurance company that knew you and your patients, or would you prefer one from across the country that knows nothing about you, your practice, or your patient population?

Answer. It's no surprise that an overwhelming majority (85%) of Americans support the ability to purchase insurance across State lines. More important than insurance companies' views about more competition or State regulators' views about greater regulatory competition is the fact that American families are desperate for more affordable health-care choices. It's our job to make certain that every American has access to the highest quality care and coverage that is possible. Opening up more health options for American families by allowing them to purchase a plan from another State will do just that. Understandably, insurance companies and States have been reluctant to take bold action to sell products across State lines with the heavy burden of Obamacare already on the books. Removing Obamacare's insurance mandates and regulations combined with the ability to reach more customers will ultimately reward American families with more choices at lower costs.

Question. One of the consistent arguments you've made against the ACA is that it was a Federal takeover of health care and that oversight of the health industry is better left to States.

If you do in fact believe that, how does undermining States and their insurance commissioners by imposing interstate sale of health insurance follow that same logic?

Answer. If confirmed, I look forward to working with States to increase access to affordable coverage.

RECUSAL FROM AMA-RELATED ACTIVITIES

Question. The American Medical Association's (AMAs) House of Delegates is, to quote their website, the "principal policy-making body of the AMA." You've been a Delegate for more than a decade and have presumably been involved in the development of the organization's policies relating to key issues before both Congress and HHS during that time. You've stated that if confirmed you intend to recuse yourself from any issues the AMA has worked on for 1 year.

How did you determine that a year is a sufficient period of time for your recusal from all AMA-related activity?

Answer. This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in my publicly available ethics agreement.

Question. Does the clock on this year start on the day you assume the role of Secretary or do you currently consider that year to have already started?

Answer. The terms of my publicly available ethics agreement, which I entered into in consultation with the Office of Government Ethics and my designated agency ethics official, make clear that the 1-year recusal window begins on the day of the confirmation.

Question. If the Department's General Counsel, Office of Inspector General or any other authority within the HHS determines that a year recusal is insufficient to properly distance yourself from your previous work with the AMA, will you commit to extending the recusal period for the remainder of your tenure as Secretary?

Answer. I will abide by the obligations agreed to in my publicly available ethics agreement, which I entered into in consultation with the OGE and my designated agency ethics official.

Question. A quick search on the AMA's website shows that the organization has formally commented on issues as varied as Medicare Advantage, the physician fee schedule, FDA oversight of laboratory developed tests, Medicaid and CHIP, CMS quality measures, Medicare prescription drug benefits, electronic health record meaningful use requirements, guidelines for opioid prescribing, and the comprehensive joint replacement model you've spoken out against so frequently. Obviously the group representing doctors has myriad interests in the workings of virtually every agency and office within HHS.

Please provide me with documentation outlining exactly how you will recuse yourself from all AMA-related activities, which includes specific details on the HHS policies this recusal impacts. Further, please provide a list of all personnel within the Department that will be designated to act on your behalf for all the listed policies for which you will be recused.

Answer. This matter has already been addressed with the OGE and designated agency ethics official, and I will abide by the obligations agreed to in his publicly available ethics agreement.

I have not yet been confirmed or hired any personnel to assist efforts in the Department of Health and Human Services.

Question. As a member of the AMA's House of Delegates for more than a decade, it's safe to presume that you are familiar with, and supportive of, their policies. One of these policies states that the "AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health" because they are the leading cause of premature death in the country.

Do you agree that guns are a top cause of intentional and unintentional death, as the AMA states?

As a member of the AMA's House of Delegates, at any point did you fight against the AMA taking a stance declaring guns to be a public health issue?

Do you oppose government prohibitions on studying how gun violence affects the public health? If confirmed, will you commit to not imposing government prohibitions on any agency, department or office from conducting gun-related health research to improve public health?

Answer. Violence is a challenge in our society that deserves greater attention. All Americans want our communities to be safe places to live, learn, work and play. To my best recollection, I have not taken an individual stance on this matter. To the question of how best to prevent the tragic loss of innocent lives, I believe we must take a hard look at the underlying issues contributing to these tragic events, including too often unmet mental health needs among our citizens. A proper diagnosis and treatment as part of patient-focused care are critical to ensuring we are identifying indicators of violent behavior that may contribute to tragic events.

EVIDENCE-BASED HOME VISITING PROGRAMS

Question. I have been a strong supporter of the Maternal, Infant, and Early Childhood Visitation program (MIECHV), which has always enjoyed bi-partisan support. MIECHV was enacted as part of the Affordable Care Act to help States build capacity to provide in-home visits to at-risk mothers and families with the stated goals of improving maternal and child health, preventing child abuse and neglect, encouraging positive parenting, and promoting child development and school readiness.

The Medicare Access and CHIP Reauthorization Act (MACRA), passed in 2015, reauthorized the program for 2 years. This reauthorization maintains current funding, which unfortunately is only enough resources to provide services to only 3 percent of the eligible population who are currently receiving MIECHV services. This points to a missed opportunity to improve the life course development of children born into low-income households, while also reducing preventable government spending in the short and long term.

Do you commit to supporting continuation of funding for the MIECHV program in the Department's annual budget submission? Do you recognize the value of the MIECHV program and its evidence-based design by proposing increases in funding to capture more than just 3 percent of those children and families who could greatly benefit through the program's services?

Answer. I share your goal of increasing access to affordable, quality health coverage for rural America. While I cannot comment specifically on legislation that would reauthorize MIECHV, I look forward to working with you on examining this program's funding and working on ways to improve rural and child health using evidence-based approaches.

DIVERSITY IN HIRING

Question. The Affordable Care Act expanded health-care coverage to millions of Americans who were previously uninsured. Because of the greater demands on the health-care industry, the ACA has also become an engine for job growth in the health related fields. This is especially true for women and people of color.

For example, women represent 75% of the health-care workforce. Nearly half of workers in the long-term/residential and home health-care services are people of color. The future of our American workforce in the health industry promises increasing diversity. Between 2003–2004 and 2013–2014 the number of doctoral degrees conferred in health profession fields increased by 61 percent (from 41,900 to 67,400

degrees).¹⁴ In 2013–2014, one-third of those doctoral degrees were awarded to people of color.¹⁵ The importance of a diverse workforce in the health industry has been well-documented in scientific literature. One of the more significant outcomes of a diverse workforce is greater access to and quality patient care.¹⁶ Diversity in the workforce also increases career opportunities for people of color.

Given the fact that the current administration intends on gutting the Affordable Care Act, which, along with leaving millions of Americans uninsured, will also leave thousands of women and minorities without an opportunity to build a career in their field of study:

Will you commit to minimizing the impact of leaving thousands of incoming women and minority health-care professionals without a career path to look forward to?

Answer. Workforce issues are a major challenge in health care. We should work together to expand career options and paths for all health-care professionals.

Question. The Department of Health and Human Services is among the most diverse agencies to work for within the government, except when it comes to its Hispanic labor force. In FY 2015, Hispanics comprised 3.08% of HHS's workforce compared to 9.96% of the National Civilian Labor Force.¹⁷

What concrete steps does the Department of Health and Human Services plan to take to increase diversity and inclusion in its agency, especially at its Senior and Executive levels?

Answer. If confirmed, I would be pleased to work with you to identify steps that could be taken to ensure the Department is drawing upon the widest and most diverse pool of applicants possible in the hopes of it resulting in an even more diverse workforce.

DIVERSITY IN HEALTH OUTCOMES

Question. Eliminating health-care disparities among Americans from minority racial and ethnic backgrounds has long been a bipartisan issue. In 1985 under President Reagan, then Secretary of Health and Human Services Margaret Heckler commissioned a report on Black and Minority Health where she noted that there was a “continuing disparity in the burden of death and illness experienced by [. . .] minority Americans as compared with our Nation’s population as a whole.” The report, as she envisioned, should have marked “the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health.”¹⁸

Unfortunately that shadow is still cast over our country. There is a significant body of literature that indicates that disadvantaged populations, such as racial and ethnic minorities, still face systemic barriers to achieving ideal health. For example, African Americans are 50% more likely to die from heart disease or stroke; Asian/Pacific Islanders are 60% more likely to have acute Hepatitis B, which causes liver disease; and African-American, Native Hawaiian/Other Pacific Islander, and Hispanic adults all have rates of HIV infection diagnosis that range from three to nine times the rate of non-Hispanic Whites.¹⁹ To that end, the Affordable Care Act established Offices of Minority Health within six agencies, thus expanding the work begun by President Reagan 30 years ago. The purpose of creating these offices was to have greater interagency coordination when it comes to eliminating minority health disparities.

To the extent that this administration has taken and will continue to take concrete steps to repeal the ACA, which created the Offices of Minority Health within the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Centers for Medicare

¹⁴ https://nces.ed.gov/programs/coe/indicator_svc.asp.

¹⁵ https://nces.ed.gov/programs/digest/d15/tables/dt15_324.25.asp.

¹⁶ Mitchel, D.A. and Lassiter M.A. (2006) Addressing health care disparities and increasing workforce diversity: The next step for the dental, medical, and public health professions, *American Journal of Public Health*, 96 (12), pp. 2093–2097.

¹⁷ <https://www.hhs.gov/sites/default/files/asa/ohr/spd/di/newsletter/dinewsletterfallwinter15.pdf>.

¹⁸ <https://minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf>.

¹⁹ https://minorityhealth.hhs.gov/assets/pdf/FINAL_HHS_Action_Plan_Progress_Report_11_2_2015.pdf.

and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA):

Will you commit to prioritizing the elimination of minority health disparities in America a priority? Please provide specifics of how you plan to make this a priority.

Answer. Health outcome disparities are a challenge and prioritizing work in this area is important. Using the proper metrics may provide important insight into new solutions.

QUESTION SUBMITTED BY HON. ROB PORTMAN AND HON. SHERROD BROWN

Question. HHS, through CMS, has a long tradition of supporting nursing education. Our State of Ohio is home to 12 facilities that receive Medicare pass-through funding for nursing education. Over the past few years, CMS support for nursing education funding has been under threat due to accreditation changes. We have authored a bill, the MEND Act that would ensure CMS support of nursing education through pass-through funding continues and that we can continue educating high quality nurses.

If you are confirmed, will you commit to work with us in Congress to provide technical assistance and ensure that the MEND Act is quickly implemented if passed?

Answer. I look forward to working with you on this issue and sharing both feedback and assistance regarding the important policy and technical issues in nursing education funding, an issue related to and similar to the challenges with physician shortages but broader in geographic scope and impact. If the law is implemented, and if confirmed, I will ensure it is implemented on the timeline Congress imposes.

QUESTION SUBMITTED BY HON. ROB PORTMAN AND HON. ROBERT P. CASEY, JR.

Question. Section 154 of MIPPA 2008 specifically excludes from the Medicare DME competitive bidding program (CBP) CRT power wheelchairs, as well as the accessories that consumers use with those wheelchairs. Consistent with the law, Congress did not include those CRT items in Rounds 1 or Rounds 2 of the DME bidding program and has repeatedly expressed to CMS that it was not the intent of the law to apply bid rates to accessories used with CRT wheelchairs. Unfortunately, CMS has interpreted MIPPA contrary to congressional intent and in December 2014 CMS posted on-line a "Frequently Asked Questions" (FAQ) document stating that starting in January 2016 CMS intended to use bid pricing information obtained from the CBP for standard wheelchair accessories to reduce the payment amounts for CRT wheelchair accessories.

At the end of 2015, Congress included in the Patient Access and Medicare Protection Act (PAMPA) a 12-month delay (through December 31, 2016) of CMS's planned application of CBP prices based on standard accessories to CRT accessories that share the same HCPCS code. In December 2016, as part of the 21st Century Cures Act, Congress included an additional 6-month delay that will expire on June 30, 2017.

Based on your support for this non-application of CBP prices to CRT accessories as a member of Congress, if confirmed as Secretary of HHS, can you commit to work with Congress to correct this CMS policy and adhere to the intent of Congress in MIPPA?

Answer. As a member of Congress, I have been engaged in understanding and improving the competitive bidding program. If confirmed, I will continue this work but with the different role of carrying out the law for the benefit of the American people. If confirmed, I fully expect to work with Congress on this issue and many others that arise when Congress's intent encounters the details of implementation. I also hope to bring to that role, if confirmed, the informative and valuable perspective of serving as a member of Congress writing and voting on these laws.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

CMMI AND HEALTH CARE DELIVERY INNOVATION

Question. What are your views of State demonstrations, State innovation, and Centers for Medicare and Medicaid Innovation (CMMI) authority?

Answer. I believe these authorities can be important ways to ensure there is flexibility in CMS programs and activities for the individual and varying needs of States.

DRUG PRICES

Question. Last year the country was shocked by a series of price-hikes on older, off-patent drugs by manufacturers who had played no part in the research and development that produced them. The Senate debated numerous solutions last Congress to prevent price gouging behavior, and many put the ball squarely in HHS's court.

What is your view on HHS's role in preventing price-gouging, and if confirmed, how do you propose to use the Office of Secretary to ensure Americans have access to affordable prescription drugs?

Answer. The issue of drug pricing and drug costs is one of great concern to all Americans. You have my commitment to work with you and others to make certain that Americans have access to the medications that they need. If confirmed, I look forward to focusing on how we can make health care more affordable, including prescription drugs. I share your concern regarding the importance of individuals and families being able to afford the prescription drugs they need.

EMERGENCY HEALTH SERVICES

Question. The Balanced Budget Act of 1997 requires Medicaid managed care organizations (MCOs), and others, to cover emergency services without prior authorization and established a Federal "prudent layperson standard." This standard defines an "emergency medical condition" as one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious bodily functions, or serious dysfunction of any bodily organ or part.

Do you support this Federal policy?

Answer. I appreciate the aim of this Federal policy is to ensure a minimum level of emergency room coverage for Medicaid managed care organizations. Every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and potential Medicaid managed care coverage requirements. While I believe that in the long run a one-size-fits-all approach is not workable for a country as diverse as the United States, my hope is to make sure that Medicaid beneficiaries need not rely on the emergency room to reliably access care because they have a doctor they trust in their community and a strong relationship and reliable access to that doctor.

Question. Will you ensure the Centers for Medicare and Medicaid Services continues to enforce the prudent layperson standard for all Medicaid MCOs?

Answer. If confirmed as Secretary, I will faithfully implement laws written by Congress and the regulations issued by the Department. This includes enforcement action as appropriate. As a doctor who has actually treated thousands of Medicaid patients, I do care deeply about the Medicaid program and the access of Medicaid patients to actual care, not just a card they can carry with them.

FEDERAL WORKERS

Question. Do you believe that the Office of the Actuary's actuarial and economic projections should be based on "best professional estimates" and remain as free as possible from political considerations? Why or why not?

Answer. In getting advice from any professional it is important that advice be objective and consistent with relevant professional standards. Just as I would expect that from any doctor I visit I would expect the same from an actuary.

GLOBAL HEALTH SECURITY AGENDA

Question. What are your views on President Obama's Global Health Security Agenda?

Answer. In an interconnected world, no nation is safe from the risks posed by infectious diseases. I agree that the international community must continue to work together towards the common goal of a world safe from infectious diseases. I also agree that the international community must build-up our capacities in order to achieve this goal. If confirmed I will meet with the Office of Global Affairs and CDC to review the progress we have made on this agenda.

Question. For decades the U.S. Government has been a leader in strengthening health systems around the world to prevent, detect, and minimize the impact of emerging infectious diseases. The United States is one of over 50 countries that have committed to the Global Health Security Agenda, which aims to help countries improve their capacity to prevent, detect, and respond to infectious disease outbreaks.

As Secretary, how would you support and enhance global efforts to detect, prevent, and respond to diseases internationally to prevent them from becoming a threat to the United States?

How will you ensure that we effectively address emerging crises and maintain our leadership role in global health?

Answer. No global effort to detect, prevent, and respond to diseases internationally can be successful without an active and engaged United States. Rapid response in fighting infectious diseases is essential. Oftentimes, we can ensure these diseases do not spread to our shores if we do what we can to stop them spreading abroad. Few responsibilities are more important than keeping the public safe from potential public health pandemics and if confirmed I will make this a top priority.

Question. America's approach to global health has been extremely successful, including the effort to move toward ending the epidemics of AIDS, tuberculosis and malaria. The hallmark of America's work against the three diseases has been to support results-oriented, accountable and transparent programming through the Global Fund and bilateral programs including PEPFAR, PMI and the USAID tuberculosis program. The Global Fund and our bilateral programs closely coordinate their work and depend on each other to implement comprehensive programming.

As Secretary, will you be committed to continuing America's leadership against AIDS, TB and malaria through Global Fund investments?

Answer. United States leadership has been crucial in fighting AIDS, TB and malaria. Should I be confirmed, I fully expect these efforts to continue as we build upon and learn from our past and current initiatives. HHS and CDC are critical to fighting a range of global health security threats from Ebola and Zika to polio and HIV/AIDS. Yet, as was made clear during the Ebola epidemic, severe shortages of health workers greatly hamper efforts for infectious disease prevention, detection and response.

Question. HHS and CDC are critical to fighting a range of global health security threats from Ebola and Zika to polio and HIV/AIDS. Yet, as was made clear during the Ebola epidemic, severe shortages of health workers greatly hamper efforts for infectious disease prevention, detection and response.

In your view, what is the role of the Department of Health and Human Services in growing and developing a better-trained health workforce worldwide?

Answer. If confirmed as HHS Secretary, I look forward to working with the health secretaries of other nations in helping the world community train an international health workforce capable of tackling the myriad public health challenges of the 21st century.

GRADUATE MEDICAL EDUCATION (GME)

Question. The current Medicare GME system is not producing enough doctors who will practice in rural America. Data show less than 5% of all graduates practice in rural areas. When Congress set limits on the number of Medicare funded GME slots (BBA 1997) there was clear intent in both the statute and the report language to treat rural training differently and provide special consideration to meet the needs of underserved rural areas. Unfortunately, the technicalities of the statute, and the regulations deriving from it, have not succeeded in achieving this intent.

What will you do as Secretary of HHS, specifically, to support changes to Medicare GME to increase the production of physicians practicing in rural areas?

Answer. I have always been a strong supporter of efforts to support medical education. Congress has used the Medicare program from its inception to invest in future generations of doctors. Regardless of what we do in Washington, health care should always be about that one to one relationship of a patient to a doctor. That relationship of course requires a doctor. And so I am hopeful we can continue to find ways to remove disincentives to the practice of medicine and its rewards as well as support the profession in other ways. This issue is all the more important in the case of a rural area, where there is already an ongoing physician shortage and difficulty in recruiting talent and capital for medical infrastructure. If confirmed as Secretary, I would look for opportunities to address these situations through GME but also through programs administered by the Health Resources Services Administration and by taking a closer look at telemedicine.

MEDICARE

Question. Your ACA replacement proposal, the Empowering Patient's First Act, eliminates benefit expansions for beneficiaries such as free preventive benefits (blood pressure screenings, colorectal screenings and immunizations) and closing the Part D donut hole which helped with out-of-pocket prescription drug costs.

If confirmed as HHS Secretary, how will you prevent any care reductions for or our-of-pocket health-care cost increases to Medicare beneficiaries?

Answer. In considering Medicare, it is important to appreciate that the bipartisan Medicare Trustees have told everyone that Medicare, in less than 10 years, is going to be out of the kind of resources that will allow us as a society to keep the promise to beneficiaries of the Medicare program. My goal, if confirmed, is to work with Congress to make certain that we save and strengthen Medicare. It is irresponsible for us to do anything else. If I am confirmed, my role will be one of carrying out the laws Congress passes and as to that I would convey to the Medicare population that we look forward to assisting them in getting the care they need.

MENTAL HEALTH WORKFORCE

Question. Mental health professions face chronic workforce shortages, and the future for many of these professions remain grim. For example, a recent survey from the American Association of Medical Colleges found that almost 60% of psychiatrists are aged 55 or older, making psychiatry the fourth oldest medical specialty in terms of practitioner age.

Along with the overall shortage, the distribution of mental health practitioners heavily favors key urban and suburban areas of the country over rural regions. The 21st Century Cures Act requires the Substance Abuse and Mental Health Services Administration to develop a strategic plan every 4 years to identify strategies to improve the recruitment, training, and retention of a mental health and substance use disorder workforce.

While this provision and similar provisions are steps in the right direction, the numbers clearly suggest that growing a robust workforce to meet the mental health and substance use needs of nearly 70 million Americans will be of paramount importance in the coming years. Please describe in detail how you, if confirmed, will support the growth of the next generation of mental health practitioners.

What strategies will you use to encourage medical students and others to pursue careers in these fields?

Answer. It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. If I am confirmed, I look forward to working closely with you and the other members of Congress to faithfully execute the 21st Century Cures Act, which aims to ensure that the mental health profession is adequately staffed for current and the future generations.

MINORITY HEALTH

Question. In Maryland, the ethnic minorities make up roughly 41% of the State's population. This is important because the health outcomes of minority populations are significantly lower and morbidity rates are higher than that of majority populations. Your Department, HHS, recognized this when it produced with what is commonly called the Heckler Report back in the 1980s, under President Ronald Reagan,

looking at what are now commonly called “health disparities” and the need for more health professionals coming from minority and underrepresented backgrounds.

Racial and ethnic communities suffer disproportionate higher rates of illnesses, disabilities and preventable deaths. In fact, according to Johns Hopkins and University of Maryland researchers, racial health disparities cost the United States \$229 billion between 2003 and 2006.

The Affordable Care Act is allowing communities coverage and access to much needed care, treatment, and prevention services from diabetes, to cancer, to asthma, and more. Specifically, how do you plan to further the elimination of racial and ethnic health disparities?

Answer. I am committed to ensuring that minorities in this country have access to the highest quality care. To address these challenges, we need to examine what is happening on the ground in these communities. From there, we can establish better metrics and better accountability, and I look forward to working with you on this when I am confirmed.

NATIONAL INSTITUTES OF HEALTH (NIH)

Question. Young scientists in the United States are finding it more difficult—and more time-consuming—to secure stable funding to launch their research careers, which stifles America’s competitiveness. More and more talented young people are dropping out of the scientific workforce or choose not to enter in the first place.

What do you plan to do to ensure barriers facing young scientists are addressed and can we count on your leadership to implement the recommendations that come out of the National Academies report?

Answer. If confirmed, I will look at flexibilities given to us through the 21st Century Cures Act and the focus on “young emerging scientists” to better recruit and retain top talent in order to help us achieve our mission of promoting innovation in order to benefit patients and their families across the country.

Question. What do you see as the future roadmap for NIH over the next four years?

Answer. If confirmed, I will work with NIH leadership to map out a forward-leaning NIH agenda. As I mentioned in my testimony, NIH is a true treasure for our country. With the increased resources provided in the Cures Act and the President’s commitment to innovation and patient-centric health care, great opportunities lie ahead for the NIH.

PEDIATRIC DENTAL

Question. According to the CDC, tooth decay (cavities) is one of the most common chronic conditions of childhood in the United States and if left untreated, tooth decay can cause pain and infections that may lead to delays in important cognitive skills, such as eating, speaking, playing, and learning.

How will you plan to ensure that children will continue to have access to early prevention services for oral health?

Answer. If confirmed as Secretary, I would hope to work with you to revisit the current CMS’ “Oral Health Strategy” for children (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/cms-oral-health-strategy.pdf>). I would also aim to provide States with flexibility in their Medicaid programs to provide both coverage and access to these services. Lastly, there may be opportunities to encourage innovation in both the coverage and payment for these services as well as the actual technology and even the relevant public health education strategies.

SOCIAL SERVICES BLOCK GRANT (SSBG)

Question. This important program funds a variety of social services programs, from child protection to elder abuse to Meals on Wheels. I see every day in Maryland how this grant program helps our neediest and most vulnerable citizens. You proposed eliminating this \$1.7 billion a year program as the chairman of the House Budget Committee.

What was your rationale for trying to eliminate this program, and what would you put in its place?

Answer. During my time in Congress, I have been acutely aware of the need to eliminate duplicative programs and strengthen those programs that work. As a 2011

GAO report pointed out, SSBG is a program of fragmentation, overlap, and duplication. SSBG essentially offers no-strings attached approach and a blank check to States. However, as SSBG continues to be a program authorized by Congress, I will do all I can to effectively administer this law should I be so honored as to be confirmed as HHS Secretary.

SUBSTANCE USE DISORDERS

Question. The United States currently faces a growing epidemic in the form of prescription drug misuse, abuse, addiction and overdose. The numbers are disquieting. One person dies every 19 minutes from a drug overdose, now the leading cause of death among those ages 25–44, according to Johns Hopkins experts.

In Maryland in 2015, fatal overdoses in the State were up 21 percent from the year before, and nearly twice the number in 2010. There is an urgent need for evidence-informed solutions ready for rapid implementation.

How will HHS balance the twin-priorities of preventing new cases of opioid addiction and expanding access to effective addiction treatment while safely meeting the needs of patients experiencing pain?

Answer. The opioid epidemic is real. This epidemic is a rampant crisis that is harming families and communities across the Nation. I firmly believe it is vital that those suffering from substance abuse have continued access to addiction treatment. If confirmed, I am committed to working closely with you and the other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration (SAMHSA) fulfills its duty of treating those who are in addiction recovery, and prioritizes prevention efforts to keep America's families and communities healthy.

Question. Last month, the Centers for Medicare and Medicaid Services (CMS) granted Maryland a Medicaid section 1115 waiver to implement initiatives to address substance use disorders throughout the State. This is great news for my home State and a first step to addressing opioid abuse and heroin use. Now, Medicaid enrollees will have access to residential treatment for substance use disorders, putting them on the road to recovery.

If confirmed as HHS, will you commit to ensuring States' ability to use Medicaid section 1115 models to provide life-saving care, including addiction treatment and recovery services covered by Medicaid, to Americans in need?

Answer. If I am confirmed, I will work with CMS and SAMHSA to help low-income adults with mental health and substance use disorders. With respect to Medicaid specifically, every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid. That is one of the reasons I devoted so much time to working with States to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. Waivers are an important tool for States to innovate within the Medicaid program. If confirmed, I would work with CMS to ensure that it evaluates waivers like Maryland's on their merits, taking into account the desirability of States charting their own course, and ensure that they are compliant with the law.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Question. I am concerned that, while the TANF caseload had declined by over 60 percent over the last 2 decades, the number of children in poverty and deep poverty (meaning income below half the poverty line) has increased.

What steps would you take to reverse this trend?

Answer. If confirmed as HHS Secretary, I am going to do all I can to effectively and efficiently administer the laws passed by Congress to address and alleviate the very real problem of children living in varying levels of poverty.

Question. Do you agree that TANF is not succeeding as a program even if caseloads are declining while the number of persons in poverty and deep poverty are increasing?

Answer. Respectfully, I must disagree with this assessment of TANF's success. Since passage of TANF, we have seen employment rates of single mothers increase, lower poverty rates among female-headed households with children and African-American households, a reduction in child poverty overall, and a sharp decline in the number of families receiving cash assistance.

THERAPY CAPS

Question. As you know, the therapy cap exceptions process expires in less than a year—on December 31, 2017. We have all heard from constituents whose therapy needs exceeded the cap and their conditions have deteriorated, necessitating more expensive medical intervention.

As Secretary of HHS, how will you support the repeal of these arbitrary and discriminatory limits and maintain access to rehabilitation therapy that Medicare beneficiaries clearly need?

Answer. If confirmed as Secretary, I will look into this issue and seek to understand the competing objectives and issues motivating the current CMS policy. Part of the frustration with the current health-care system is rules like this that do not make sense to many people. However, that is not surprising when one considers that Medicare Parts A, B, C, and D have each developed in silos and that even payment for particular types of services sometimes reflect silos within the silos. It may be that other approaches to therapy provide greater quality care at reduced cost with more respect for the individual needs of each patient in consultation with their doctor. If confirmed as Secretary, I would hope to break down these silos and encourage approaches based on a broader perspective.

Question. Given the problems associated with monitoring the therapy cap, are the Centers for Medicare and Medicaid capable of achieving a timely uniform and defensible streamlined, responsive, and transparent process for manual medical review of Medicare records by Medicare administrative contractors?

Answer. Any time there is manual review of anything in an organization with the scale of Medicare, there is a recipe for something to go wrong. If confirmed as Secretary, I would be pleased to work with you to confirm whether the staffing and other resources needed would be up to the challenge you describe.

QUESTIONS SUBMITTED BY HON. DEAN HELLER

MEDICAID EXPANSION

Question. Do I have your commitment to working with Congress, and members of this committee, to protect access to care for all patients in Nevada, particularly the over 600,000 Nevadans currently covered under Medicaid?

Answer. I am committed to ensuring that Medicaid is available for eligible beneficiaries, and working with States to ensure they are able to make the most use of available resources to serve their citizens, if confirmed as Secretary of Health and Human Services. Each State has different needs, and I believe CMS needs to work with States to ensure that, consistent with those needs, the Medicaid and CHIP programs provide the best possible coverage to their residents.

Question. Under your leadership, how will the U.S. Department of Health and Human Services work with States like Nevada, who expanded Medicaid, to ensure that they are successful in protecting access to health care, particularly the 200,000 newly eligible Nevadans, as we transition out of Obamacare?

Answer. I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I will promise you this: Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

DOCTOR SHORTAGE

Question. Nevada is 47th in the Nation for doctor-to-patient ratio. What can Congress and HHS do to attract more health-care providers to practice medicine in rural and underserved areas in States like Nevada that are facing a significant doctor shortage?

Answer. If confirmed, I would work closely with the Center for Medicare within CMS to see that critical access hospitals are able to serve rural populations well. I would also work with the HRSA (Health Resources and Services Administration) Administrator to consider how CMS and HRSA can best cooperate with regards to community health centers and other issues. I would also consider how we can allow

for reimbursement of telehealth in general and to further help address provider shortages.

Question. Do you believe that tele-medicine would be helpful for predominantly rural States like Nevada expand access to care for patients in underserved areas?

Answer. Telemedicine is an exciting innovation that will allow for individuals to access resources that are otherwise not available. In the State of Georgia, we have a program that is a spoke and wheel program. There is a neurologist who works with a network of clinics and hospitals around the State. If somebody comes in with symptoms of a stroke, that neurologist is able to see the patient in real time and determine if they are having a stroke, whether they can be treated in the community or ought to be transferred. Innovations like this have been particularly helpful for rural areas.

FINANCIAL DISCLOSURE

Question. To the best of your knowledge, as a member of the House of Representatives, did you fully comply with the Stop Trading on Congressional Knowledge Act (STOCK Act, Pub. L. 112-105) and the Office of Government Ethics (OGE) to publicly disclose your personal financial transactions?

Answer. To the best of my knowledge, I have met all compliance obligations for the disclosure of personal financial transactions by members of the House of Representatives.

Question. If confirmed, do you commit to fully complying with the law that would require you to sell stock in companies regulated by HHS?

Answer. If confirmed, I commit to fully comply with all applicable ethics and conflict of interest obligations required by law, including the divestment of all applicable securities identified for sale in my publicly disclosed ethics agreement with the Office of Government Ethics ("OGE").

NEVADA STATE LEGISLATURE

Question. Please see the attached questions from the Nevada State Legislature. I respectfully ask that you respond to these important issues in the State, and cc Governor Sandoval.

Answer. I look forward to writing to you and the Governor regarding these important issues. I expect my response will include the following.

Q. What steps do you plan to take to ensure that the more than 88,000 Nevadans who have purchased health insurance through the Silver State Health Exchange continue to have the ability to purchase health insurance with adequate coverage in a transparent marketplace?

A. I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons. And so when we talk about coverage we ought to make clear what we really mean and want to have happen. In any case, the President has made clear his hope and plan for a replacement to Obamacare. The goal is to make certain that every single American has access to the coverage they want for themselves.

Q. What steps do you plan to take to ensure that the more than 77,000 Nevadans who are eligible for Federal tax credits under the Affordable Care Act to help purchase private insurance will continue to have access to affordable health insurance options with adequate coverage?

A. I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons. And so when we talk about coverage we ought to make clear what we really mean and want to have happen. In any case, the President has made clear his hope and plan for a replacement to Obamacare. The goal is to make certain that every single American has access to the coverage they want for themselves.

Q. What steps do you plan to take to ensure that the 217,000 Nevadans who are receiving health care under the Medicaid expansion remain covered?

A. Regardless of the final legislative outcome, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

Q. The Affordable Care Act guarantees coverage vital to preventative services for women, including cancer screenings and birth control. What steps do you plan to take to ensure that the Affordable Care Act's coverage guarantees remain intact for women's health?

A. My hope is to move in a direction where insurers can offer products people want and give them the coverage they want. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans. And note that I refer to care because ultimately, having maternity or other coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off. So we must work towards both coverage and care.

Q. The Affordable Care Act guarantees that Nevadans with pre-existing conditions will not be denied health care and ends lifetime minimums on coverage. It also allows younger people, many of whom are saddled with college debt and cannot afford insurance, to stay on their parents' insurance until they are 26. What steps do you plan to take to preserve those coverage guarantees?

A. Nobody ought to lose insurance because they get a bad diagnosis. As to coverage until age 26, the insurance industry has applied that across the board. In any case, if confirmed as HHS Secretary, my role would be to implement the replacement passed by Congress and signed by President Trump. Regardless of my own ideas, it is Congress that will ultimately decide what a replacement bill will look like, and my job would be to faithfully execute the law as passed by Congress.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. The Medicare Advantage program has been used to provide quality, affordable health care to about 18 million seniors and individuals with disabilities. Many of these seniors indicate that they are satisfied with their choice of Medicare Advantage program. In fact, 36% of Coloradans are in Medicare Advantage plans.

In your role as Secretary of HHS, how do you plan to support Medicare Advantage plans? What other steps do you plan to take to ensure that seniors have access to coordinated care plans?

Answer. Medicare Advantage provides an important option for Medicare beneficiaries to access coordinated care and greater benefits. If confirmed as Secretary, I would seek to ensure Medicare Advantage remains a stable option for beneficiaries and that Medicare Advantage plans are afforded the flexibility to design plans that beneficiaries want and give them the coverage they want.

Question. According to the Medicare Boards of Trustees, the Affordable Care Act (ACA) has extended the solvency of the Medicare hospital insurance trust fund by 11 years in total. The Committee for a Responsible Federal Budget estimates that a full repeal of the ACA would push up the insolvency date to 2021 and more than triple the program's 10-year deficit.

How would you structure an ACA replacement bill that does not reduce the solvency of the Medicare Hospital Insurance Trust Fund?

Answer. Neither President Trump nor I are wedded to a particular plan to the exclusion of all others. We are looking forward to giving the American people what they've been longing for, for 7 long years: real health-care reform. But they have never wanted Obamacare: It has raised premiums and deductibles, narrowed doctor networks, reduced choices of plans, limited Americans' liberty, and undermined the doctor patient relationship. A replacement need not affect the Medicare trust fund if the provisions related to Medicare are ones that are carefully considered.

Question. Do you plan to advise the administration to advocate for premium support as a means of extending the Medicare trust fund?

Answer. One of my goals in discussing these matters is to lower the temperature regarding what we are talking about. These issues have real-life impact for folks in their lives and so, if confirmed, I would advise the administration that we convey

to the Medicare population that they do not have reason to be concerned and that we look to assisting them in getting the care they need and the caregivers that they need too.

Question. Colorado has 2.3 million people living with a pre-existing condition that rely on the protections of the ACA to receive coverage.

How would your plan keep coverage for pre-existing conditions and control costs while dissolving other parts of the ACA such as the individual mandate, the exchanges, and Medicaid expansion?

Answer. Our goal is to ensure every single American has access to the coverage they want for themselves and ensures the individuals who lost coverage under the Affordable Care Act get or maintain coverage. If we preserve the patient-doctor relationship and put the patient at the center, then we will see quality go up and costs go down. In any case, I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed.

Question. I have heard from rural hospitals in Colorado that may lose significant funding if the ACA is repealed. The Medicaid Expansion provided some financial stability to hospitals that were on the brink of closure before the bill was passed. In fact, hospitals in Colorado saw a 30% drop in uncompensated care.

What metrics would you use to ensure that an ACA replacement does not hurt rural or critical access hospitals?

Answer. Our goal is to ensure every single American has access to the coverage they want for themselves and ensures the individuals who lost coverage under the Affordable Care Act get or maintain coverage. This of course includes individuals who access care at rural or critical access hospitals. And so the best metric in the end is one that measures the extent of access to actual care, not just coverage and the quality of that care as determined by patients working individually with their doctors.

Question. You have included health savings accounts in previous proposals to replace the ACA. As you know, health savings accounts are essentially a way for people to save their own money that they can then spend on health care. They are not a substitute for quality coverage and are paired with a high deductible, making it difficult to obtain health care.

How can a middle-class family making \$60,000 a year successfully use a health savings account if they live paycheck to paycheck and can't afford to set aside thousands of dollars to pay for their health-care bills?

Answer. Our goal is to ensure every single American has access to affordable coverage they want for themselves and their families. Health savings accounts are powerful tools that can be used to help lower costs and empower individuals, providing greater flexibility to spend health-care dollars as they see fit.

Question. The ACA took steps to enhance price transparency of health-care services by requiring health plans to be more explicit about what they cover. A knee replacement in the United States could cost \$11,000 in one area of the country and nearly \$70,000 in another area. Consumers are still largely unaware of what they will be billed after a certain test or procedure.

What steps do you plan to take as HHS Secretary to improve price transparency for consumers?

Answer. If confirmed as HHS Secretary, I would work to improve price transparency to foster and facilitate patient choice. In so doing, I would be focused on actual costs and not costs billed to insurance companies or from a master price list no one uses. At the end of the day though, until patients rather than government are making the purchasing decisions, the price transparency information we might aim to provide is of limited utility because it does not reflect the patients' collective choice and willingness to pay but the government's.

Question. I worked with Senator Portman to introduce the Medicare PLUS Act which would set up a pilot program to help the top 15% of the highest-cost Medicare beneficiaries by coordinating their health care needs. As you may know, 15% of Medicare beneficiaries have six or more chronic conditions and account for 50% of total Medicare spending.

What steps will you take as HHS Secretary to pilot this program and ensure that these patients get the coordinated care they need?

Answer. If confirmed as Secretary, I would explore what voluntary options we can make available to the Medicare beneficiaries with the greatest needs and their physicians. I think many will appreciate the opportunity to work with a care manager and possibly others who will spend the time and effort needed to help the patient make different choices to manage their own care. I would seek to work with you on your proposal to explore how it and others like it can be a path to empowering those who are subjected to the most uncoordinated and challenging aspects of our health-care system.

Question. Congress and the last administration have made it a priority to pursue delivery system reforms that improve quality and lower costs. The Advancing Care for Exceptional (ACE) Kids Act, on which I worked with Senator Grassley, aims to coordinate care for vulnerable children with complex medical conditions.

What steps will you take as HHS Secretary to promote increased emphasis on reforms that target the needs of children with complex medical conditions?

Answer. If confirmed as Secretary, I would look across the Department to identify all the ways in which HHS aims to help these children in need. And I would hope to encourage our use of existing authorities and funding to better align resources to meet this challenge. I would also work with members of Congress on their ideas on this important topic.

Question. Over 500,000 children in Colorado are enrolled in Medicaid. Nationally, the program covers over 30 million kids.

If Medicaid is transformed from an entitlement program to a block grant, can you guarantee that those children will maintain coverage? What metrics will you use to ensure that those children are covered and have access to the same services that they do today?

Answer. It is important that every child has access to high-quality health coverage, and Medicaid plays an important role in accomplishing this objective. If confirmed as Secretary, my goal would be to ensure that no child in Colorado or anywhere else is left behind.

Question. The Children's Health Insurance Program (CHIP) currently covers 60,000 children in Colorado, increasing access to routine check-ups, prescriptions, and emergency services for vulnerable kids. Extension of the program needs to occur early this year in order for States to plan and have budget certainty.

What is your position on CHIP? What reforms would you recommend as HHS Secretary before supporting extending the program?

Answer. It is important that every child has access to high-quality health coverage, and CHIP plays an important role in accomplishing this objective. CHIP plays a major role in this, but there is also a need for coordinated family coverage in the private market and employer plans, and giving States the needed flexibility.

Question. The National Health Service Corps Loan Repayment Program has been vital in supporting primary care providers who then practice in Health Professional Shortage Areas (HPSAs). The ACA expanded this program and it has added necessary primary care providers in Colorado.

If confirmed as HHS Secretary, will you recommend that Congress support this program to increase the number of primary care providers in rural and underserved areas?

Answer. As a physician, I understand the value and importance of the National Health Service Corps (NHSC) and the NHSC Repayment Program. I have included loan forgiveness for primary care providers in past legislative proposals, and I look forward to working with Congress on this issue when I am confirmed.

Question. The Pharmacy and Medically Underserved Areas Enhancement Act recognizes pharmacists as health-care providers in underserved areas in order to expand access to care. In areas with a shortage of primary care providers, pharmacists may play a key role in helping patients manage their diseases to avoid Emergency Department visits and hospitalizations. These services are especially important for patients with multiple chronic conditions who may be taking several medications at a time. As HHS Secretary, would you support this approach as a way to increase care in rural and underserved areas?

Answer. We ought to step back and say, "What are we doing wrong?" as one out of every eight physicians no longer sees Medicare patients. Therefore, if confirmed as Secretary, I would be open to all options to address the impact of the ongoing

physician shortage in rural areas. Paying pharmacists in underserved areas to engage in certain medical services could work well in those States where pharmacists have such licensure and a setting appropriate to the services, where primary care doctors continue to be involved in care, and where there is a patient and consumer demand for such services.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

MEDICAID EXPANSION

Question. During your testimony in front of the Senate HELP Committee last week, you told Senator Murkowski that Medicaid is an absolutely imperative program. You also said, in a response to one of Senator Young's question, that Medicaid is a program where "the States know best how to care for their Medicaid population."

I agree that every State's role in the Medicaid program is significant, which is why I want to protect State flexibility when it comes to this program. Thirty-one States—including my home State of Ohio—have made the decision to expand Medicaid coverage under the Affordable Care Act (ACA).

Ohio's Governor John Kasich, in a letter to Senator Hatch just last week, wrote "we strongly recommend that States be granted the flexibility to retain the adult Medicaid coverage expansion and Federal matching percentage."

Governor Kasich's letter also said that those States that have opted to expand Medicaid are experiencing significant positive results. In Ohio, high-cost ER utilization has gone down, health status has improved, and most enrollees have found it easier to keep or find work. Further, thanks to ACA's Medicaid expansion, Ohio was able to extend coverage to 700,000 previously uninsured Ohioans.

Do you support the flexibility provided to States under the ACA to expand Medicaid?

Answer. State flexibility is an important component in making Medicaid more workable for patients. Every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and Medicaid expansion. That is one of the reasons I devoted so much time to working to help identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States.

Question. As a cabinet-level advisor to the President, how will you advise the President on any bill that would limit a State's flexibility to expand Medicaid—like Ohio did—as provided for under the ACA?

Answer. I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. Furthermore, I am committed to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fit the needs of their States.

Question. As part of the Medicaid program in Ohio, Governor Kasich has led efforts to engage providers, payers, community organizations, and employers and encourage them to work with the Medicaid population and provide a ladder out of poverty. As a result, more than 70% of the expansion population in Ohio reports that, since getting covered, it has been easier for them to keep or find a job.

One program in particular, CareSource's Life Services pilot program provides supports and mentoring to help individuals achieve physical and behavioral health and economic stability. The CareSource Life Services program could serve as a national model for lifting individuals out of poverty.

As Secretary of Health and Human Services, how will you work to support and expand funding for programs like Life Services?

Answer. I understand that some enrollees in CareSource's Medicaid managed care product have access to a program called Life Services which provides services and supports to help the enrollees obtain and keep jobs. Although I understand this Life Services program is a benefit of the managed care plan and not part of an Ohio Medicaid 1115 waiver demonstration, I would be interested to explore with you and others how such programs might be integrated or associated with a Medicaid waiver. This kind of development shows why waivers are an important tool for States

to innovate within the Medicaid program, as they have for many years prior to the ACA becoming law.

MEDICARE NEGOTIATIONS/DRUG PRICES

Question. Last week when you testified in front of the HELP Committee, you were also asked how we should address the high cost of prescription drugs.

You avoided answering questions from many of my colleagues by saying that, as Secretary of HHS, your job will be to “administer” programs and not “legislate.”

President Trump supports the elimination of the noninterference clause in Medicare Part D. He would like to have the Centers for Medicare and Medicaid Services (CMS) negotiate directly with drug manufacturers to get the best deals on prescription drugs for our Nation’s seniors.

If Congress passes legislation supported by the President that gives the Secretary of HHS the authority to negotiate and this legislation is signed into law—would you use this administrative authority to negotiate better prices on behalf of the more than 40 million Part D beneficiaries?

What are your ideas on effective ways to reduce out-of-pocket prescription drug costs for Medicare beneficiaries?

Answer. We all share concern when prescription drug prices are too high for anyone to access the drugs they need. This especially concerns me as a doctor. If confirmed, I look forward to using tools Congress provides to lower health-care costs. In addition, we need to continue to build on the gains towards affordability allowed by the Generic Drug User Fee Act and find additional ways to facilitate more efficient generic entry. This starts with making sure that we are giving generic sponsors clear guidance so that they can prepare approvable applications on the first try. If I’m confirmed, I’m committed to working with the FDA (and Congress, if appropriate) to find additional efficiencies and administrative steps that can help facilitate appropriate generic entry.

FAIR PAY/HOME-CARE WORKERS

Question. The majority of the home-care workforce—or those individuals who provide services to older Americans and individuals with disabilities who receive home- and community-based services through Medicaid—is made up of female workers.

This workforce is primarily paid through Medicaid and, on average, States pay these workers an average of just \$13,000 a year. This means that those women caring for the disabled and elderly are often forced to rely on Medicaid themselves.

In order to provide the highest level of quality care to our most vulnerable Americans—the elderly and those with disabilities—do you agree that those home-care workers providing this care full time should be paid more than \$13,000 a year by their State Medicaid program—“yes” or “no”?

Answer. I agree it is important to provide those who care for our most vulnerable total compensation that reflects the important work they do. In many cases, this compensation may include more than wages and could, depending, *e.g.*, on housing prices, be significantly more than the number given.

Question. Past leadership at CMS committed in writing to exploring Federal actions under its current authority that could work with States to strengthen and support home-care workers. In a meeting with Finance Committee Staff last week, you expressed an interest in building off of the work of the prior administration.

Will you commit to continuing this work to ensure fair pay and advancement opportunities for the home-care workforce. Describe how you would go about achieving this goal.

Answer. If confirmed, I would be pleased to work with you to explore such options. One potential issue is to ensure that such workers are not somehow considered State employees and therefore subject to unique requirements and diversions from income that relate to that labor workforce. Another longer term situation is to empower patients, as the ultimate recipient of these services to make choices regarding providers of these services that leads to a competitive market for higher performing workers who satisfy customers.

INFANT MORTALITY/TOBACCO

Question. Ohio has one of the highest infant mortality rates in the country. In 2015, our State ranked 42nd in the Nation for infant mortality, and even worse for African American babies.

We don't know exactly why Ohio does so poorly when it comes to infant mortality, but one thing that we do know is that health complications caused by preterm births are the leading causes of infant mortality. We also know that a major factor in premature births is tobacco use, and Ohio's smoking rate among pregnant women is nearly twice the national rate.

In addition to providing coverage to an additional 20 million Americans, the Affordable Care Act also strengthened Medicaid coverage of services that help tobacco users to quit. Local groups have taken advantage of these provisions in their fight against infant mortality.

Medicaid covers nearly 50 percent of births in this country. Do you support the current requirement that State Medicaid programs provide pregnant women with effective tobacco cessation services without cost sharing?

Answer. The science is pretty clear that tobacco use during pregnancy is risky for both moms and babies. States should have maximum flexibility to prioritize critical health risks such as smoking during pregnancy. When it comes to Medicaid requirements, I hope to return a lot of control to States, and if confirmed, I will be reviewing such requirements and their efforts in order to develop policy recommendations for reform.

Question. How will you work with Congress to maintain this requirement so that all pregnant women—regardless of their income—has access to tobacco cessation services?

Answer. The science is pretty clear that tobacco use during pregnancy is risky for both moms and babies. Availability of cessation programs is important. I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. Regardless, I commit to work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fits the needs of their States.

INFANT MORTALITY

Question. As I mentioned in the hearing and in my question above, the infant mortality rate among African American infants in the State of Ohio is among the worst in the United States. The overall rate of infant mortality in Ohio is 42nd in the Nation. I have introduced legislation to improve prevention efforts nationwide by improving Federal reporting of infant and childhood deaths, putting the power in the hands of the Secretary of HHS to generate the metrics by which these incidences are reported.

As Secretary of HHS, how would you work to ensure adequate funding for the issue of infant mortality, and which metrics and protocols would you use to improve reporting of infant mortality cases across the country?

Answer. Infant mortality is a serious concern for our Nation. While many of the underlying factors that contribute to infant mortality are poorly understood, we know that certain health behaviors, including alcohol consumption and tobacco use during pregnancy, have contributed to higher rates of infant mortality in the United States. Access to prenatal care is also vitally important.

If confirmed as Secretary of HHS, I would work to examine the range of HHS programs, including research to prevent infant mortality, programs to prevent child abuse and neglect, efforts to increase access to health services for low-income pregnant women and infants, childhood vaccination initiatives, home visitation programs, and other initiatives across the Department to ensure these resources are used more effectively to address this issue and, if necessary, seek additional funds.

Regarding metrics used to report infant mortality, I agree that measurement is extremely important as we tackle this problem. I intend to work with the Congress and within the Department to bring more consistency and accuracy to how we measure infant mortality.

Question. As you know, community pharmacies serve on the front lines as health-care providers and play an integral role as part of the Medicare Part D benefit. In recent years, however, pharmacies have faced increasing uncertainty in their ability to serve Medicare beneficiaries due to the increasing use of post-claim adjudication price concessions and fees imposed by pharmacy benefit managers, called Direct and Indirect Remuneration (DIR) fees.

CMS has recognized issues with how DIR fees are reported by part D plan sponsors, how these fees impact pharmacy business, and the resulting challenges they create for Part D beneficiaries. To respond to these issues, CMS proposed guidance (*Proposed Guidance on Direct and Indirect Remuneration and Pharmacy Price Concessions*) to standardize the timing of how these fees are reported on September 29, 2014. This proposed guidance would help pharmacists better serve Part D beneficiaries by providing greater clarity about their reimbursement when medications are dispensed and would benefit beneficiaries in that they would be able to make more accurate comparisons in plan selections.

Will you commit to supporting the finalization of such guidance? Are there other things you would do to ensure pharmacies have the information they need—in real time—to best serve their beneficiaries? If so, what are they?

Answer. If confirmed, I will look forward to working with you to consider how to resolve this pending guidance issue. Incidentally, I understand that on January 19, 2017, CMS released a fact sheet with information about recent trends in drug costs and Direct and Indirect Remuneration (DIR) under Medicare Part D.

EPSDT

Question. Identifying and treating conditions early in life—during childhood—before they become expensive long-term liabilities, is not only the right thing to do, but also cost effective. In 1967, Congress added a guaranteed benefit for children in the Medicaid program called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

To this day, EPSDT continues to guarantee that children in the Medicaid program are appropriately screened and given the necessary treatments they need to thrive. If Medicaid were turned into a block grant—and existing Federal standards were cut back—EPSDT would be at serious risk, and child health would be put in jeopardy.

Are you committed to maintaining EPSDT as a guaranteed benefit for children in the Medicaid program?

Answer. Children are, and will continue to be, a high-priority population within the Medicaid program. States are well-positioned to determine the most appropriate ways to ensure access to the highest quality care for children, which includes diagnosis and screening procedures and the illnesses and conditions they uncover.

Question. What are the most important metrics in evaluating the success of the EPSDT program?

Answer. From a clinical perspective, successful diagnosis and screening procedures are determined by how well they identify illnesses and conditions. Successful treatment of those illnesses and conditions is best evaluated by the extent to which the patient's care goals are achieved.

Question. If confirmed, how will you use your authority to make sure EPSDT remains an effective program in ensuring children's health through Medicaid?

Answer. I look forward to working with States interested to advance initiatives designed to improve the quality of care provided to all Medicaid members, especially children.

Question. Through the creation of the EPSDT benefit, Medicaid solidified dental services as a necessary component of coverage for low-income children and adolescents. Similarly, Congress recognized the need to include dental coverage as a requirement in the second iteration of the Children's Health Insurance Program (CHIP). The ACA then built on these two programs, and now pediatric dental coverage and preventive oral health services are included in many private insurance packages. Despite these advances, tooth decay remains the most common chronic condition among children.

How would you ensure that any major health reform efforts appropriately prioritize children's oral health, both in terms of benefits and affordability?

Answer. If confirmed as Secretary, I would hope to work with you to revisit the current CMS's "Oral Health Strategy" for children (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/cms-oral-health-strategy.pdf>). I would also aim to provide States with flexibility in their Medicaid programs to provide both coverage and access to these services. Lastly, there may be opportunities to encourage innovation in both the coverage and payment for these services as well as the actual technology and even the relevant public health education strategies.

MEDICAID PAYMENT PARITY

Question. On average, Medicaid pays providers about 70 percent of what a Medicare provider receives for the same service. The only difference is the age of the patient being served. There are 45 million children enrolled in Medicaid and as you noted in your hearing, and inappropriately low Medicaid payments impede the ability of providers to accept more patients—both pediatric and adult—covered through this program.

Along with Senator Murray, I have worked to introduce the Ensuring Access to Primary Care for Women and Children Act in past Congresses, legislation that would solidify parity between Medicare and Medicaid reimbursements for primary care.

In today's hearing, you mentioned that only one in three providers accepts Medicaid patients. You cannot deny that lower Medicaid reimbursements is a contributing factor to this issue.

This is a platform in which the HHS Secretary can take a stance and move legislation forward. Do you believe that a child's care should be valued at only 70 percent of that of an adult?

Answer. A child's care should not be valued at only 70 percent of that of an adult. The current Medicaid payment system is an inelegant combination of base rates set by States, supplemental payments to providers, and other Federal and State funding sources for care to the Medicaid or uninsured populations.

Question. If confirmed, how will you work to improve access to care under Medicaid by adequately and equitably reimbursing physicians that treat Medicaid patients?

Answer. I agree that adequate Medicaid reimbursement is essential to ensuring care for some of our most vulnerable citizens, and I look forward to working with Congress to accomplish this important objective.

LEAD

Question. Dr. Price, do you believe that there is no safe level of lead in children's blood?

Answer. Science should guide our conclusions in this area. If confirmed, I look forward to working with you to ensure safe environments for America's children.

Question. The CDC very recently lowered its reference level for public health intervention for elevated childhood blood lead levels from 5 to 3.5 micrograms per deciliter.

Lead is a neurotoxin, and exposure to it can have devastating lifelong consequences for children. Ohio is one of 29 States receiving funding from CDC for a State-wide lead poisoning prevention program. In 2014, almost 6,000 children under age six in Ohio, or 3.85% of those tested, had elevated blood lead levels.

If confirmed, will you keep the CDC's lowered lead reference level?

Answer. If confirmed, I pledge to work with our public health specialists at CDC and throughout the Department to learn more about the impact of lead poisoning and communicate the dangers to families and communities.

Question. At the end of 2016, CMS committed to developing and improving a targeted blood lead screening policy to ensure more children eligible for EPSDT benefits are tested. Can you commit to continuing this work and improving coordination across Federal agencies to enhance our lead screening and treatment policies and achieve better outcomes?

Answer. If confirmed, I commit work to improve coordination across Federal agencies to enhance our lead screening and treatment policies to achieve better outcomes.

Question. What additional actions would you have HHS take to reduce the number of American children with elevated blood lead levels?

Answer. If confirmed, I pledge to work with our public health specialists at CDC and throughout the Department to learn more about the impact of lead poisoning and communicate the dangers to families and communities in order to reduce the number of American children with elevated blood lead levels.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Question. As part of welfare reform, Congress restructured the Temporary Assistance for Needy Families—or TANF—program as a fixed block grant. Evidence shows that one effect of turning TANF into a block grant program has been that States are spending less and less on TANF programs and instead using these Federal dollars to support gaps in State budgets. This change has resulted in more Ohioans who struggle to support their families with earnings below the poverty level.

What does that say about other proposals to block grant programs like Medicaid? Do you think that the block grant approach should be a model for other safety net programs?

Answer. While this would ultimately be a matter for Congress to decide, I have long supported States finding their own solutions in addressing unique or complex situations in their States.

Question. In November 2015, the State of Ohio asked HHS for a TANF waiver that would have (1) removed the distinction between “core” and “non-core” hours, (2) increased the vocational education training limit from 12 to 36 months, (3) increased the job search and job readiness time limit from 6 to 12 weeks and removed the 4 consecutive week time limit, and (4) removed the 16 hour monthly cap on good cause hours credited towards work participation (while maintaining the 80 hour annual cap). HHS never acted on this request.

Given that this application has the support of Governor Kasich, if confirmed as HHS Secretary, would you grant this waiver to the State of Ohio?

Answer. In 2012, GAO responded to a congressional inquiry about an ACF Information Memorandum inviting States to apply for waivers to the TANF work requirement. GAO concluded that the Information Memorandum was a rule that must be submitted to Congress and the Comptroller General before taking effect. If confirmed as HHS Secretary, I will enquire about the status of this matter and the waiver request from the State of Ohio, and provide a response if one has not previously been sent.

MEDICARE OBSERVATION STATUS/3-DAY RULE

Question. Instead of privatizing Medicare or raising the eligibility age, we should be discussing ways to make Medicare stronger for our Nation’s seniors. One way to strengthen the program—which you brought up in today’s hearing—is to enable beneficiaries better access to skilled nursing facilities after hospital stays by revisiting the 3 day rule.

In order for Medicare Part A to cover skilled nursing facility care, a beneficiary must be admitted to a hospital for 3 days under inpatient status. I have heard from too many Ohioans whose skilled nursing facility care was not fully covered by Medicare because their hospital stays were classified as “observation” rather than inpatient.

My Improving Access to Medicare Coverage Act, which I plan to reintroduce this Congress, which would enable time beneficiaries spend in the hospital under observation to count toward the 3-day requirement for Medicare coverage.

If confirmed, will you work to administratively correct this billing technicality that adversely impacts Medicare beneficiaries? If you are unable to do so administratively, will you work with me to pass this legislation to correct the deficiency in current law?

Answer. If confirmed, I will be pleased to work with you to further consider the necessity of the 3 day rule and its pros and cons. I will endeavor to work with CMS

to identify what more can be done with regard to the observation status issue as well. And if the best path forward involves legislation, I would be pleased to work with you on that as well.

BIOSIMILARS

Question. Last year, a number of my colleagues and I sent a letter to then President-elect Trump, encouraging him to work with us on reducing prescription drug prices for all Americans. Specifically, we highlighted the need to promote innovation and foster competition in drug development.

I have introduced legislation in the past that would help achieve this by shortening the patent exclusivity period for expensive, brand-name biologic drugs and allow biosimilars to enter the market sooner. Biosimilars, which are equivalent in safety and efficacy to their reference biologics, have the capacity to reduce prescription drug costs, yet physicians must be willing to prescribe them and patients need the information necessary for them to be confident in taking them.

As a physician, do you believe physicians and patients understand what biosimilars are and how they work? Do you believe the patients and physicians see biosimilars as a safe, effective, and less-costly alternative to biologics?

What do you believe to be the FDA's role in educating patients, providers, and other stakeholders about biosimilars? How will you, as Secretary of HHS, support and encourage the robust uptake of biosimilars in the United States?

Answer. As a doctor, I appreciate your concern that health-care providers and patients be informed when making health-care decisions. It is important that the FDA provide clear and timely guidance as it carries out its responsibilities with respect to biosimilars. I understand that this is particularly important given that the number of biosimilars available to consumers is expected to increase and the potential that these products have to increase consumers' health-care options.

COST-SHARING

Question. More than 25 years ago, Congress implemented protections to ensure that Medicare beneficiaries are treated and billed fairly by their providers in response to growing concerns that patients charged more than the standard 20% Part B coinsurance were opting out of critical care due to high out-of-pocket costs. However, while you were in Congress, you backed legislation that would have weakened these protections, allowing Medicare providers to enter into private contracts with seniors and people with disabilities to determine cost sharing amounts.

Do you maintain your position that these patient protections should be undone and will you continue to advocate for permitting doctors who serve seniors to charge them more than 20% over what Medicare pays, your concern being that those limits compromise access to care for seniors?

Answer. If there are any program changes in this area, they should be voluntary for both patient and physician.

Question. Do you believe that Medicare doctors should be allowed to charge patients whatever they choose?

Answer. If there are any program changes in this area, they should be voluntary for both patient and physician.

Question. What would you say to fixed-income seniors who receive unexpected additional costs simply so that physicians can be paid more than the agreed-upon insurance coverage limit? Is this not putting patients above profits?

Answer. Our goal is to ensure all Medicare recipients are able to obtain the highest quality health care. If there are any program changes in this area, they should be voluntary for both patient and physician.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPS)

Question. The State Health Insurance Assistance Programs (SHIPS) are the only source of one-on-one Medicare counseling for seniors and people with disabilities. In 2015, over 7 million people with Medicare received help from SHIPS, including 375,000 Ohioans using the Nation's best-ranked SHIP program in the country. Since 1992, counseling services have been provided via telephone, one-on-one in-person sessions, interactive presentation events, health fairs, exhibits, and enrollment events. Individualized assistance provided by SHIPS almost tripled over the past 10 years.

This modest program is operated in every State and U.S. territory, and has been significantly under-funded for years despite the growing demand for services by our Nation's seniors and individuals with disabilities.

Will you pledge to support increased funding for SHIPs as the country's Medicare-eligible population continues to grow in the President's proposed budgets?

Answer. If confirmed, I will fairly consider the needs and work of the SHIPs in light of a growing Medicare population, as well as consider other ways to support them to make them even more efficient. SHIPs and others like them play an important role in making sure patients are actual health-care consumers. This is a virtuous cycle because it facilitates putting the patient at the center of both health care and health-care coverage decision-making.

DRUG PRICING

Question. In December, President Trump told *Time* magazine, "I'm going to bring down drug prices. I don't like what has happened with drug prices."

Do you agree with President Trump? If confirmed as Secretary of HHS, will you work to bring down drug prices?

Answer. Yes. We all share concern when prescription drug prices are too high for anyone to access the drugs they need. This especially concerns me as a doctor. If confirmed, I will ensure that CMS looks for ways to ensure that it uses the authorities and tools it has at its disposal to ensure drug prices in the Medicare program, in both part B and part D, are manageable for beneficiaries.

Question. Given the significant burden prescription price tags have on individuals and taxpayers, what do you see as the best market-based solution to combat prescription drug price gouging?

Answer. In addition, we need to continue to build on the gains towards affordability allowed by the Generic Drug User Fee Act and find additional ways to facilitate more efficient generic entry. This starts with making sure that we are giving generic sponsors clear guidance so that they can prepare approvable applications on the first try. If I'm confirmed, I'm committed to working with the FDA (and Congress, if appropriate) to find additional efficiencies and administrative steps that can help facilitate appropriate generic entry.

Question. Do you believe that Americans deserve more information about when and how prescription drug prices rise so that they can make the most informed decisions for their families?

Answer. Yes. I support empowering patients by putting more information in their hands so they can make health care consumer choices that make sense for them and their families.

OFFICE OF REFUGEE RESETTLEMENT

Question. The Secretary of HHS responsible for overseeing the Office of Refugee Resettlement at HHS. This office is in charge of providing for the basic needs of refugees when they first arrive in the United States, including victims of human trafficking, torture survivors, individuals who are granted asylum, and those who are resettled here after helping our troops abroad because it is no longer safe for them in their home country.

If confirmed, what will you do to ensure these necessary services are provided despite a significant lack of funding for this program? What are your plans for this office?

Answer. The law is clear when it comes to administering services for refugees, survivors of torture, and other populations who receive assistance through ORR. If I am confirmed, I will work to effectively and efficiently administer this Office.

Question. Will you advocate for additional resources for this office, given the current refugee crisis across the globe?

Answer. Should circumstances on the ground change, and current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

Question. How will you work with our partners around the globe to ensure a safe and smooth transition for refugees coming into the United States?

Answer. Should I be confirmed, it would be my expectation to work with the U.S. Department of State, as well as our partners around the globe, to ensure a safe and smooth transition for refugees coming into the United States.

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI)

Question. You've stated that you support innovation and see potential in CMMI. Would you support continued testing through CMMI in its current form?

Answer. CMMI is a program providing significant opportunity for testing new models for health-care financing and delivery. I defer to the Congress regarding the funding of the Innovation Center and any ACA repeal and replacement legislation. If confirmed, as HHS Secretary—and if the Innovation Center remains funded—I will ask CMS to pursue models that will lower health-care costs and improve quality for Medicare and Medicaid beneficiaries.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Question. Many hospitals, physicians, nursing facilities, and others have invested significant resources to participate in ACOs and bundled payment systems. Ohio is home to some of the largest ACOs, by membership, in the Nation.

How would you respond to the concerns of ACO administrators and providers that there may be delays or disruptions in their innovative models due to a repeal of the ACA?

Answer. If confirmed, I am committed to working with all providing health care to incentivize innovative models for care financing and delivery.

Question. Do you support the continued implementation of the current voluntary models—ACOs and bundled payment models?

Answer. In general, yes. I look forward to reviewing all models, if confirmed. As a physician, I appreciate the goal behind the creation of the ACO model: better patient care. As a legislator, I would agree their successes have been modest to date, and there are some challenges they face as well. ACOs are a tool in the toolbox to help ensure high quality, low cost health care for beneficiaries. They are not a silver bullet to all of our country's delivery system challenges. If confirmed, I plan to work with the CMS Administrator to ensure that we learn from ACOs' successes and challenges to date as we chart the path forward.

For certain populations, bundled payments make a lot of sense. And they can often lead to both better health outcomes and reduced costs. But it is important we not get fixated on one of those two outcomes. That is, I support making certain that we deliver care in a cost-effective manner but we absolutely must not do things that harm the quality of care being provided to patients.

What we ought to do is allow for all sorts of innovation. Not just in this area. There are things that haven't been thought up yet that would actually improve health-care delivery in our country and we ought to be incentivizing that kind of innovation. And in finding our way to those innovations, we ought to remember we are not talking about science experiments in a lab or a computer simulation, but about experiments involving real patients' lives.

PAMA IMPLEMENTATION

Question. In 2014, Congress passed the Protecting Access to Medicare Act (PAMA), which included a provision to change the way labs are reimbursed under the Medicare program by moving away from the Clinical Laboratory Fee Schedule (CLFS) and toward a more market-based payment methodology.

We are concerned that CMS's regulations implementing this provision, finalized in June 2016, contain a reporting deadline that is difficult for the laboratory community to meet. In addition, many of our community-based and regional laboratory constituents serving the Medicare program have expressed significant concerns over requirements from the regulation that make reporting accurate data a concern, and requirements from the regulation that result in the exclusion of market data from the hospital outreach laboratory community. Lastly, we have concerns over CMS's definition of an "applicable lab" in the final regulation. We believe the current definition would result in very few labs having to report their data.

The Office of the Inspector General has also raised each of these issues—the timeline, accuracy, exclusion of hospital labs, and lack of required reporting—as potential flaws in the regulation in their September 2016 report, which addressed

PAMA implementation. In fact, the OIG reported that only 5% of labs will be required to report payer data, excluding 95% of the market and thereby potentially skewing the market rates.

In order to fulfill the goals of PAMA, it is critical that the market data collected and assessed by CMS represents the entire laboratory market, consistent with the statute, to ensure both equitable and successful implementation of the law. Understanding that this regulation is on a short time-line, given that CMS is set to finalize a new fee schedule in 2017 for implementation in 2018, what would you do to address the concerns listed above and ensure the new market-based payment methodology and payment processes for clinical laboratory tests are not unduly burdensome on community-based labs or potentially detrimental to patient access?

Answer. I appreciate your concerns regarding the implementation of PAMA. Certainly, we should strive for accuracy in this market data collection process. I look forward to following up with CMS staff and agree that community-based labs should not be unduly burdened and thus limiting patient access.

Question. Will you commit to revisiting the definition of “applicable lab” to ensure equitable and successful implementation of the law, accurately reflecting the entire market?

Answer. As you know, section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) added section 1834A to the Social Security Act (the Act), which requires revisions to the payment methodology for clinical diagnostic laboratory tests paid under Medicare, including reporting requirements for laboratories.

CMS finalized a low expenditure threshold to reduce the reporting burden on small laboratories. Under the final rule, CMS will generally exclude a laboratory from being an applicable laboratory, and thus from having its private payor data reported, if it is paid less than \$12,500 under the CLFS during a data collection period. CMS expects that 95 percent of physician office laboratories and 55 percent of independent laboratories will not be required to report. Additionally, I understand CMS-imposed reporting requirements at the TIN level will be less administratively burdensome for the laboratory industry as compared to requiring data to be reported at the NPI level.

MEDICAID AND FAMILY PLANNING SERVICES

Question. Two-thirds of births from unintended pregnancies in the United States are paid for by Medicaid or the Children’s Health Insurance Program (CHIP). In 2010, these unintended pregnancies cost a total of \$21 billion dollars, including \$824 million in Ohio.

We know that publicly funded family planning allows families to prevent unwanted pregnancies, and it is estimated that investing in family planning services would have saved public funding of unintended pregnancies by a total of \$15 billion, including \$607 million for Ohio. That’s striking—almost 75 percent of the money that would otherwise be spent could be saved through more robust, fully funded family planning programs.

Do you acknowledge the effectiveness of investing in contraception and the need to continue the Medicaid State option to expand family planning services?

Answer. If confirmed, I would work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue approaches that fit the needs of their States. That being said, I would be hesitant to develop policy on the basis of financial cost of life.

Question. How will ensure that family planning services, included access to preferred contraception methods, will remain available to all women, as you committed to do in today’s hearing?

Answer. Women should have the health care that they need and want. The system we ought to have in place is one that equips women and men to obtain the health care that they need at an affordable price. As we work towards a replacement for the ACA, I expect this will be one of the topics of discussion.

FEDERAL RESEARCH

Question. As chairman of the House Budget Committee, you stated in your FY17 Budget Resolution that “the Federal Government has a role to play in supporting breakthrough research.” As a medical doctor, you must understand the importance

not only of funding research to find better cures for your patients, but also of funding the training of the next generation of doctors and researchers.

If confirmed, how do you pledge to protect and advocate for the government's critical Federal research initiatives?

Answer. As a physician, I am keenly aware of the progress that has been made and still to be made through important research initiatives that are fully or partially funded by the Federal Government. Implementing the recently passed 21st Century Cures Act will be a priority in coming months and years, including leveraging the significantly increased funding for the NIH. NIH plays a leading role in so many public-private initiatives, and if confirmed, I look forward to working with leaders at the NIH to advance their important mission and our administration's efforts to promote innovation on behalf of the American people.

SYRINGE EXCHANGE PROGRAMS

Question. Like many communities in Ohio, your district in Georgia has been hit by a significant increase, a 4,000 percent increase, in opioid-related deaths in the last 5 years. Simultaneously, we are also seeing an increase in hepatitis C infections and HIV infections among those who inject opioids and share syringes. One of the clearest examples of this connection is the HIV outbreak in Scott County, Indiana, the home State of Vice President Pence. In response to this crisis, then-Governor Pence declared a public health emergency and changed Indiana's policy to allow State dollars to support Syringe Exchange Programs or SEPs.

The Centers for Disease Control and Prevention (CDC), Institute of Medicine, and many other scientific bodies have stated unequivocally that SEPs are highly effective in stopping the spread of HIV/AIDS and Hepatitis C. Cleveland has one of the longest standing SEPs, and as a result has seen a decrease in the rate of new HIV infections as a result of intravenous drug use. In response to progress like this, Congress partially lifted the restrictions related to the use of Federal funds for SEPs in 2015. In fact, I note that your wife, who serves in the Georgia House of Representatives, has also worked to expand access to needle exchange programs.

In the past, you have voted against funding for needle exchange programs. Has your position changed?

Answer. As I mentioned in the hearing, I recognize that the opioid epidemic is real and that substance abuse disorders are plaguing many Americans. It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. I have a broad and open mind and welcome proposals to our Nation's mental health and substance-abuse related crises, particularly those solutions that are evidence-based. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President.

Question. Do you support continued availability of Federal funds for SEPs, based on local public health department determination of need? Why did you oppose it in the past?

Answer. The opioid epidemic is real and substance abuse disorders are a serious concern for communities across the country. It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. I recognize that we may not always agree on the solutions, but we have a duty to those who are suffering to work together to find the best answers to these severe problems. I welcome proposals to our Nation's mental health and substance-abuse related crises, especially those that are well supported by evidence. Funding decisions ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the HHS Secretary, I will follow the policies adopted by the Congress and signed into law by the President.

Question. If confirmed as Secretary of HHS, how will you work with States to ensure they have the resources and support necessary to continue and open new SEPs?

Answer. It is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. All levels of government need to engage and collaborate to identify effective solutions to these problems.

ANTIBIOTIC RESISTANCE

Question. The emergence of this superbug is extremely serious and illustrates both how quickly infectious pathogens can spread across the world and the need for international cooperation in detecting newly emerging health threats.

Do you agree that a dedicated effort to improving surveillance, data collection and research efforts is needed to prevent such rapid spread and evolution of antibiotic resistant bacteria?

Will you advise President Trump to continue President Obama's National Strategy for Combating Antibiotic-Resistant Bacteria (CARB initiative)?

How will you ensure that the threat of antimicrobial resistance remains a high priority for HHS and its affiliates the National Institutes of Health (NIH), Food and Drug Administration (FDA), and CDC? In your opinion, how should the United States work with other nations to combat these threats?

Answer. I share your concern regarding the need to take seriously the public health threat posed by antibiotic resistance. I appreciate the important role HHS can play in combatting this public health threat, from identifying resistance and educating the American people about it, to helping to advance innovative, new therapies to treat emerging infections. If confirmed, I look forward to continuing to work in this area as part of HHS' public health mission.

POWDERED CAFFEINE

Question. In 2014, Logan Stiner—who was a senior at Keystone High School in LaGrange, OH—died just 3 days before his high school graduation from ingesting too much powdered caffeine. For the last several years, I have worked with Logan's family to raise awareness about the dangers of powdered caffeine and encourage the FDA to take meaningful action to limit access to powdered caffeine.

Right now, children and teenagers can buy this potentially deadly chemical in bulk from domestic and international retailers by simply going online and clicking a button—without their parents even knowing about it. Further, companies are trying to find creative new ways to reach consumers and to dodge States like Ohio that have already passed laws cracking down on this dangerous substance.

The FDA advises consumers against using powdered caffeine and has called upon manufacturers to more accurately label these products. But these actions by the FDA do not go far enough. As Secretary of HHS, which has jurisdiction over FDA, how will you ensure that the Department's affiliates, particularly the FDA, are effectively educating and protecting consumers about the products available to them?

Answer. FDA plays a valuable role in providing the American public with timely information about FDA regulated products. I appreciate the importance of FDA informing individuals and families about whether or how to use these products. If confirmed, I will ensure that FDA is fulfilling its statutory responsibilities consistent with its public health mission.

MEDICARE ADVANTAGE STAR RATINGS PROGRAM

Question. As you know, CMS uses a star rating system to display the quality of Medicare Advantage plans. High performing plans receive quality bonus payments. CMS also has an audit and appeals process by which to periodically evaluate plans on specific measurements.

Over the past several years, there have been several circumstances we are aware of where plans are penalized in their star-ratings based on deficiencies found in an audit. We have heard from a plan based in our home State of Ohio that was penalized by the interaction between the audit and appeals policies and the star-ratings program.

If you are confirmed, can you commit to taking a deeper look at the interaction of these two policies and the potentially negative effect on plans, on beneficiaries, and on innovative care delivery?

Answer. Yes. If confirmed, I would be pleased to work with your office and CMS to ensure that the Medicare Advantage stars system reflects quality and the Medicare Advantage sanctions system reflects program audit performance, as well as explore whether and how these policies can be made to work in concert rather than against each other.

CANCER MOONSHOT

Question. During last year's State of the Union address, President Obama announced the Cancer Moonshot initiative, an ambitious project aimed at improving cancer prevention, diagnosis, and treatment at twice the rate of current progress of clinical cancer research. The 21st Century Cures Act re-committed to this critical initiative through the inclusion of funding for the next 5 years of the program.

Academic and clinical centers in Ohio are playing important roles in the execution of this initiative, through partnerships like that that exists between The Ohio State University's Comprehensive Cancer Center and Columbus's Richard J. Solove Research Institute with Tampa's Moffitt Cancer Center to form the ORIEN partnership. This initiative is particularly focused on inclusion and retention of minorities in cancer-specific clinical trials, an important diversity metric to improve clinical care for all Americans.

As Secretary of HHS, how will you work to facilitate collaborations between researchers and clinicians to improve cancer care under the goals outlined by the Cancer Moonshot?

Answer. If confirmed, we will make treating and helping to cure cancer a priority and there likely will be overlap with the Cancer Moonshot goals. Implementing the recently passed 21st Century Cures Act will be a priority in coming months and the administration will accelerate efforts to promote innovation in many areas—including the prevention, diagnosis and treatment of cancer.

TUBERCULOSIS

Question. Globally, tuberculosis is now killing more people than HIV/AIDS, with a death toll of nearly 5,000 per day. In 2015, the United States experienced the first national increase in TB cases since 1992, with 9,557 total cases. And in 2013, CDC identified drug resistant TB as a serious public health threat.

CDC provides critically important support to local health departments to address the TB epidemic, and it supports crucial TB research. CDC also provides crucial support to the global fight against drug resistant TB.

Despite these sobering statistics and impressive work done by the CDC, funding for CDC's domestic TB program has remained stagnant since FY 2005 at \$135 million. As a result, the CDC has stated that are our national response to TB "has stalled."

If confirmed, will you implement the U.S. National Action Plan for Combating Multi-Drug Resistant Tuberculosis, and will you support increased Federal funding for the U.S. response to this deadly, airborne infectious disease?

Better TB drugs and diagnostics are being developed, thanks to U.S. ingenuity, and these new tools can help us stop this epidemic. What will you do, if confirmed as Secretary of HHS, to advance these drugs and diagnostics and provide support to the communities working to develop new treatments?

Answer. As a physician, I recognize and share your concern regarding the public health threat posed by tuberculosis, particularly drug resistant tuberculosis. If confirmed, I look forward to working with CDC officials in their efforts to combat the spread of tuberculosis.

LOW-INCOME HEATING ASSISTANCE PROGRAM (LIHEAP)

Question. As you may know, the LIHEAP program plays a key role in helping low-income families stay warm in the winter and avoid dangerous heat in the summer. It is a program that is critical to nearly 450,000 households in Ohio that otherwise would be forced to choose between keeping warm or going hungry.

If confirmed, will you commit to maintaining the program as currently structured?

Answer. If I am confirmed, I will implement the program dutifully in as effective and efficient manner as possible.

Question. Nationwide, nearly 7 million of our Nation's poorest and most vulnerable households rely on the program. Will you commit to maintaining and possibly even supporting an increase in the program's annual appropriation?

Answer. If I am confirmed, I will implement the program dutifully in as effective and efficient manner as possible. Should circumstances on the ground change, and

current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

NUCLEAR MEDICINE

Question. Diagnostic nuclear medicine procedures help millions of Medicare beneficiaries detect life altering illnesses, such as heart disease and cancer, each year. The quick turnaround on nuclear testing, when used appropriately, helps improve the quality and efficiency of care by helping to reduce inappropriate or unnecessary procedures. Despite these positives, CMS continues to treat the diagnostic radio-pharmaceutical drugs used in nuclear medicine procedures as supplies—not drugs—and, as a result, they are not appropriately reimbursed under this system.

Physician and industry groups have been working for years to try to address this issue. If confirmed, will you work with stakeholders to develop superior payment models to these drugs and nuclear medicine procedures are appropriately reimbursed?

Answer. I share your concerns and look forward to working with you, if confirmed.

THERAPY CAPS

Question. As you know, the therapy cap exceptions process expires in less than a year—on December 31, 2017. We have all heard from constituents whose therapy needs exceeded the cap and their conditions have deteriorated, necessitating more expensive medical intervention.

As Secretary of HHS, how will you support the repeal of these arbitrary and discriminatory limits and maintain access to rehabilitation therapy that Medicare beneficiaries clearly need?

Answer. Rehabilitative therapy is a vital component of recovery for many patients. Arbitrary limits on its use are not a wise decision for patient-centered care. If confirmed as Secretary, I will look into this issue and seek to understand the competing objectives and issues motivating the current CMS policy. Part of the frustration with the current health care system is rules like this that do not make sense to many people. However, that is not surprising when one considers that Medicare Parts A, B, C, and D have each developed in silos and that even payment for particular types of services sometimes reflect silos within the silos. It may be that other approaches to therapy provide greater quality care at reduced cost with more respect for the individual needs of each patient in consultation with their doctor. If confirmed as Secretary, I would hope to break down these silos and encourage approaches based on a broader perspective.

Question. Given the problems associated with monitoring the therapy cap, is CMS capable of achieving a timely uniform and defensible streamlined, responsive, and transparent process for manual medical review of Medicare records by Medicare administrative contractors?

Answer. We will strive to do so. Any time there is manual review of anything in an organization with the scale of Medicare, it is a recipe for something to go wrong. If confirmed as Secretary, I would be pleased to work with you to confirm whether the staffing and other resources needed would be up to the challenge you describe.

ADDICTION TREATMENT

Question. If confirmed as Secretary of HHS, how will you prioritize the prevention, treatment, and recovery from mental and substance use disorders in States like Ohio?

As our country continues to explore potential reforms to our health care delivery systems, what will you do to prioritize access to behavioral health services?

Answer. Mental and substance abuse disorders continue to be a serious challenge felt in communities across the Nation. I firmly believe, that it is absolutely vital that substance abuse disorders and other mental health problems are treated. If confirmed, I will work closely with you and the other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration fulfills its duty of treating those who are in addiction recovery while working to prevent people from becoming addicted in the first instance.

PHARMACISTS

Question. The Pharmacy and Medically Underserved Areas Enhancement Act recognizes pharmacists as health-care providers in underserved areas in order to expand access to care. In areas with a shortage of primary care providers, pharmacists may play a key role in helping patients manage their diseases to avoid Emergency Department visits and hospitalizations. These services are especially important for patients with multiple chronic conditions who may be taking several medications at a time.

If confirmed as HHS Secretary, would you support this approach as a way to increase care in rural and underserved areas?

Answer. We ought to step back and say, "What are we doing wrong?" as one out of every eight physicians no longer sees Medicare patients. Therefore, if confirmed as Secretary, I would be open to all options to address the impact of the ongoing physician shortage in rural areas. Paying pharmacists in underserved areas to engage in certain medical services could work well in those States where pharmacists have such licensure and a setting appropriate to the services, where primary care doctors continue to be involved in care, and where there is a patient and consumer demand for such services.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

MEDICAID AND CHIP

Question. You have proposed eliminating the Patient Protection and Affordable Care Act, an action that would end the expansion of Medicaid to millions of people and would result in an additional \$1.1 trillion being cut from State budgets. This action would throw millions of people into the realm of the uninsured, including hundreds of thousands with disabilities. They would no longer have access to such services and treatments as behavior health care, mental health treatment, and preventative services. The services provided by Medicaid expansion have greatly improved the quality of life for millions of citizens, particularly those with disabilities.

Do you propose those individuals return to being uninsured? Do you propose that their health care, including mental health treatments, be discontinued? Does your plan mean you support returning hundreds of thousands of people with disabilities into the category of the uninsured?

Answer. Our goal is to ensure access to affordable, quality health care for all citizens.

Question. If your plan is implemented, many people who will lose Medicaid coverage will be people with disabilities who depend on Medicaid for services that are unavailable through private insurance; services such as personal care services, respite care, or intensive mental health services. These health, personal care, and preventative services allow individuals to live in the neighborhoods of their choice, be independent, work, and participate in their communities. Many of these people, capable, able people, will be forced into institutions if they lose access to these crucial services. They will lose their independence and we will pay more tax dollars for their care.

How is this a good outcome for these people and for America?

Answer. Changes to the ACA should not be done in isolation. Our goal is to ensure access to affordable, quality healthcare for all citizens. This, of course, includes people with disabilities who depend on Medicaid. I note that community integration, beneficiary autonomy in decision making, and person-centered planning are central tenets articulated in CMS' approach to Home and Community Based Services and the HCBS Settings Rule with a compliance date in March 2019, and I support each of those principles. It is also important to note that many residential, disability-specific settings have long provided a safe and integrated community alternative to institutional placement for individuals with disabilities, and appropriate weight should be given to the preferences of families and individuals with disabilities because they are in the best position to decide what type of setting best meets their individualized needs and circumstances.

Question. Federal flexibility in Medicaid has allowed Pennsylvania to take extra steps to ensure that children with extensive health care needs have access to Medicaid, in what's referred to as Family of One program. This program, in addition to

the Medicaid expansion for parents, has improved the economic security of families in Pennsylvania. The State's budget relies on the Federal share in order to support these Medicaid programs. However, the budget you authored in the House last year would have cut Medicaid funding by \$1 trillion dollars, about one-third over a 10-year period.

Given that half of Medicaid enrollees in this country are children, how will you ensure that children and families aren't harmed by cuts in Medicaid funding through block grants?

Answer. Changes to the ACA should not be done in isolation. Our goal is to ensure access to affordable, quality health care for all citizens.

Question. As a physician you know that Medicaid covers a broad range of services to address the diverse needs of the populations it serves. In addition to covering the services required by Federal Medicaid law, many States elect to cover optional services such as prescription drugs, physical therapy, eyeglasses, and dental care. Coverage for Medicaid expansion adults contains the ACA's ten "essential health benefits," which include preventive services and expanded mental health and substance use treatment services. Medicaid provides comprehensive benefits for children, known as "EPSDT," that are considered a model of developmental pediatric coverage. EPSDT is especially important for children with disabilities because private insurance, which is designed for a generally healthy population, is often inadequate to their needs.

Unlike commercial health insurance and Medicare, Medicaid also covers long-term care, including both nursing home care and many home and community-based long-term services and supports. More than half of all Medicaid spending for long-term care is now for services provided in the home or community that enable seniors and people with disabilities to live independently rather than in institutions. Given that both EPSDT for kids and long term services and supports are not generally covered in commercial health plans, I fail to see how people will not be worse off if the structure or financing of the Medicaid program is restructured in the ways that you and other administration officials have suggested.

Can you guarantee that under a block grant, per capita cap and/or an HSA structure that all of these vital services will be covered for the millions of Americans who count on them?

Answer. My work in the Congress has been to improve Medicaid and provide additional flexibility. If I have the privilege of being confirmed as Secretary I would look forward to the opportunity to work with States and Congress using the tools and authorities given by Congress in legislation to ensure the highest number of people get access to the highest quality care.

Question. Forty percent of Pennsylvanian children rely on Medicaid and CHIP, which serves our State's most vulnerable children: children living in or near poverty; infants, toddlers and preschoolers during key developmental years; children with special health-care needs; and children who have been placed in foster care due to neglect or abuse. Medicaid's comprehensive, pediatrician-recommended services under EPSDT—Early and Periodic Screening, Diagnostic and Treatment services—are critical for their health and to ensure that they hit key development milestones. In recent years, there is clear evidence of the long-term return on investments in Medicaid. Children enrolled in Medicaid are healthier as adults and more likely to graduate from high school, attend college, resulting in greater economic success.

Do you support the EPSDT benefit package for children which ensures that America's most vulnerable children receive the services they need to thrive? Are you willing to protect these benefits by not allowing States to waive this important benefit?

Answer. Every State has different demographic, budgetary, and policy concerns that shape their approach to Medicaid and Medicaid expansion. That is one of the reasons I devoted so much time to working with States to help them to identify creative solutions, and why I believe a one-size-fits-all approach is not workable for a country as diverse as the United States. If I am confirmed, I will work with CMS as they take a look at waivers that are pending and appropriate for my input and will have to make a decision at that point.

Question. Your 2016 budget proposal would have block granted Medicaid and would have eliminated many critical patient protections. With our current Medicaid structure, children have a right to the full array of services they need, from critical health screenings for cancer treatment to services for children with autism or mental health needs. For many children, this coverage can be the difference between life

and death. Medicaid as currently structured also enables children with disabilities to live up to their potential, be successful in school, and have the opportunities to be full citizens.

Do you support the continuation of Medicaid's requirement to cover a comprehensive array of services for children through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program? Will you commit to ensuring that HHS will actively enforce the requirement to provide screenings, diagnosis, and treatment for children with disabilities or with potential disabilities?

Answer. Our goal is to ensure every single American has access to the coverage they want for themselves or their children and dependents. I think the conversation and focus in these topics has been the question of coverage rather than true access for too long. By that I mean that Americans might have an insurance card and yet not be able to afford care or it might not be available to them for other reasons.

Question. Many people with disabilities want to work and can do so with the services only available through Medicaid, to help them work. These services include supported employment for people with mental health disabilities or personal care attendants for those with intellectual or physical disabilities. Without these services, many people with disabilities will be unable to work.

How will you ensure that a person with a disability, mental health, intellectual, physical, sensory, or any other type of disability as defined by the Americans with Disabilities Act, has access to the services currently available through Medicaid?

Answer. I look forward to faithfully executing whatever law that Congress passes and the President signs, if I am confirmed. I commit to work as HHS Secretary to ensure that the Medicaid program is well administered, effective, and available for eligible beneficiaries and that the States/Governors are given the flexibility to pursue innovative approaches that fit the needs of their States.

Question. As economies evolve, professions change and while new types of jobs emerge, certain types of jobs are reduced or eliminated and workers must make transitions. This happens to people across the workforce, but it happens almost twice as often to workers with disabilities.

Do you support taking away people's Medicaid coverage because they lose their jobs? How will you ensure that people with disabilities who become unemployed are able to retain Medicaid benefits?

Answer. Medicaid is a vital safety-net program, and it is our goal to strengthen it. If confirmed, I look forward to faithfully executing laws to strengthen the Medicaid program that Congress passes and the President signs.

Question. In 1999, in the *Olmstead* decision, the U.S. Supreme Court agreed that individuals with significant disabilities have the right, under the Americans with Disabilities Act, to access services in the community rather than only in an institutional setting. Since the *Olmstead* decision, the U.S. Department of Health and Human Services has employed its authority over Medicaid waivers to encourage States to expand home and community-based services and to shift away from over-reliance on institutional care.

Will you continue this longstanding Federal policy? If no, why not? If yes, what steps will you take?

Answer. I support encouraging the use of home and community-based services if the services are appropriate, the individual does not oppose the treatment, and the services can be reasonably accommodated.

Question. Since the *Olmstead* decision, Congress has authorized several programs to incentivize States to meet their obligations under the *Olmstead* decision by increasing Federal dollars for providing community-based services. These programs include the Money Follows the Person program, the State Balancing Incentive Program, the Community First Choice State Plan option, and the Home and Community Based Services option. These programs are implemented and managed through the Department of Health and Human Services.

Is it your view these programs should continue? Why or why not?

Answer. I support ensuring that individuals are able to receive services in community-based settings.

Question. You are a vocal proponent of passing Federal laws to change Medicaid from a program that includes an open-ended Federal financial commitment to fixed block-grant payments to the States.

Would this change end the Federal oversight and incentive programs that have helped State systems transform into systems that allow individuals with significant disabilities to live in the community? How would you ensure that any changes in Medicaid would not move people with disabilities back into nursing homes and other institutional settings that are linked to significantly poorer quality of life, physical and mental health outcomes, and longevity?

Answer. We are committed to supporting high-quality health care for all Americans, including individuals with disabilities. If confirmed, I look forward to working with you to achieve these goals.

Question. In 2011, the Department of Health and Human Services promulgated a rule to ensure that Medicaid funds designated for services in home and community-based settings were not used to fund services in segregated, institutional settings. For example, the second floor of a building used to provide inpatient hospital care could not be considered a community-based setting. That rule has been championed by the disability community as critical to afford people with disabilities the chance to live independent and fulfilling lives in their own homes and communities.

Do you support the continuation of this rule? Do you commit to ensure that HHS assertively enforces it?

Answer. Community integration, beneficiary autonomy in decision making, and person-centered planning are central tenets articulated in the Home and Community Based Services (HCBS) Settings rule you refer to, and I support each of those principles. It is also important to note that many residential, disability-specific settings have long provided a safe and integrated community alternative to institutional placement for individuals with disabilities, and appropriate weight should be given to the preferences of families and individuals with disabilities because they are in the best position to decide what type of setting best meets their individualized needs and circumstances. States must come into compliance with the final rule by March 17, 2019, and I plan to work with States during this transition period to ensure continuity of services for Medicaid participants and minimize any disruptions to them and the service systems they currently rely on.

Question. With an additional 16 million people gaining access to Medicaid since its expansion and a total of 75 million people covered by the program, Medicaid continues to be a critical, State-based health care program. In order to provide effective, high-quality care, States need dedicated funding for the full Medicare-eligible population as well as sufficient Federal funding that reflects actual State costs and increases in health-care costs.

As Secretary of HHS will you ensure that State-funding for health care is adequate and reflects the actual costs of caring for each State's Medicaid population?

Answer. States are not just regulatory partners in the Medicaid program but also co-funders. As we look to provide them with more flexibility but also continue to provide Federal funds, I agree it is important States meet their funding commitments and the Federal Government oversee and check that is the case.

Question. Medicaid provides care to some of the Nation's most vulnerable and complex populations. In order for States to continue to provide high-quality and effective care, adequate and sustainable funding is required.

As Secretary of HHS, will you work to prevent disruption and ensure adequate and sustainable funding for Medicaid?

Answer. If confirmed, as Secretary I will work to prevent disruption and ensure adequate and sustainable funding for Medicaid. In fact, it is just this goal that is at the root of many improvements I have offered in my career.

Question. During the hearing in the Finance Committee, you gave your commitment that you would "absolutely" support an extension of the Children's Health Insurance program, and even expressed support for a longer extension of the program, beyond the typical 5-year authorization. Yet Gene Sperling wrote in the New York Times on Christmas Day that—"Mr. Price's own proposal, which he presented as the chairman of the House Budget Committee, would cut Medicaid by about \$1 trillion over the next decade. This is on top of the reduction that would result from the repeal of the Affordable Care Act, which both Mr. Trump and Republican leaders have championed. Together, full repeal and block granting would cut Medicaid and the

Children's Health Insurance Program funding by about \$2.1 trillion over the next 10 years—a 40 percent cut.”

Do you deny that you have advocated for these changes to Medicaid and CHIP? You also said during the hearing that there were elements of the budget that you did not support. Which parts do you not support?

Answer. In the past, as a member of Congress, I have advocated policies that would strengthen our health-care programs so that they remain solvent for the sake of future generations.

Question. During the hearing, you claimed we were looking at CHIP and Medicaid in a silo, instead of looking at the entire range of what the policy will be with respect to health insurance programs. We do not have anything to compare CHIP and Medicaid to, because this administration cannot provide a clear plan that is a viable alternative to the Affordable Care Act, the CHIP program and Medicaid.

What will those policies be, and how will they provide better options for the children and individuals with disabilities who rely on CHIP and Medicaid?

Answer. If confirmed, I look forward to working with you to ensure there are better options available.

Question. In your answer to Senator Alexander's question at the HELP Committee hearing, you stated, “folks at the State level know their populations better than we (in Washington) ever could know them.” The bipartisan, consensus-driven National Association of Medicaid Directors advocated for continuing the State Innovation Model (SIM) out of the Center for Medicare and Medicaid Innovation. The SIM has fueled 35 States (led by both Democrats and Republicans) to improve their local health-care systems.

Given your desire to move decisions and innovation to the local level, as HHS secretary would you continue to support CMMI's State-level initiatives?
<http://medicaiddirectors.org/wp-content/uploads/2016/12/Key-Considerations-in-Affordable-Care-Act-Replace-and-Replace-Initiatives.pdf>

Answer. CMMI is a program providing significant opportunity for testing new models for health-care financing and delivery.

Question. In reference to your reply to Senator Alexander, 16 States who have expanded Medicaid have Republican leadership. As of January 19th, at least 5 Republican governors have publicly advocated to retain the Federal-State Medicaid expansion partnership.

Given that several local leaders—including Republicans—favor retaining this program, what is your plan as HHS secretary to honor the wishes of State leadership, preserve this program, and avoid adverse consequences to States?
<http://www.politico.com/story/2017/01/gop-governors-republicans-obamacare-233576>

Answer. If confirmed, I look forward to working with Congress and Governors to ensure access to affordable, quality health care for all citizens.

Question. In the past, you have stated support of expanding State waiver authority for the Medicaid program. Do you support efforts to evaluate the impact of these waivers in terms of access to care, quality of care, and costs of care?

Answer. It is my strong belief that we need to look at all possible outcomes of policy changes.

Question. In 2015, your budget proposal would have repealed the Affordable Care Act, reduced Medicaid spending, and cut the Supplemental Nutrition Assistance Program—all told, up to \$519 billion in cuts to needy families—yet your proposal would have increased defense spending higher than the administration requested, gathering criticism from other Republicans.

Are you only concerned with increased Federal spending when it benefits families and children?

Answer. In my time in Congress, I have been concerned with increased Federal spending at all levels.

Question. In your conversation with Senator Warren and Senator Kaine during your appearance at the HELP committee, you cited access to care as your critique for the Medicaid program. You stated that Medicaid recipients have access to insurance, but they do not have access to the care they need. Yet the Government Ac-

countability Office has stated that "Medicaid enrollees report access to care that is generally comparable to that of privately insured individuals and better than that of uninsured individuals." The report does cite more challenges with accessing specialty and dental care.

Do you agree with the GAO's assessment? If so, what strategies would you suggest to increase access to specialty and dental care for Medicaid recipients? If you don't agree with the GAO's assessment, please outline your plan to increase access to Medicaid-eligible Americans.

Answer. As a doctor who has actually treated thousands of Medicaid patients, I do care deeply about the Medicaid program and the access of Medicaid patients to actual care, not just a card they can carry with them. I know from personal experience the difficulties Medicaid patients face, and I receive letters about it all the time. My plan is to work with States to ensure they have the flexibility to make high quality care truly available.

Question. It is true that Medicaid faces challenges, including low payment rates and barriers to interstate care which limit access and must be improved. Greater consistency of national data could significantly improve Medicaid's ability to serve children and other beneficiaries and drive quality improvement. Access to certain services, such as pediatric mental health services is a pressing concern.

What would you do as Secretary to drive improved outcomes in child health across States?

Answer. Ensuring children have access to the health care they need is undoubtedly a top priority. If confirmed, I look forward to working with you to increase access to affordable health plans for families and children as well as taking the necessary steps to strengthen American families.

Question. A major focus of Congress and the administration has been on pursuing delivery system reforms that improve quality and reduce costs. The Federal Government over time has focused more on the needs of children in these reforms, but Medicaid for children still lags behind Medicare in supporting improvements in care.

What steps will you take to promote increased emphasis on reforms targeting the unique needs of children?

Answer. Our goal is to make certain that every single American has access to the coverage they want for themselves and their children; and we must ensure that the individuals and children who lost coverage under the Affordable Care Act are able to access quality health care. If confirmed, I look forward to working with you on this effort.

Question. To ensure kids continue to receive the critical care they need under Medicaid, any potential restructuring needs to consider children's unique health care needs and the impact of limiting our investments into their future and the Nation's as a whole. Any reforms must ensure children's funding is stable, clearly defined, protects current services, and begins to remediate shortages in critical areas, such as mental and behavioral health services.

How will you ensure that Medicaid continues to deliver essential services tailored to the unique needs of children?

Answer. If confirmed, I look forward to working with you to prioritize a nation of healthy children through increased access to affordable health plans for families and children, as well as taking the necessary steps to strengthen American families.

MEDICARE

Question. Do you support converting Medicare's successful Independence at Home (IAH) demonstration into a nationwide program? Do you support the inclusion of licensed mental health professionals on the primary teams for home-based team care?

Answer. If confirmed, I look forward to working with you on this issue. As a general matter, I believe we ought to allow for all sorts of innovation. Not just in this area. There are things that haven't been thought up yet that would actually improve health-care delivery in our country and we ought to be incentivizing that kind of innovation. And in finding our way to those innovations, it is important to remember many of these experiments involve real patients' lives.

Question. The Medicare program requires that to receive telehealth services, a patient must be in a rural area and at an eligible originating site that currently does

not include the patient's home. Do you support making a rural Medicare beneficiary's home as an eligible originating site for the use of telehealth services?

Answer. This is certainly something that we will take under consideration. Telehealth holds great promise, particularly for rural areas experiencing physician shortages and for patients with limited mobility. At the same time, allowing a beneficiary's home to qualify as an eligible originating site could create significant Program Integrity challenges. If confirmed, I will certainly direct CMS to take another look at this issue to ensure we are doing everything we can to maximize beneficiary access to care with appropriate safeguards against fraud.

Question. Do you support the continuation of the new Merit-based Incentive Payment System as presented in the final rule on the Medicare Access and CHIP Reauthorization Act (MACRA)?

Answer. The recent CMS MACRA final rule approached the first year of the Quality Payment Program as a transition year, and took steps to address physician concerns regarding the burdens associated with program participation. I think significant challenges remain with respect to provider burden, and, if confirmed, I plan to direct the CMS Administrator to ensure that the program is structured to achieve its quality and budgetary goals, while ensuring that patients and the providers who care for them are at the center of our reform efforts.

Question. In both the Medicare and Medicaid programs, we are witnessing increased participation in managed care plans. Yet in 1995, you objected to managed care as "the antithesis of our society," citing that managed care threatens the doctor-patient relationship.

As HHS Secretary, what plans do you have to monitor the quality and effectiveness of Managed Care plans offered in Medicare (through Medicare Advantage) and Medicaid programs?

Answer. If confirmed, I will not pick winners and losers among different plans or methods of health-care delivery. It is my intention to fairly and accurately monitor the quality and effectiveness of our entire care system, including managed care Medicare and Medicaid plans. The facts on the ground will determine our plan ahead.

Question. In September 2011, DHHS released a new policy that implements the recommendations of the Memorandum on Hospital Visitation. The rules updated the Conditions of Participation (CoPs). The policy states that hospitals receiving Medicare or Medicaid payments should allow patients to designate visitors, regardless of sexual orientation, gender identity, or any other non-clinical factor. The HHS policy has enhanced hospital visitation rights of same-sex couples.

Assuming no legislative changes are made, as HHS Secretary, will you continue to support and enforce these existing rules?

Answer. It is essential that health-care services be available to all people with the highest level of quality, affordability, and respect for their human dignity. As a physician, I believe that patients should be at the center of health care. This policy allows patients to designate their visitors, regardless of their identity, and I believe patients should have that authority.

Question. In 2012, the Center for Medicare and Medicaid Innovation under Provision 5590 of the ACA funded the Medicare Graduate Nurse Education Demonstration project to address the primary care provider shortage, including the Hospital of the University of Pennsylvania. In Philadelphia alone, the project has produced 703 advanced practice nurses, the majority of whom have assumed primary care roles, a 78% increase since before the project launched.

As HHS Secretary, do you plan to continue to support novel reimbursement models to address the Nation's shortage of primary care providers? Would you consider expanding the successful Graduate Nurse Education demonstration project to other sites?

Answer. I remain committed to ensuring that every American receives access to the care that he or she needs. Funding decisions, however, ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress and signed into law by the President.

Question. There is universal agreement on the need to improve patient care and reduce costs. One way to do so is for the Federal Government to continue to promote

the growth of health information technology and electronic health records. One success in this space over the past several years has been the development and growth of the Direct Exchange network, which has allowed for millions of health care record exchanges over the past several years.

Will you as HHS Secretary continue to support the expansion of Health IT and the use of networks such as Direct Exchange working with HHS–ONC to encourage and ensure the safe and interoperable exchange of medical records?

Answer. Electronic information sharing, as supported by interoperable health information technology (IT) systems, impacts overall care and the patient experience. Patients and providers often rely on the fast exchange of relevant, trustworthy information across health IT systems. Methods to improve flexibility and patient engagement, and clear the way for increased health IT interoperability should be examined as we work to improve health-care delivery. I look forward to continued discussions with you regarding various means to improve the current health IT infrastructure.

FOSTER CARE AND CHILD WELFARE

Question. You have hardly any record on child welfare issues. The largest Federal investment in child welfare is made through title IV-E of the Social Security Act, which reimburses States for activities associated with foster care, and it is managed by the Department of Health and Human Services. While foster care is a critical, often life-saving intervention, we should be moving toward a system that not only supports children who can no longer remain safely with their families, but one that also helps stabilize struggling families so that they can keep their children when it is possible to do so safely. This focus on prevention is not only often in the best interest of children, but also in the best interest of State budgets, and States that have started shifting to a prevention-focused model have seen lower downstream costs associated with foster care, homelessness, health care and criminal justice. This is an especially critical issue right now, at a time when we are seeing foster care caseloads increasing as a result of the opioid epidemic.

Do you agree that we must make investments in services aimed at helping vulnerable families?

Answer. Yes. The family is the foundation of society. It is critical that we build and sustain strong families by providing assistance when necessary for those struggling with addiction and mental health issues so that we prevent child neglect and violence against children.

Question. The Department of Health and Human Services is the lead Federal agency responsible for addressing child abuse and neglect, including prevention, foster care, reunification, and adoption when children cannot return home. As was discussed during your hearing, the new administration is proposing to block grant Medicaid, which is the primary source of services to help families involved in the child welfare system. This system is experiencing additional strain as a result of the opioid epidemic, which has shattered many families across the Nation.

Have you considered the potential implications of block-granting Medicaid for families in the child welfare system?

Answer. I look forward to working with the Congress to ensure that all children have access to the coverage, regardless of family situation or personal circumstance.

Question. Will you commit that, if confirmed as Secretary of Health and Human Services, you will take action to guarantee parents coverage of and access to mental health and substance use disorder services, to prevent child abuse and neglect and help reunify families?

Answer. Substance abuse disorder is a problem and the opioid epidemic is real. As I mentioned in the hearing, this is a rampant crisis that is harming families and communities across the Nation. This harm includes the potential for abuse and neglect that you mention. I also said, and I firmly believe, that it is vital that substance abuse disorder and other mental health problems are treated. If confirmed I will work closely with you and other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration (SAMHSA) fulfills its duty of leading public health efforts to advance behavioral health and reduce the impact of substance abuse and mental illness on America's communities.

Question. According to the Substance Abuse and Mental Health Administration, there are 21.6 million people that have a substance use disorder, with just 9.3 per-

cent receiving treatment. According to research by Richard G. Frank, the Department of Health Care Policy at Harvard Medical School, and Sherry Glied, Dean of the Wagner School of Public Service at NYU, repeal of the Affordable Care Act will take \$5.5 billion from the treatment of low-income individuals with mental and substance use disorders—11 times the funding that Congress just provided through the 21st Century Cures Act.

Do you think such a reduction in both mental health and substance use treatment funds through a repeal will have an impact on the child welfare system and foster care numbers?

Answer. Changes to the ACA should not be done in isolation. I remain committed to ensuring that every American receives access to the mental health and substance abuse care that he or she needs. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress and signed into law by the President.

Question. The Affordable Care Act included a provision to allow children aging out of foster care to continue their health coverage through Medicaid up to age 26. Block-granting or capping Medicaid would essentially end this guarantee.

Do you believe we should end this right to health coverage for former foster youth?

Answer. This would be a part of the new legislation that Congress will be voting on, so that decision is in Congress's hands. If confirmed, I will work to ensure that HHS appropriately implements the statutes within its purview.

Question. Currently, when families adopt children with special needs from foster care, those children are guaranteed Medicaid coverage through the age of 18. This is an important support for these children and their adoptive families.

If confirmed as Secretary of Health and Human Services, what assurances can you give to these children and their adoptive parents that their health-care needs will continue to be met?

Answer. The life and health of children with special needs is of great importance to me, as it has been when I practiced medicine and while I have been in Congress. I offer every assurance to children and their adoptive parents that I will do all I can, if confirmed as HHS Secretary, to ensure their needs continue to be met to the best of the Department's ability.

ETHICS OF PROVIDING HEALTH CARE TO PEOPLE ON PUBLIC PLANS

Question. You have been a member of a fringe physician group, the American Association of Physicians and Surgeons (AAPS), which espouses a number of very dangerous ideas, including perpetuating debunked myths about vaccines and claiming that it is "immoral" for doctors to provide care to people who rely on publicly funded health plans such as Medicare, Medicaid, and CHIP.

Were you aware of these positions published by AAPS before joining the organization, and do you support those positions?

Answer. My initial membership in AAPS was based on their successful opposition to destructive health policy changes promoted in the early 1990s.

THE OPIOID EPIDEMIC

Question. According to the recent *Facing Addiction: Surgeon General's Report on Alcohol, Drug, and Health*, "Substance misuse and substance use disorders are estimated to cost society \$442 billion each year in health-care costs, lost productivity, and criminal justice costs." The National Survey on Drug Use and Health (NSDUH) reported in 2015 that 21.5 million people in the United States, over 8 percent of the population, had a substance use disorder. The Center for Disease Control and Prevention reported over 52,000 drug overdose deaths in 2015. Of the millions of people struggling with a substance use disorder, only about 10 percent receive substance use disorder treatment in a given year.

If confirmed as Secretary of Health and Human Services, what actions will you take to address the needs of Americans struggling with substance use disorders, especially those who are seeking treatment?

Answer. Substance abuse disorder is a problem and the opioid epidemic is real. As I mentioned in the hearing, this is a rampant crisis that is harming families and communities across the Nation. This harm includes the potential for abuse and neglect that you mention. I also said, and I firmly believe, that it is absolutely vital

that substance abuse disorder and other mental health problems are treated. If confirmed, I will work closely with you and other members of Congress to ensure that the Substance Abuse and Mental Health Services Administration (SAMHSA) fulfills its duty of leading public health efforts to advance behavioral health and reduce the impact of substance abuse and mental illness on America's communities treating those who are in addiction recovery while working to prevent people from becoming addicted in the first instance, and explore other means available to HHS to assist those struggling with substance use disorders obtain treatment and to prevent addiction.

Question. If confirmed as Secretary of Health and Human Services, will you commit to supporting, and as a Cabinet member advising the President to support, continued funding for opioid crisis grants, as administered by SAMHSA?

Answer. I remain committed to ensuring that every American receives access to the mental health and substance abuse care that he or she needs. Funding decisions, however, ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress and signed into law by the President.

Question. If confirmed as Secretary of Health and Human Services, will you commit to supporting, and as a Cabinet member advising the President to support, funding for the Substance Abuse Prevention and Treatment Block grant to preserve the critical safety net for Americans who require substance abuse treatment but who are uninsured?

Answer. Access to mental health and substance abuse care is absolutely vital. If I am privileged to serve as the Secretary of Health and Human Services, I will implement the policies agreed upon by the Congress which holds the power of the purse, and signed into law by the President.

Question. If confirmed as Secretary of Health and Human Services, would you commit to supporting, and as a Cabinet member advising the President to support, funding requests for the National Institute of Mental Health and the National Institute on Drug Abuse to develop better treatments for substance use disorders?

Answer. I remain committed to ensuring that all Americans maintain access to the mental health and substance abuse disorder treatments; however, funding decisions ultimately rest with the Congress, which holds the power over the purse. If I am privileged to serve as the HHS Secretary, I will implement the policies adopted by the Congress and signed into law by the President.

Question. Integrated primary care and mental health care is one promising strategy to improving outcomes for Americans with substance use disorders. If confirmed as Secretary of Health and Human Services, will you support demonstration programs—which as Secretary you would have the ability to direct—to integrate primary and behavioral health care, through the Center for Medicare and Medicaid Innovation?

Answer. CMMI is a program providing significant opportunity for testing new models for health-care financing and delivery. If confirmed, as HHS Secretary, I plan to work closely with CMS to ensure that CMMI—after appropriate consultation with Congress, the States, health-care stakeholders, and Innovation Center staff—tests innovative models that reduce costs and improve quality for Medicare and Medicaid beneficiaries.

Question. A key challenge to effectively addressing the opioid epidemic in the United States is a shortage of qualified providers. The Affordable Care Act included a provision to establish a National Healthcare Workforce Commission, yet this Commission has never met.

If confirmed as Secretary of Health and Human Services, would you commit to supporting, and as a Cabinet member advising the President to support, a congressional appropriation to convene this commission so we can understand the root cause of mental health provider shortages and develop evidence-based strategies to address them?

Answer. As I mentioned in the hearing, it is important that we as a nation make sure that every single individual has access to the kind of mental health and substance abuse care that they need. I look forward to working closely with you and the other members of Congress to ensure that the mental health profession is adequately, if not robustly, staffed for this and the future generations.

COVERAGE

Question. On January 7, 2009, you penned a commentary in the *Wall Street Journal* that advocated for “access to coverage for all Americans and coverage that is truly owned by patients.” Yet under the policy proposals you have authored, according to the Congressional Budget Office, “the number of people who are uninsured would increase by 18 million in the first new plan year.” After repeal of Medicaid expansion and exchanges, 32 million Americans would be uninsured by 2026.

How do you reconcile your position in 2009 with the analysis by the CBO in 2017?

Answer. I disagree with the conclusion drawn by CBO. If there are any changes to Medicaid, they should not be done in isolation.

Question. You introduced the Medical Freedom Act of 2015, which would repeal the requirement that insurers offer dependent coverage until the age of 26. HHS estimates this provision has affected 2.3 million young adults.

If confirmed, what is your plan to protect the health and well-being of young adults under the age of 26?

Answer. This would be a matter for Congress to determine through legislation. If confirmed, I will work to ensure that HHS appropriately implements the statutes within its purview.

CHILDREN

Question. Oftentimes, changes in the larger health-care landscape take place, for example in the Medicare program, without a full examination of how these changes could potentially impact children, even inadvertently.

As you look at health-care changes at the national level as Secretary, how will you ensure that children’s unique health-care needs are taken into account?

Answer. I look forward to working with Congress to ensure that children will not be inadvertently impacted by potential changes to the health-care system.

LIHEAP

Question. The Low-Income Home Energy Assistance Program (LIHEAP) provides short-term aid to vulnerable populations for heating or cooling assistance, crisis assistance or weatherization assistance. Without this support, many low-income participants would quickly fall behind on their bills and face shut-off of essential energy services. The program effectively utilizes a partnership between the Federal Government, State government and the private sector.

LIHEAP protects the most vulnerable in our society. According to the Campaign for Home Energy Assistance, in Pennsylvania in 2014, 35% of households receiving LIHEAP were elderly, 30% were disabled, and 18% had children under 5. You were a member of the Task Force on Poverty, Opportunity, and Upward Mobility that drafted the “A Better Way” plan that proposed to combine LIHEAP with 10 other social program grants to create a large block grant to States. Should such a plan come to pass, it would eliminate a dedicated fund for utility crisis assistance. In addition, your recent budget took across the board cuts from safety net programs and highlighted LIHEAP as one of several “duplicative anti-poverty programs.” While the Department of Energy also oversees an energy program (the Weatherization Assistance program), this program provides grants to States to improve the weatherization and energy efficiency of low-income homes. Thus, serving a different, though just as important, service from LIHEAP.

Can you explain why you think LIHEAP is a duplicative anti-poverty program and which other programs in particular you think are providing the same services?

Answer. One of the main goals of the “A Better Way” plan was to match poverty-fighting programs with the needs of those on Federal Aid more effectively so that it is easier for them to get back on their feet. Using block grants, rather than dedicated grants, gives States and communities more freedom to use the funds where they are most necessary.

Question. According to the National Energy Assistance Directors Association, States have been forced to reduce the number of households served by LIHEAP from 8 million to the current level of 6.7 million due to Federal cuts to the program. This equates to 1.3 million eligible households nationwide that did not receive assistance.

LIHEAP is a critical safety net program to support the elderly and families as the country recovers from the economic recession. Families should not have to choose between heating their homes and putting food on the table. You have previously voted in the House of Representatives against increasing funding for LIHEAP.

Do you support increasing funding for LIHEAP? If not, why do you not support it?

Answer. If confirmed, I will administer LIHEAP as effectively and efficiently as possible. If once in office, and should circumstances on the ground change and current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

Question. Will you support maintaining the funding at the current level of \$3.3 billion in the President's final recommendations for FY 2017 and proposed FY 2018 budget?

Answer. If confirmed, I will administer LIHEAP at the levels passed by Congress.

TAX ISSUES

Question. Do you think the President should disclose how much he stands to benefit from the repeal of the net investment income tax prior to signing the repeal of the Affordable Care Act into law?

Answer. This is a matter for the President.

Question. With respect to subsidizing the cost of health care, please explain why an annually disbursed refundable tax credit is superior to a monthly insurance premium support credit.

Answer. There are many health-care scholars who have promoted the superiority of a credit versus a subsidy, as it may provide greater flexibility and options for patients.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

CONTINUOUS COVERAGE

Question. Last week we held a forum and asked folks from around the county to share their stories and help inform the debate around repeal of the ACA. One of the women on the panel, Holly Jensen, was a small business owner insured with a plan she selected on the marketplace. Holly was living with undiagnosed depression, anxiety, and obsessive compulsive disorder that was getting worse by the day. It got to the point that she withdrew from her community, her work, and was really struggling. She was unable—understandably—to make her monthly premium payments. Luckily, because of Medicaid expansion, she was able to get the treatment she needed a few months later and is doing well today. Her small business is back up and running. However, she did not maintain coverage continuously, as your plan and many others require.

If the continuous coverage requirement were in place, Holly would re-enter the health insurance market and could be labeled with a pre-existing mental health condition, correct? How do you believe this problem is best addressed?

Answer. I believe it is important that we as a nation make sure that every American has access to the kind of mental health care and health coverage that best meets their need. Additionally, it is imperative that all Americans have access to affordable coverage and that no one is priced out of the market due to a bad diagnosis. This is a matter for the legislative branch, however, and if confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

MATERNITY COVERAGE

Question. As I mentioned today, prior to the ACA, the vast majority of plans on the individual market did not offer maternity coverage. You said today that women would likely opt not to purchase one of those plans if they were pregnant or planning to be. However, over the course of a health plan year, couples and families make many decisions about their health-care future, sometimes including whether or not to have a child.

Given this fact, do you believe that all health plans should be required to cover maternity and newborn care?

Answer. My hope is to move in a direction where insurers can offer products people want and give them the coverage they want. That, of course, can and would in many cases include maternity and newborn care. Getting to that kind of system requires changes that will inevitably involve working with Congress and considering the tradeoffs of various proposals to achieve our shared objective of the best and highest quality care being available to Americans. And note that I refer to care because ultimately, having maternity or other coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off. So we must work towards both coverage and care.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

LONG-TERM CARE

Question. Do you share my view that patients should be able to age in their homes and communities instead of in nursing homes and other institutional/inpatient settings, so long as the patient chooses this option and it is clinically appropriate?

Answer. Our health-care system should be able to accommodate the choices of patients, in consultation with their physicians, regarding the ideal setting for their care.

Question. Do you agree with me that home- and community-based care is, in general, far less costly and more convenient for patients compared to institutional care in nursing homes?

Answer. Home- and community-based care is often less costly and more convenient as compared to institutional care in nursing homes. Our goal ought to be the right care in the right setting and the best care possible for Medicaid patients and all Americans. Too many Medicaid beneficiaries lack access to care.

Question. Do you support incentives for States to transition or “rebalance” their Medicaid long-term care population from nursing homes to home- and community-based care?

Answer. If confirmed, I will work to provide States the flexibility to pursue innovative approaches that fit the unique needs of their citizens.

Question. Are you aware that, under the Affordable Care Act’s Balancing Incentive Program (section 10202), the State of Georgia was approved for \$57 million to transition Medicaid beneficiaries from institutional long term services and supports (LTSS) settings to home-and community-based settings (HCBS), and, as a result of that investment, Georgia has been able to shift more than 10 percent of its long-term care costs *from* high-cost nursing homes *to* low-cost home and community care, according to reports submitted to CMS and Georgia’s program application?

Answer. Each State has different needs, and I believe CMS needs to work with States to ensure that, consistent with those needs, the Medicaid program provides the best possible coverage to their residents. It is not surprising that providing States with flexibility to tailor their Medicaid program leads to good results in general.

Question. Do you support the Balancing Incentives Program in the Affordable Care Act?

Answer. I am committed to ensuring that Medicaid is available for eligible beneficiaries, and working with CMS to make sure that States are able to make the most use of available resources to serve their citizens with the highest quality care, if I am confirmed.

Question. If you do support this program, or if you at least agree with its intent and goals, will you commit to working with me and my staff to expand Federal incentives for States to “rebalance”?

Answer. Yes, I will look forward to working with you and your staff to explore proposals you have in mind and otherwise consider how best to provide States with flexibility to provide the highest-quality care for Medicaid beneficiaries.

Question. Do you believe that, if executed well, “rebalancing” programs such as Balancing Incentives can improve the care experience for patients and reduce State Medicaid costs?

Answer. The experience of our system is that while many different States may face the same problem, the approach that is most likely to succeed may depend on the particular State and other details specific to the circumstances.

BASIC HEALTH PROGRAM

Question. The Basic Health Program (section 1331 of the Affordable Care Act) is a State option that is providing health insurance and access to care to more than 750,000 working low-income individuals in New York and Minnesota. States that have taken advantage of this voluntary program are seeing lower costs for beneficiaries, higher enrollment, and net State budget savings, compared to not implementing the program. Through the Basic Health Program, States are price-makers, not price-takers.

Do you support the Basic Health Program as a way to empower States to negotiate a better deal on health insurance for their citizens?

Answer. I support the efforts of States to innovate and find solutions for their citizens with respect to health care, in the area of insurance and otherwise.

Question. Will your Department and CMS commit to funding and administering the Basic Health Program as required under current Federal law?

Answer. If confirmed as Secretary of HHS, my role will be to administer the laws of the land as they originate from the Congress, including those relating to the Basic Health Program.

Question. If Congress repeals the Affordable Care Act, will you commit to “not pulling the rug out” from the 750,000 low-income individuals who are benefitting from the Basic Health Program?

Answer. In working through the current situation and options for the future, I am committed to working towards solutions that provide meaningful access to care, not just insurance but actual care, for all, including—of course—these individuals.

Question. In other words, will you use your administrative discretion as HHS secretary to not rescind funding for State Basic Health Programs, unless a rescission of that funding is explicitly required by a change to the statute?

Answer. If confirmed, I will follow the directions of Congress as contained in appropriations and other law regarding funding for health-care programs.

DELIVERY SYSTEM REFORM

Question. Washington State and the Pacific Northwest have led the way in pioneering nationally recognized innovations in the delivery of health care—whether it is the Qliance Direct Primary Care medical home model, Group Health Cooperative’s highly popular integrated coverage and care model, the Everett Clinic’s price transparency initiatives, Boeing’s Accountable Care Organizations, or dozens of others. Despite their innovations, health-care providers in my State are paid nearly \$2,000 less (per Medicare enrollee, per year) than the national average, based on CMS spending data compiled by the Kaiser Family Foundation. I would argue that, due to our current volume-based system, my constituents are paid less specifically because they are efficient and because they do a good job of keeping patients healthy.

Should the Federal Government reward such high-value health care providers, as long as we clearly define and agree upon metrics for what constitutes “high-value” care?

Answer. I look forward to faithfully executing the laws Congress passes pertaining to health-care provider reimbursement.

Question. Does the current fee-for-service system encourage unnecessary health-care spending? If so, can you please explain specifically how this system encourages unnecessary health-care spending, including in which specialties of medicine?

Answer. The current system encourages unnecessary spending since too many of the decisions providers and patients make are determined by a distant Federal bureaucracy and not based on the value of care that is provided to patients by their

health-care providers. If confirmed, I look forward to executing laws that reduce unnecessary health-care spending.

Question. As a physician, do you share my view that clinicians should focus more on keeping their patients healthy and less on paperwork?

Answer. Clinicians should focus more on keeping their patients healthy and less on paperwork. Unfortunately, it does not seem that is the current trend.

Question. As a physician, do you share my view that the current fee-for-service system requires significant paperwork, including substantial time spent on coding and billing for each individual procedure or service rendered?

Answer. Clinicians should focus more on keeping their patients healthy and less on paperwork. Unfortunately, it does not seem that is the current trend.

Question. You voted for the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) when it was considered on the House floor. Will you commit to working with Washington State health-care providers to help them succeed in Medicare's new Quality Payment Program, as outlined in regulations by CMS, including Advanced Alternative Payment Models?

Answer. If confirmed, I commit to work closely with the CMS Administrator to make sure we implement MACRA in a way that is easy to understand, minimizes burden, and is fair to all affected providers.

Question. Will you commit to fund and administer Medicare's Accountable Care Organizations, including the Medicare Shared Savings Program under section 3022 of the Affordable Care Act, and will you commit to helping health-care providers participate in these models, should they choose to do so? Will you commit to not taking any administrative action that would make it more difficult for Medicare beneficiaries or health-care providers to participate in this voluntary program?

Answer. As a doctor, I appreciate the goal behind the creation of the ACO model: better patient care. As a legislator, I would agree their successes have been modest to date, and there are some challenges they face as well. ACOs are a tool in the toolbox to help ensure high quality, low cost health care for beneficiaries. They are not a silver bullet to all of our country's delivery system challenges. If confirmed, I plan to work with the CMS Administrator to ensure that we learn from ACOs' successes and challenges to date as we chart the path forward.

Question. Will you commit to fully fund approved grants under the Center for Medicare and Medicaid Innovation (CMMI), and will you continue to fund and administer future payment initiatives under CMMI, consistent with the legislative intent of Congress in the Affordable Care Act?

Answer. If confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

Question. Do you share my view that, given Congress's significant ongoing investment in the delivery of health-care services, the Federal Government should fund research into health-care quality? Will you commit to not taking administrative actions that would weaken the work of the Agency for Healthcare Research and Quality (AHRQ) within HHS?

Answer. I appreciate your concerns about health-care quality. I also appreciate the fact that health-care research may address patient safety, care management and methods to broaden access to health-care services, among other issues. Health-care studies also help to inform the discussion on ways to improve the quality of care and reduce costs. As you know, Congress will ultimately make the decision on whether to fund the Agency for Healthcare Research and Quality (AHRQ). Nonetheless, if confirmed, I look forward to working with you to more carefully examine AHRQ and determine how it may best drive positive patient-centered solutions in healthcare. And if confirmed, I will work to ensure that HHS (appropriately) implements the statutes within its purview.

HEALTH CARE LEGISLATION

Question. I have authored bipartisan legislation (S. 2259 in the 114th Congress) to make it easier for rural health-care providers to participate in the Medicare Shared Savings Program by allowing CMS to adopt a broader beneficiary assignment method than is provided under current law. Will you commit to providing me and my office responsive and accurate technical assistance on this legislation?

Answer. I look forward to working with you on this issue and sharing both feedback and assistance regarding the important policy issues in beneficiary assignment for the Medicare Shared Savings Program.

Question. I have authored bipartisan legislation (S. 2373 in the 114th Congress) to require Medicare to cover an essential preventive product, compression therapy items, for beneficiaries who experience swelling from lymphedema. Will you commit to providing me and my office responsive and accurate technical assistance on this legislation?

Answer. As you know, CMS has a detailed process for making determinations regarding whether items and services are reasonable and necessary, if they can be considered eligible for Medicare coverage given other restrictions and prohibitions. From time to time, Congress sees it fit to make its own determination regarding specific items or services. If confirmed, I would be pleased to work with your team to provide information on the Medicare coverage process and potentially relevant considerations.

Question. I have cosponsored bipartisan legislation (S. 3129) to preserve patient access to outpatient therapeutic services in Critical Access Hospitals and other rural hospitals. Similar legislation has been signed into law the last 3 years. Will you commit to working with me, my staff, and bill sponsors and cosponsors, on this issue?

Answer. If confirmed, I look forward to working with you and others in the Congress to see that critical access hospitals are best enabled to serve rural populations well.

Question. Will you commit to providing me and my office responsive and accurate technical assistance on any future legislation I author or on which I seek assistance?

Answer. Federal agencies play a significant role in the legislative process, often including providing technical assistance. Such technical assistance can involve situations where the agency provides feedback but clarifies that the assistance does not reflect the views or policies of the agency or administration. If confirmed, I will endeavor to work with you in this way as appropriate to ensure proposed legislation is consonant with the existing statutory and regulatory scheme.

WASHINGTON STATE'S SECTION 1115 MEDICAID WAIVER

Question. On January 9, 2017, CMS approved Washington State's proposed Medicaid waiver ("Medicaid Transformation Project, No. 11-W-00304/0") under section 1115(a) of the Social Security Act. In securing agreement on this waiver, Washington State health officials and CMS spent countless hours over more than a year in good-faith negotiations. This approved waiver will help Washington State pursue a smarter and more innovative Medicaid program that reflects changes in health-care delivery, technology, and the preferences of patients.

Will you commit to honor this approved waiver and not take any administrative action to rescind, weaken, or de-fund its components?

Answer. It would be inappropriate at this point to comment on any specific waivers under consideration at CMS, but, if confirmed, I would work with the CMS Administrator to ensure that CMS uses its waiver authority to provide much needed flexibility to States to innovate within the Medicaid program.

GRADUATE MEDICAL EDUCATION

Question. The vast majority of Washington State counties are Health Professional Shortage Areas (HPSA's) according to HHS's HRSA. Do you agree with an established body of research illustrating that there are physician shortages in the United States, especially in primary care specialties and in rural communities?

Answer. Access to care is a critical issue in many parts of the country, particularly for primary care in rural areas. The underlying physician shortage is sometimes worsened by government policies. If confirmed, I look forward to the opportunity to address these physician shortages, particularly as they relate to the Medicare and Medicaid programs.

Question. Do you agree with previous congressional intent that the Federal Government, through Medicare and other programs, has a strong role to play in graduate medical education (GME) policy and funding?

Answer. I have always been a strong supporter of efforts to support medical education. Congress has used the Medicare program from its inception to invest in future generations of doctors. Regardless of what we do in Washington, health care should always be about that one to one relationship of a patient to a doctor. That relationship of course requires a doctor. And so I am hopeful we can continue to find ways to remove disincentives to the practice of medicine and its rewards as well as support the profession in other ways.

Question. Was your own surgery residency funded by Medicare?

Answer. Both my wife and I were residents at Emory University. I completed my residency in 1984. The Medicare program has paid for some portion of GME at participating hospitals since its inception in 1965.

QUESTIONS SUBMITTED BY HON. MARK R. WARNER

AFFORDABLE CARE ACT

Question. In December 2016, the Congressional Budget Office issued a report noting that it would define as insurance coverage only “a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals.” The ACA established a set of services, known as Essential Health Benefits, that all insurance policies must include to make sure patients have appropriate health coverage.

What would you advise the President define as “coverage” under a Republican ACA replacement plan?

In a repeal-and-replace scenario, will coverage obtained by individuals provide adequate financial protections against high medical costs?

Will you advocate for insurance policies under the Republican replacement plan that provide meaningful coverage so that insurers could not once again: (1) charge higher premiums to women, people with pre-existing conditions, or others for reasons such as their profession or the industry in which they work; (2) drop or severely limit benefits such as maternity care and prescription drugs, which insurers must currently cover as “essential health benefits;” (3) reinstate annual and lifetime limits on coverage; or (4) charge deductibles, co-payments and co-insurance without limits?

Will you commit to safeguarding the consumer protections that the Affordable Care Act put in place?

Answer. This is a work in progress. If confirmed, I would appreciate your thoughts on how best to address these matters. It is important that any system have safeguards so that no one loses access to care due to a bad diagnosis. Additionally, credible coverage is important. Patients should be provided an array of options so they may select the one best for themselves and their family; and consumer protections are integral to any patient-centered system.

DRUG PRICES

Question. The rise in prescription drug costs is squeezing American families as well as Federal spending. We need to address this now. In your testimony to the HELP Committee last week, you agreed that we need to work in “a bipartisan way (to address the) root causes of drug prices, (and) to make sure that drug pricing is reasonable.” But you refused to commit to specific policies. President Trump has said that we should allow Medicare to leverage its power as a payer, and negotiate drug prices with pharmaceutical companies.

Do you agree with President Trump that Medicare should negotiate drug prices?

Answer. The issue of drug pricing and drug costs is one of great concern to all Americans. You have my commitment to work with you and others to make certain that Americans have access to the medications that they need. If confirmed, I look forward to focusing on how we can make health care more affordable, including prescription drugs. I share your concern regarding the importance of individuals and families being able to afford the prescription drugs they need.

DRUG PRICE AND VALUE

Question. While we are moving towards paying for value in many areas of healthcare, in the drug space we have largely lagged behind. In the past year, we

have seen some insurers and drug manufacturers pilot value-based arrangements that hold the manufacturer accountable for how their product performs in the real world on an agreed upon set of metrics. In 2015, I led a letter with my colleagues, Senator Kaine, Senator Nelson, Senator Shaheen, and Senator Heitkamp, to the Centers for Medicare and Medicaid asking them to examine the potential of using value-based arrangements in Medicare and other public programs.

Will you commit to working with me to identify potential regulatory policy barriers that should be reviewed in order to continue to move towards reimbursement for value rather than volume in the drug space?

Answer. If confirmed, I look forward to working with you and others to ensure that we are moving toward a health-care system defined by high-quality, patient-focused care. I appreciate how reimbursement—and other regulatory policies impact physician behavior. If confirmed, I will ensure that HHS is a good steward of taxpayer dollars, with the goal of delivering the highest-quality care through its health-care programs, including the Medicare program serving our Nation's seniors.

GABRIELLA MILLER/NIH

Question. Gabriella Miller, a 10-year old girl from Leesburg, VA who suffered from pediatric brain cancer, became an extremely impressive activist on behalf of childhood cancer awareness before her untimely death. Her work led to the passage of the Gabriella Miller Kids First Act, and NIH has been moving forward to implement this law and expand pediatric research.

Will you prioritize pediatric cancer research and implement the Gabriella Miller Kids First Research Act?

Answer. I am always inspired by the courage cancer patients bring to their fight against this devastating disease. This is particularly true when the patients are some of the youngest amongst us. It underscores why we must cure cancer. The NIH plays a pivotal role in supporting cutting-edge biomedical research across our country, including key efforts related to pediatric research, and I recognize that we must make progress on this front for the adults and children fighting cancer. If confirmed, I look forward to continuing HHS's important work to advance cancer research and bring forward innovative treatments as part of our shared goal of defeating cancer.

CYBERSECURITY/INTERNET OF THINGS

Question. The declining cost of digital storage and Internet connectivity have made it possible to connect an unimaginable range of products and services to the Internet, with medical devices at the forefront of this trend. However, in many cases, manufacturers have brought insecure devices to market, with few incentives to design the products with security in mind, or to provide ongoing support to address vulnerabilities. For example, we have seen cases where an implantable device lacked meaningful authentication methods, leaving it susceptible to unauthorized or malicious commands sent remotely.

The FDA has taken important steps to addressing cybersecurity in the "Internet of things." This includes promulgating post-market guidance, working closely with cybersecurity researchers, and engaging manufacturers to promote development of more secure devices. Will you commit to continue and build on these efforts?

Answer. The safety of American citizens will always be a top priority of the HHS and ensuring the security of medical devices against the threat of hacking is critical to that end. If I am confirmed, the FDA will continue and improve upon its efforts to strengthen cybersecurity within the medical device industry as well as other related industries.

BAN ON CDC GUN RESEARCH

Question. Since 2013, Americans have died from incidents involving firearms and automobiles at almost identical rates. Over the last two decades, the Federal Government has spent \$240 million a year on motor vehicle safety research, and motor vehicle deaths plummeted nearly 25 percent from 2004 to 2013 thanks to data supporting new policies. CDC has done virtually no research into gun-related injuries and deaths after an appropriations rider was added that prohibits the CDC from "participating in advocacy or promotion of gun control." Roughly 100,000 Americans injured or killed each year by guns, including over 2,000 in 2016 from accidental shootings alone. The original author of the appropriations rider, Representative Jay Dickey (R-AR), has declared he regrets it and would like to see the CDC able to

research violence and injury related to firearms. To make smart policy, it's necessary to have accurate information and data.

If confirmed, would you direct CDC staff to interpret the appropriations rider in a reasonable way, so that CDC could in fact conduct unbiased research on the relation of firearms to public health?

Answer. The CDC performs an important role in helping to understand and communicate public-health issues. If confirmed, I will work to faithfully ensure that the Department and its operating divisions fulfill their statutory responsibilities.

RURAL HOSPITALS

Question. Rural hospitals, serve older, sometimes more economically disadvantaged populations challenged by less access to primary, dental, and mental health care than their urban counterparts. Rural hospital leaders from across Virginia continue to share with me their concerns with efforts to repeal the Affordable Care Act. The ACA lowered the percentage of uninsured by 8 percentage points in rural counties, decreasing bad debt for providers in these areas, and providing them with some financial breathing room. Yet despite this progress, the Virginia Hospital Association estimates that 43% of rural hospitals in Virginia operate at a financial loss.

Should there be supports included in an ACA replacement proposal to ensure these safety net providers can afford to keep their doors open to serve these vulnerable patients?

Answer. Our goal is to ensure access to affordable, quality health care for all citizens. This of course includes individuals who access care at rural or critical access hospitals. And so the best metric in the end is one that measures the extent of access to actual care, not just coverage, and the quality of that care as determined by patients working individually with their doctors. I look forward to working on this important issue with you, if confirmed.

Question. Last week, CBO reported that in the first year after a repeal of the ACA marketplace subsidies would take effect, about half of the Nation's population would live in an area that would have no insurer participating in the individual market, increasing to three-quarters of the population by 2026. You have emphasized "access" to coverage but the report suggests repeal in its effects will eliminate choice, competition, and access in rural communities, reversing much of the progress we've made to reduce the number of the uninsured, as well as reducing uncompensated care.

What advice would you give President Trump on addressing the bad debt issues these rural hospitals would face post-repeal?

Answer. Changes to the ACA should not be done in isolation. Our goal is to ensure access to affordable, quality health care for all citizens.

HOME INFUSION

Question. While I supported the 21st Century Cures Act when it passed in December, I remain concerned about a provision which caused the misalignment of effective dates of two important policies. The act included a provision Senator Isakson and I fought hard to include that would pay for services associated with allowing Part B to reimburse for Medicare patients to receive infusion drugs at their home starting in January 2021. However, a provision which was used to help pay for such payment, a cut to the reimbursement rates for Part B Durable Medical Equipment (DME) home infusion drugs, had an effective date of January 2017. This leaves a 4-year gap where home infusion services will not be adequately reimbursed. While I work with my colleagues in Congress to fix this issue, I hope that the Centers for Medicare and Medicaid Services (CMS) will make every effort to ensure Medicare beneficiaries continue to have access to these lifesaving medications.

Can you commit to report back on actions CMS and HHS can take to protect beneficiaries from losing access to life-saving care?

Answer. Yes. I look forward to working with you to find approaches to this issue that ensure access to the highest quality care.

TELEHEALTH

Question. I've worked with bipartisan members of the Finance Committee to expand the use of telehealth, especially in Medicare, and I was glad that at your hear-

ing last week you called telehealth an “exciting innovation for rural and underserved areas.”

As Secretary, will your Department work with my staff and others to find ways to fully leverage HHS’s existing authority to lower barriers for telehealth and remote patient monitoring in Medicare?

Answer. I share your interest in promoting telehealth. Telehealth can provide innovative means of making health care more flexible and patient-centric. Innovation within the telehealth space could help to expand access within rural and underserved areas. If confirmed, I look forward to continued discussions on telehealth, including on the best means to offer patients increased access, greater control and more choices that fit their medical needs.

SUBMITTED BY HON. DEBBIE STABENOW, A U.S. SENATOR FROM MICHIGAN

**DPCC FORUM ON HEALTH AND HUMAN SERVICES
NOMINEE TOM PRICE**

THURSDAY, JANUARY 19, 2017

**OPENING STATEMENT OF HON. DEBBIE STABENOW,
A U.S. SENATOR FROM MICHIGAN**

Senator STABENOW. Well, good afternoon. We so appreciate all of you being with us, and I want to thank all of my colleagues for being here and for their hard work.

Senator Murray will be joining us; she has been involved in helping to create the success of today, as well as Senator Warren. Senator Kaine of course is here, and Senator Hassan. It’s very important for us to have an opportunity to hear from all of you as we are reviewing and making decisions on who will head the Health and Human Services Department for our country.

And Senator Murray has joined us; welcome. Let me just start by saying that on all of these issues this is not personal to any nominee, this is about differences, fundamental differences, and ideas and policies and what helps people, what hurts people. I mean these are very important debates, and your voice, your opinions are very important to all of us.

So you’re here at a critical time, and we know that just last week Republicans in both the House and the Senate pulled the first thread that will unravel potentially the entire health-care system, voting to adopt a budget resolution that would allow for repeal of the Affordable Care Act, and we don’t know what comes after that. If this happens, according to the Congressional Budget Office, 32 million people, including many of you on this panel today, would lose health insurance coverage and individual market premiums would double in the next 10 years, according to the budget office.

Unfortunately, the damage would not end there. Another 52 million adults, including 1.7 million in my own home State of Michigan, could become uninsured due to pre-existing conditions. Forty-eight million people could lose mental health parity protections, which makes sure that diseases are treated above the neck, as well as below the neck. We could be sent back to a time when being a woman was a pre-existing condition, when insurance companies would cut you off when you hit an annual or lifetime limit on coverage, even if you needed more care.

One hundred and five million Americans no longer face bankruptcy when they get sick because those caps have been eliminated, and that is a good thing. The Medicare trust fund has been extended by 11 years, preserving future benefits, and 11 million seniors have saved an average of \$2,000 because what has been called the “donut hole,” this gap in coverage, has been phased out; it’s now closed so there is continuous coverage.

I could go on with the numbers, but the most important thing is not the numbers. The most important thing is how all of this effects your families, our families, our children, our parents, our grandparents.

If confirmed by the Senate, the Secretary has tremendous power. His or her decisions in office will affect all of us. His or her voice will strongly influence the President's decision to promote, sign, or veto legislation.

We have heard mixed messages. Our President-elect campaigned on not cutting Medicare or Medicaid. Just over the weekend he said we would have insurance for everyone. We would certainly welcome the opportunity to see that plan, we do welcome it. But at the same time, just this fall, Congressman Price said he expects Medicare to be overhauled "within the first 6 to 8 months" of President Trump's administration. He also believes, "the age of eligibility needs to be increased," and that, "the better solution is premium support," which is another word for vouchers.

When it comes to covering pre-existing conditions, he has indicated that he thought that was, "a terrible idea." So this is important, this is about ideas and policies and values and perspectives, and we are very grateful that all of you are here.

We had asked the Chairmen of the two committees responsible for the nomination if we could in fact have a panel of all of you, of others, to share voices at the formal confirmation hearing. That was rejected, and so we're doing a public forum to give you an opportunity to share your thoughts.

So thank you again, and before introducing our panelists, our terrific ranking member from the Health, Education, Labor, and Pensions Committee, Senator Murray, is here, if you would like to say a few words.

**OPENING STATEMENT OF HON. PATTY MURRAY,
A U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Well, I won't talk long because I really do want to hear from all of you, it's so important, and I want to thank Senator Warren and Senator Stabenow for putting this together, because, as all of you know, we did have a hearing yesterday.

I was disappointed we couldn't ask more questions of the nominee himself. We were only given one round. There is a lot to be concerned about.

Congressman Price has a long record of making decisions I would not make, taking away affordable health care, going after people who depend on Medicaid. He is a politician who has worked hard to undermine reproductive rights, seniors who rely on Medicare—the list goes on—and this is a cabinet secretary who will oversee the lives of literally every family in this country.

So we have a responsibility to hear from those families in this country and the impact this department will have on them. So I really appreciate your doing this, and I look forward to all of your testimony.

And I just want to give a shout out to our Democrats, both here and on my committee, who really did an excellent job, both with this hearing and the DeVos hearing, in really, in the very limited amount of time we had, showing some of their record.

So, thank you all very much for being here.

Senator STABENOW. Thank you so much. Senator Warren, who has played such an integral role as we have been bringing forth public voices on the nominees, is here. Thank you.

Senator Warren?

**OPENING STATEMENT OF HON. ELIZABETH WARREN,
A U.S. SENATOR FROM MASSACHUSETTS**

Senator WARREN. So, thank you very much, Senator Stabenow, for your leadership in pulling this together so we get to have these people's hearings, and I also want to say "thank you" to Senator Murray. She really is our leader, and the one who is keeping us in this fight on the nominees, and the fight to protect what it is that we stand for here.

And I welcome our newest member, Senator Hassan, who is also on the committee, and Senator Kaine. So we have a bunch of people who are in there fighting.

You know, President-elect Trump has spent the past few weeks filling his cabinet and putting together his team for how he wants to run his administration. The decisions that he makes will have tremendous consequences on the lives of everyone in this country, and when it comes to the Secretary for the Department of Health and Human Services, President Trump's choice will have an enormous effect on the lives of everyone in this room and everyone in this country.

They will help determine whether millions of Americans continue to have access to medical care, whether contraception or cancer screenings or flu shots must be covered by your health insurance, whether Medicare and Medicaid are protected for the 100 million Americans that rely on this program. In short, the hiring decisions that President-elect Trump is making tell us about the values of the incoming Trump Administration.

Now, unlike many of President-elect Trump's nominees, who have little or no experience as they take over their various departments, Congressman Price has a lot of experience in health-care policy, and that is why we are so worried. His record makes clear that he has some very radical, scary ideas about how to change health care in America. Congressman Price once described the ACA's ban on discriminating against individuals with pre-existing conditions as "a terrible idea." He has voted 10 times to defund Planned Parenthood, which provides lifesaving cancer screenings and treatment for sexually transmitted diseases to millions of people a year. He has proposed privatizing Medicare and increasing the eligibility age for coverage, and he has championed massive cuts to the Medicaid program that will leave millions of people either uninsured or with fewer benefits.

Twenty-four Senators, led by Senator Casey of Pennsylvania, sent letters to Senator Hatch and Senator Alexander, asking them to include witnesses in Congressman Price's nomination hearings, witnesses who could talk about what the impact of his radical policy proposals would be on the lives of real people.

Now, I am sorry that the Republicans refused to hear your voices, but I am deeply grateful that you came here today to make sure that your voices are heard anyway. I am grateful to my colleagues who are doing everything they can to amplify your voices, and to make sure that as the United States Senate considers its sacred obligation on advice and consent of the nominees in front of us, that we remember, most of all, that we are here to serve you. So thank you for being here.

Senator STABENOW. Thank you so much.

We have been joined by Senator Hirono from Hawaii, and with the indulgence of the rest of our distinguished Senators who are here, I think I'll move to hearing from our guests and then move to questions, if that is all right with everyone.

So let me first take home State advantage here, our prerogative, by introducing Anne Serafin from Ferndale, Michigan. She lives with Multiple Sclerosis and is covered by Medicare.

Anne and her husband also supported Anne's mom for the last decade, and after years of financial stress were able to get her mom into a nursing home, with the cost of her care covered by Medicaid, and we greatly appreciate hearing your story.

We'll introduce everyone and then we will come back to you. And I am going to turn now to Senator Warren for our next guest.

Senator WARREN. That's right. I have the privilege of introducing Kanisha Hans, who is here today with us to talk about the impact of the Affordable Care Act on her personally.

I just want to add that Kanisha discovered her passion for advocacy by volunteering in political campaigns, good for you, candidates for local office.

Today Kanisha lives in Boston, and she works in a Cambridge tech start-up. She graduated from Boston University in 2015 with a B.A. in Political Science and a minor in Public Health.

She is taking off time from work to be here today, and we are very grateful that she is willing to share her story, which underlines the critical protections that the Affordable Care Act gives us for women's health care.

So thank you very much for joining us today, Kanisha.

Senator STABENOW. Kanisha, welcome.

Now we have also been joined by Senator Blumenthal from Connecticut; welcome.

Alyce Ornella from Harpswell, Maine. So you've come a little bit, how is the snow up there right now? Much colder; okay.

Alyce and her husband were self-employed when they were able to get health insurance coverage through the ACA exchange. Alyce's plan provided free pre-natal care, including prenatal tests while she was pregnant with her son, Sam. When Sam was unexpectedly born with serious birth defects, her plan covered all of his intensive care and surgery costs, and Sam now receives care through Medicaid, which has covered every test and exam that he has needed, and we wish him well, we hope where is Sam?

Oh, well we want to see Sam.

Okay, is that who I met earlier, with the terrific sweater on?

Okay, we need to have him come back.

So welcome, we're so glad to have him, and close to home, riding the Metro in I think today to avoid all the traffic, Diane Fleming. Diane is 75 years old, lives in Washington, DC, went on Medicare at age 65, 5 years ago was diagnosed with thyroid cancer. Medicaid has covered the bills from the four surgeries, radioactive iodine treatment, CT scans, sonograms, MRIs, and needle biopsies she has needed to treat her cancer.

We are very grateful to have you here to hear from your story and have you elaborate as well.

And I know that Senator Brown is hoping to join us. I know I just left him a while ago in the Finance Committee.

So, Holly, he wanted to introduce you, but I know he is going to join us if he can. Holly is from Cleveland, Ohio. Self-employed as a non-profit consultant in Cleveland, runs her own LLC., was able to access mental and behavioral health services through Medicaid, and has been able to go on—I'll let you tell your story about what you have been able to actually receive in terms of help as a result of that, but we are so pleased you are here as well.

And Senator Bob Casey from Pennsylvania has just joined us. So I am going to ask Anne if you could share your story. We ask everyone to take no more than 5 minutes to start so that we can have an opportunity to ask questions as well, but, Anne, thanks so much for you and your husband being here.

STATEMENT OF ANNE SERAFIN, PANELIST FROM FERNDALE, MI

Ms. SERAFIN. Good afternoon. My name is Anne Serafin. I live in Ferndale, Michigan, and I am 66 years old. I just want to say, I'm reading this statement, so it may not convey the real passion I feel about this issue. But please know how important this is to me.

I've had personal experience with Medicare since I was 40 years old, when I was diagnosed with multiple sclerosis.

As you may know, MS is a neurological condition, which varies in severity and it's very unpredictable. My particular version resulted in functional quadriplegia. As a result, I am unable to walk, but I can stand up with personal assistance and a grab bar. I can use my right arm, in a limited fashion, but have no use of my left arm. Fortunately my vision, speech and cognitive abilities have been spared.

At the time I was diagnosed, I was a marketing professor at University of Detroit-Mercy. The University placed me on disability, and a year later my application for Social Security disability benefits and Medicare was approved. Thanks to strong union support, the University picked up my secondary health insurance until I turned 65.

Within a few years, new MS medications started coming onto the market, and my neurologist and I chose Copaxone. The price started out at about \$8,000 a year, but is now \$84,000 a year. After ten years, it became apparent that Copaxone was not working, so I tried several other medications, including Acthar Gel.

In the '70s, this cost \$50 a month, but when the drug company realized it could benefit many people with MS, it shot up to \$30,000 a month. Because it was off label, my insurance would not cover it. The National Organization for Rare Diseases helped for two months, but I could not afford to continue after that.

I am currently on Gilenya, with a co-pay of \$38 per month. Without Medicare or secondary insurance, this one drug would cost about \$75,000 a year, which is nearly our total household income including our Social Security benefits. I have a handout that can show you if you'd like to see it about how prices have shot up for all MS medications.

Disability is costly even beyond medications. Making our home accessible, purchasing an accessible vehicle, the scooter I drive, and hiring personal assistance; it gets expensive. This is why my 68-year old husband continues to work part time as a self-employed writer, while also serving as my primary caregiver. His monthly insurance costs were \$900 before he turned 65.

We rejoiced when he was able to get Medicare and have that number come down to \$200 for supplemental insurance. Without Medicare, I would have had to decide: do I eat, or do I get my meds? Without Medicare, I would have to pay an astronomical cost for private insurance, if I can get coverage at all.

While I was dealing with my own health issues, my aging parents needed increasing care and support. My father was a U.S. Army veteran who served as a paratrooper in World War II. He helped liberate Normandy with his D-Day combat jump. He was also an independent artist and relied on Medicare and the VA hospital for his health care. Even though my dad worked until his death at age 91, my husband and I needed to financially support my parents to keep them in their home. This is what they wanted, to age with dignity. We're Greek, and Greeks take care of their own.

I also have experience with Medicaid, which my mother relied on for the last 3 years of her life. My husband and I took care of her financially before she passed away at 98 this past October. Until my dad passed, my mother had Medicare with supplemental insurance. But my parents had no savings and no assets—we had bought them a condo and took over the mortgage payments. When my mother's dementia worsened to the point that she needed full-time care, we had to place her in a nursing home. I could not care for her complex needs; I needed help for my own care.

Even a bare-bones nursing home would've been too much for us at \$6,000 a month. She received \$1,190 a month in Social Security and widow's VA pension benefits. It was only because of Medicaid that she was able to get the help that she needed at the end of her life. Without Medicare and Medicaid, things would have been very different for my family. I don't know how I could have cared for my mother on top of managing my own care. My family would have lost our home and all our savings trying to keep up with the bills.

So many families are squeezed like ours, having to afford care for their aging parents and their own care or childcare at the same time. But with support, we don't have to suffer just being alive.

I can't cook for myself, I can't get myself out of bed, but I can still contribute. Because of these public programs, I can be productive and be involved in things that are important to me. This includes being here with you in Washington, talking with legislators, and volunteering as an advocate with Michigan United, Caring Across Generations, and the MS Society. All because of the support I get from Medicare.

If these programs are cut, people will face more catastrophes than ever before. People are panicking. If these services are cut, it will have a huge, huge, huge impact on the lives of many people. Congress needs to know that. Thank you for listening.

Senator STABENOW. Thank you so much, Anne. We really appreciate it. Kanisha Hans, welcome again.

STATEMENT OF KANISHA HANS, PANELIST FROM BOSTON, MA

Ms. HANS. Hi my name is Kanisha Hans, and I am from Boston, Massachusetts. I am 23 years old and an Indian immigrant, and a recent college graduate. Thank you to Senator Warren and all the Senators here who have invited me today to share my story about how important the affordable care act and access to reproductive health-care providers like Planned Parenthood cannot be repealed without devastating impacts on the health and well-being of millions of people.

Like the vast majority of American women, I rely on birth control. And like millions of young people I rely on my parent's insurance plan for my health-care coverage. Both have allowed me to pursue a college education and ultimately secure and maintain employment. When I was 15 years old I needed a birth control prescription for debilitating periods I was having that caused me to pass out during class. Being from a reserved Indian family I didn't feel comfortable discussing my situation at home. So I told a friend whose mother brought me to Planned Parenthood. My doctor at Planned Parenthood prescribed me birth control and helped me to afford it. This was one of the first times I felt like someone was listening to me about my own health-care needs. Remembering the caring and non-judgmental services provided to me, I saw Planned Parenthood again when I needed to change birth control methods due to other health concerns.

Unfortunately my insurance failed to cover the high cost of the specific type of birth control that I needed. Forcing me to use a prescription that didn't suit me and even exacerbated my symptoms. Luckily, I was eventually able to rely again on a doctor I trusted at my local planned parenthood to manage my condition. There they were able to cover the cost of my long acting reversible contraceptives at a cost that I could afford. This was before the Women's Preventative Benefits in the ACA and I was charged \$100 instead of \$1,000. This was critical for me because I would have been unable to afford the method that was best for my health while I was also pursuing an undergraduate degree and balancing other living expenses like tuition and rent.

Unfortunately, I know many women and many students who were priced out of this private care. But today thanks to the Affordable Care Act these same barriers no longer exist like they once did for me.

Six years ago the passage of health-care reform was a historic step for women of all ages. Thanks to the Affordable Care Act, I've joined the 55 million women nationwide who benefit from no co-pay for birth control and expanded insurance coverage. What's more important is that women like me are able to afford the right of birth control for our bodies or conditions with no out of pocket cost and in consultation with our doctors.

Beyond just birth control I now join millions of young people getting access to needed health-care coverage as a result of being able to stay on my parents insurance until age 26 and I am not forced to pay more because I am a woman or because I have a preexisting condition. I am grateful to have a job and while I am not financially dependent on my parents I am able to stay on their health care. So by staying on my parents plan I am both able to stay healthy and pay my student loans on my own every month. Hopefully someday I will also be able to pursue a graduate degree and pay that off as well.

This winter I was able to go back to Planned Parenthood to get a new IUD. After the results of the election I became fearful that I wouldn't be able to afford this care anymore. Tom Price has a history of working to reduce access to care and leading the Federal health care agency. I am concerned he is out of touch of the health-care needs of patients like myself. To be clear without Planned Parenthood and the Affordable Care Act I would not have been able to afford the birth control I needed to manage my condition. If Congressman Tom Price is successful in rolling back the ACA I will be forced to pay for care I need, charged more because I am a woman and could even lose my health insurance all together. He isn't looking out for me and he isn't looking out for women, men, or young people. And he isn't looking out for the well-being of Planned Parenthood patients. He cannot be trusted with my health or the health of this country. Thank you.

Senator STABENOW. Thank you very much. We have been joined by Senator Jeff Merkley from Oregon. Welcome, and, Alyce, I believe Sam has entered the room. Yes, welcome, Sam. Sam has the coolest sweater on, you have to see Elmo. Hi, Sam. He is living proof of the importance of affordable access and health care.

Senator KAINES. He can have my seat if I can have the sweater.

Senator STABENOW. Yes, just not for a while. Yes, welcome.

STATEMENT OF ALYCE ORNELLA, PANELIST FROM HARPSWELL, ME

Ms. ORNELLA. Yes, thank you. I hear myself echoing. Three years ago my husband and I were expecting our first child. At the time we were self-employed as small

business owners and we couldn't afford the high cost of health insurance. This was before the ACA. When the Affordable Care Act was passed we found an affordable plan on the market place. Suddenly all of my prenatal care was covered, my pregnancy was completely normal and uneventful. Just as everyone hopes the plan we signed up for through the marketplace covered advance testing for genetic conditions and all my results came back clear. But then the unexpected happen as tends to happen. No one wants to face the devastation of their baby being born with life threatening medical problems but that is exactly what happened to us.

Our son Sam was born with multiple congenital birth defects, none of which could be detected before he was born. He was rushed by ambulance teams to the Maine Medical center in Portland. When he was just 2 days old the pediatric surgeons performed surgery there to save his life. The medical bills in his first month alone topped \$100,000. Within his 2 years of life Sam has been seen by nearly a dozen specialist and has gone through 20 tests and procedures to ensure that his health remains stable.

Later in his infancy Sam was approved for SSI benefits which meant he also became covered by Medicaid—the transition to that coverage was seamless I only needed to make sure his pediatrician put in an authorization for his medication and specialist. He was able to continue seeing the same specialist that he'd seen since birth and his Medicaid coverage has fully provided for every test and exam he's needed. Knowing that Sam can receive all the care his doctor's want for him has greatly lessened anxiety we've felt regarding his multiple conditions. His access to testing has enabled us to confirm positive side changes in his conditions which has allowed him to go off certain medications sooner than expected.

Sam is now a thriving happy 2 year old who seems like any kid his age. I've been able to return to work part time since he is doing so well. Sam's health will still require a team of pediatric specialists to ensure care for him throughout his childhood.

The protections the Affordable Care Act has provided ensure that we have been able to get him the tests, medicine, therapies, doctor visits that he needs to stay healthy. The Affordable Care Act ensures that he can never be denied coverage. And that our family is not charged exuberant premiums fees and high deductibles because of his medical needs and means he will never face lifetime limits in coverage for the conditions he has had since he was born. The Affordable Care Act has been critical to how well he is doing today.

Due in part to our fears regarding the ACA repeal my husband and I have given up self-employment so that we can attain more security regarding health-care coverage in the future. My husband has recently accepted a job that will take him away from home more than we are used to but comes with a solid employment based health-care coverage for our family. This is our priority now that the new administration and Senate Republicans have made the ACA repeal their first goal. However I cannot rest assured that Sam's long-term future will be as secure if we lose the provisions for no denial pre-existing conditions. I fear the return of yearly or lifetime limits on coverage. And high risk pools. What if my husband loses his job? What will health-care access look like for Sam 5 or 10 years from now? What will be available to him when he is an adult looking for coverage as a person who was born with multiple medical conditions and has a complex medical history? No one should face financial ruin because they need medical help and no one should be forced to go without the medical care they need.

It would be irresponsible to our representatives in Washington to pull the rug out from under millions of people around the country who have health care because of the Affordable Care Act. I know how it would affect my son's life if that were to happen and it would be devastating for him and our family.

Senator STABENOW. Thank you so much for sharing your testimony and for sharing Sam. It is a blessing to see him acting so well, like a normal 2-year-old. Oh, before I forget, welcome, Senator Sheldon Whitehouse, joining us from the Great State of Rhode Island. So, Diane, welcome.

STATEMENT OF DIANE FLEMING, PANELIST FROM WASHINGTON, DC

Ms. FLEMING. Good afternoon, everyone. It is such a pleasure, and thank you for allowing us to be here. My name is Diane Fleming. I am a 75-year-old young adult.

I live in Anacostia neighborhood which is ward eight, 10 minutes from the Capital here. I am a retired member of the International Association of Machinists. And I am here today on behalf of the alliance for retired Americans. I am pleased to be surrounded by others who are fighting to protect our hard earned Medicare benefits. I worked for United Airlines for 35 years as a reservation and ticket agent. But when the airline went bankrupt I lost most of my pension. So you know that is a little less money. Luckily, my job provided me with health care coverage until I was 65 and went on Medicare.

Five years ago I was diagnosed with thyroid cancer. Since then I have had four surgeries, radioactive iodine treatment twice, the cancer has recurred and I will need to have surgery again. After being diagnosed with the thyroid cancer I've had CT scans, sonograms, MRIs to detect the target areas, little biopsies, and most of these procedures are very expensive. We are talking \$1,000 to \$3,000, to \$3,000 for one thing. I have also had to have blood work regularly to check the levels. And I don't know how I would have been able to afford all of these treatments and test done without Medicare to cover the bills.

In addition to the cancer, I suffer from glaucoma, which is hereditary through my family, and I need daily drops.

Medicare has help to make sure I receive treatment every 4 months to check the eye pressure. While others have private Medicare advantage plans. I chose the traditional Medicare. It has made my cancer a lot more bearable, enabling me to focus on getting better rather than going bankrupt. I know I speak for millions when I say no cuts to Medicare and no privatization. With premium support of vouchers a person with my pre-existing condition, with my age, I probably wouldn't be able to get insured, and if I could it would be very costly. So I need the guaranteed coverage that Medicare offers. Not a coupon or voucher. Those things don't work anyway that I could not afford. Millions of older Americans are able to enjoy their retirement without astronomical medical expenses because of Medicare.

In the age of small or nonexistent pensions, minimal retirement savings, and skyrocketing prescriptions, Medicare is literally a lifesaver. My sister just had to go on a medication, and a 28-day supply is \$30,000. So without Medicare she would not be able to do this. I retired at age 62, but I was lucky that United did provide health coverage and I was able to continue with that until I turned 65. So most Americans don't have that. We must make sure that Donald Trump keeps the promise not to cut Medicare so medical expenses don't bankrupt millions of seniors and their families.

Since November the President-elect and Republican support on Capitol Hill have taken steps towards dismantling and cutting our earned Medicare benefits. President-elect Trump has named house budget committee chairman Tom Price of Georgia to be the Secretary of U.S. Health and Human Services. Representative Price has spent years trying to privatize and cut Medicare in the past. I wonder what he is cutting out of his area. Representative Price has promised to cut and change Medicare into a voucher program. As Secretary, Price will have significant control over Medicare including RD plan and policies affecting the price of prescription drugs. His views are out of touch and he is just not a very sensitive person. We Americans have paid for decades and we continue to pay. Money comes out of my monthly Social Security checks to cover Medicare.

So Representative Price and the President-elect will be working closely together with House Speaker Paul Ryan. He has tried to do this over and over again. If Speaker Ryan's plans were to become law, seniors would become deeply hurt. We simply cannot afford to wait until we are 67 to go on Medicare and the privatization that the speaker calls for. The members of the Alliance will fight Donald Trump, and thank all of you all, fighting Paul Ryan and Price every step of the way. We need to guarantee the benefits that Medicare offers, not coupon care that leaves seniors like me hanging out to dry. Thank you very much.

Senator STABENOW. Thank you very much. We are pleased to be joined by Senator Baldwin; welcome. And we are so pleased now to hear from Holly Jensen. Welcome again.

**STATEMENT OF HOLLY JENSEN, PANELIST FROM
CLEVELAND, OH**

Ms. JENSEN. Thank you so much and good afternoon. I am Holly Jensen, and I am 32 and from Cleveland, and I am honored to tell you how the ACA and Medicare saved my life. I own a small business that helps nonprofits with communications and fundraising. I am a really hard worker and I love what I do. Most of my business comes from referrals from causes I support and I am proud to say that I am good at my work. This is my first business card, I still am proud of it and am excited by it. Part of the gig economy comes with the risk. If I don't produce I don't get paid. I don't get paid sick days. I don't get paid vacation days. So when the Affordable Care Act passed, it was huge relief.

I had never had my own insurance before. I had been living before undiagnosed with anxiety, depression, and OCD. It began to severely impact my life. Tasks that normally took an hour began to take all day and things began to feel insurmountable. I remember one project I was excited about working with the Compassionate Communications Center for Ohio and was going to go down from Cleveland to Columbus to meet with the board to discuss their Middle East peace activism. As I was preparing my disorder was beginning to spiral out of control and pretty much fell apart. I had to cancel this trip that I was really looking forward to at the last minute. This is one example of the way my untreated disorders were effecting my life. It was horrible and really embarrassing. My increasing inability to function dealt not only a blow to my bank account but also my livelihood and self-respect. I withdrew from my community and the arts world, which often involved organizing small business owners such as myself. My once active life became small and empty. I felt like I was slipping out of society.

However, the most painful act of being untreated was seeing my relationship with my loved ones crumble. Including my mom who is my best friend in the world. She just turned 65 in August. I hope she doesn't mind me saying that. Sorry, mom. She is going through the process of Medicare and is having tests that she has never had before. So my mother lives three blocks from me, and my brother lives one block from me. And at this point weeks would go by without me as much as answering a text message from them. So it was getting scary. And about a year ago I hit rock bottom. I couldn't keep up with my premiums or any bill. And it was winter in Cleveland and I don't have a car, so I slug through the snow and sleet to the free medical clinic in Cleveland. At this point I didn't have anywhere else to turn. Asking for help took a really long time and was incredibly humbling. When I got there my mind was so rattled that I didn't even know how to begin filling out the paperwork. A women there walked me through it, helped me through it, and treated me with respect and efficiently helped me re-figure out my life. Ta-da; this is my ticket, my golden ticket.

On that day, I felt like a person who deserved to care. And even before the process of receiving treatment started, that glimmer of hope meant so much. It meant I wasn't a disposable person. And it took so long to ask for help, if I would've been turned away, I really might have lost hope entirely. And if they'd said I needed regular employment to access Medicaid, I definitely would've continued going in a downward spiral. Requiring employment for Medicaid would've been like telling me you'll throw me a life preserver after I stop drowning.

My psychiatric care has given me the foundation on which to rebuild my life. I take medications, such as this, and I have weekly counseling therapy sessions that help me heal and grow. I also do an enormous amount of work on my own to make sure that I keep up my progress. This care not only saved my life, it gave me back my life. Thanks to Medicaid, I'm becoming the professional I want to be again. But more important, I'm becoming the person I want to be.

I have faith in growing my business, not just struggling to keep it alive. I'm back, actually working with [the] compassionate Communications Center of Ohio, doing psych redesign and branding, and I really love working with all of my clients. And once again, organizing and participating in arts events in my community and I'm volunteering at my local recovery clubhouse, applying my communication and development skills to help them to continue to support the community. I'm reconnecting with my friends and loved ones. Perhaps most important, [I'm] restoring my relationship with my mom. It feels good to pay my bills, but it feels even better to be part of something.

Mental and behavioral health is no joke. Without Medicaid, I know I would have eventually depended on emergency care, taxpayer funded rehab, and the legal system. I would've cost taxpayers much more than the expense of my basic care now. My goal is to continue healing, regain my earning potential, get my private health coverage, and happily support Medicare and Medicaid in my tax dollars. Despite my relatively high tax rate for self-employed people, I would be proud to support these life-saving and tax dollar saving programs. And I know I'm not alone. We cannot afford to discard and destroy the ACA and Medicaid for millions of people like me who would be turned away. For me, that would've meant discarding me exactly when I needed support the most. Thank you for allowing me to share my story.

Senator STABENOW. Well, thank you so much. Hi, we've been joined by my friend and colleague, the great Senator of Michigan, Gary Peters. You have the full Michigan delegation here, Anne. You have all of us here with you. So, let me begin. We want to give all of our colleagues the chance to ask a question.

I have to say that listening to all of you, whether it's talking about maternity care, I remember the fights in the Finance Committee when colleagues did not believe that that should not be in the central service and it makes me smile to hear you talk about maternity care and to see Sam and to have each of you talk about things that so many of us fought so hard for. But, I do want to particularly, Holly, thank you for being here, as the author of the mental health parity provisions in the ACA because of my own family's situation. I want to thank you for your courage, because we have done less research over our country's history on the organ called the brain, we're finally doing that. But, whether it's a chemical imbalance in the brain, like my dad had, and was finally diagnosed as bipolar. And once that happened and he got the mediation he needed, he went on to live a very effective life. So, I saw what it was like when he didn't and when he did. And, a tremendous difference. So, I have always felt that, and I know my colleagues have, that whether it's diabetes and you're checking your sugar, or whether it's a chemical imbalance in your brain, we want to have the same view in terms of access to care. And not have a stigma, depending on which part of our body the disease is in. So, I just want to thank you for your courage and for speaking out for millions of people; one out of five people in our country are struggling with a disease that involves behavior health. And so, thank you very much for doing that.

Anne, I wanted to ask you a question, actually a couple of questions. You were talking about your prescription drug costs. When we look at these numbers, unbelievable, \$50/month to \$30,000/month or \$8,000/year, was it, to \$84,000/year. I mean, these are astronomical increases, and there's a whole range of things, dealing with cost of medicine that we need to tackle still in this country for sure. But, I wonder if you might speak about where you would be right now without Medicare, speak a little bit more about that. So, costs, what that would mean to you. And if we saw Medicare turn into some kind of a voucher, no matter what we call it, being in support of a voucher, where it wasn't guaranteed coverage and guaranteed prescription drug coverage, how would that work for you?

Ms. SERAFIN. Well, first of all, without Medicare, I would have to get insurance and because of my preexisting condition, I would not be able to get insurance. Second, without Medicare, I think my husband and I would've ended up on Medicaid because we would've been bankrupt. I mean, we have a small nest egg, which we have, as I've shared before, used a substantial portion of to help out my parents. That would've been gone. The costs are just prohibitive; we couldn't have done that. \$6,000, \$8,000, \$84,000/month and actually, the MS—

Senator STABENOW. A month? So, it's \$84,000/month?

Ms. SERAFIN. No, sorry; that was a year.

Senator STABENOW. Oh, a year, okay. Either way it's a lot of money. More than most people make a year.

Ms. SERAFIN. It's a lot of money, but the Acthar Gel is \$30,000/month.

Senator STABENOW. All right, thank you. We have many colleagues I want to make sure have a chance to ask questions. So, thank you, for now and, Senator Warren.

Senator WARREN. Thank you, and thank you all again for being here. You know, yesterday at the hearing for Congressman Price to be Secretary of HHS, I asked him about the cuts that he has proposed to Medicare and Medicaid. You know, he's already proposed \$449 billion in cuts to Medicare and over \$1 trillion in cuts to the Medicaid program. And so I asked him if he would commit to follow through on

Donald Trump's promise, "I won't cut Medicare or Medicaid." And, there was a lot of dancing back and forth, but the bottom line is, no, he would not commit, which I'm suppose should not have been a surprise. But what I just want to do, as briefly as I can, is to just focus in, just a little bit, down the line and put a face to that. What it means to put those kind of cuts into the system. So, if I can, let me start with you Ms. Fleming. You used to work at United Airlines, as I understand. How many years did you pay into the Medicare system?

Ms. FLEMING. [Mic did not pick up.]

Senator WARREN. And how long have you worked there?

Ms. FLEMING. Thirty-nine years.

Senator WARREN. Thirty-nine years that you paid into the Medicare system. So, when Congressman Price proposes cutting \$449 billion out of the Medicare system, I just want to ask, that's going to put more out-of-pocket costs on you. Does that sound fair to you?

Ms. FLEMING. [Mic did not pick up.]

Senator WARREN. Nice question. Where else is it we so much need to spend \$449 billion that you can spend more out of pocket so that money can go somewhere else—like tax cuts for rich people. Ms. Jensen, can I ask you—just because I want to be clear about this. One of the things that Medicaid does is make sure you get access to mental health services. If you lose that access, what happens to your life?

Ms. JENSEN. Um, that would entirely change my life. I wouldn't be able to afford the services I need. My medications alone right now run about as much as my rent. And I know that weekly counseling or therapy sessions would really be out of reach. It would threaten not only the growth of my business but the existence of my business. Basically no Medicaid, no business. That would kind of be the end of one of my dreams. And, untreated disorders—my untreated disorder, I know I would retreat from society. I would retreat from my loved ones. I would not be a productive citizen. I would probably get in trouble and cost the taxpayers some money. Mental and behavioral health is no joke. There are fatal consequences, and it's a matter of life and death for a lot of people—including me.

Senator WARREN. Thank you. Thank you. And Ms. Serafin—I know that you have dealt with both systems, both Medicare and Medicaid. For just 1 minute, I'd like to focus on the Medicaid part of that. Your mother, after your father passed, your mother declined, needed full time care. And she was supported by Medicaid during that period of time. She was able to be in a facility that could take care of her. If Medicaid hadn't been available to you—if there had been a trillion dollar cut to Medicaid, what would have happened to you and your husband?

Ms. SERAFIN. Well, physically I could not take care of anyone else, I can hardly take care of myself. So, we would have had to hire someone or we would have had to move because our home was not accommodating for another person with a disability. Second, the care my mother received in the nursing home was so personally gratifying; I could sleep at night. My mother was a really strong woman, she could have been a CEO. She was born in the wrong era. But as a daughter, as mothers and daughters often do, we didn't always see eye to eye on everything. And people in the nursing home loved her—they loved her feisty manner, they loved the things that she would say. And I would think, "Oh god, I would never say that." But they thought she was wonderful.

Senator WARREN. My mother was like that too.

Ms. SERAFIN. I could sleep at night. I could feel good because I so cannot do things as it is for myself, and there were loving people who would go to her and say, "I love you, Anita," and it just made my heart feel that wonderful feeling.

Senator WARREN. That's the face of Medicaid. And one more on Medicaid. And that is Sam. Right, Ms. Ornella?

Ms. ORNELLA. Yes.

Senator WARREN. Sam is the happy face of Medicaid. If there's \$1 trillion in cuts to Medicaid, and Sam is not able to get help through Medicaid, what happens to Sam?

Ms. ORNELLA. We barely qualified for Medicaid as it was, so if there are any cuts to it, we would have been in that group of people who I believe wouldn't have qualified on the financial basis. Medicaid has provided him to be able to go to his kidney

doctors and to keep his status check on his kidneys, which is what we think his long-term issues are going to be. Medicaid has been there to cover tests for swallowing, for swallowing functions, for all the different parts of his body that are affected by his disorder. So, my fear is that if we do get employer based coverage, anything can happen in life—what if my husband lost his job and then we didn't qualify for Sam to get Medicaid anymore? How would we deal with that double whammy of losing employer coverage and then not qualifying for Medicaid for a medically complex child?

Senator WARREN. Thank you. I'm very grateful to all four of you for putting a face on what Medicare and Medicaid mean. I suggested yesterday to Congressman Price that if he is confirmed to be the head of HHS, that he cut out the statement of Donald Trump, "I will not cut Medicare or Medicaid," and tape it above his desk and look at it every single day—because you are what that's all about. You are the reason we must not cut Medicare and Medicaid. Thank you, thank you for being here.

Senator STABENOW. Thank you so much, that is so true. Senator Kaine?

Senator KAINES. Well thank you, Senator Stabenow, and to my colleagues for doing this. Thank you for sharing your stories, these are very important.

Kanisha mentioned the words, "kind of afraid of what might happen," and I just kind of jotted that down. There's about 66 million Americans who are really disappointed about what happened in November, but there's a subset of people who are really personally very, very afraid. And I think the job of us, the job of those of us who are disappointed is to have the backs of those who are afraid.

People are afraid because they might lose their healthcare. People are afraid because they're worried about rollback of marriage equality. People are afraid because they're worried that they might be deported. People are afraid for a lot of reasons. And it gives me a lot of motivation to try to have the backs of folks who have legitimate concerns and fears. And coming and sharing your stories is important.

Congressman Price poses particular challenges to us because you can kind of look in vain in his record to see support for virtually anything that's a part of the healthcare coverage safety net. He wants to turn Medicaid into a block grant program and is against ESGIA, voted repeatedly against it, called it "socialized medicine." Most programs cover more than 800,000 Virginians.

He wants to repeal the Affordable Care Act. That's a program that helps millions of Virginians, if you add up all pieces of it together. He wants to change Medicare into a premium support program that would raise costs, by CBO estimate, of 1.3 million Virginian seniors. And he wants to defund Planned Parenthood which is the primary health care provider of choice for tens of thousands of Virginians. If you look at everything that's in the coverage space, that's in the access space, he is opposed to it. And so that's what makes him so problematic as a next HHS Secretary.

On my webpage I put up a little thing, kaine.senate.gov/ACASStory, and a week ago I asked Virginians to share stories much like you shared today. We have more than a thousand submissions of stories just like yours.

I'm going to ask one question based on a theme that's emerging from the stories that I have not been paying much attention to but both Alyce and Holly, you mentioned it in your testimony. The ACA makes it easier to be self-employed and start your own business compared to what we had before. And if we can get over the rush to repeal that's injecting so much uncertainty into this question of, "will we be able to count on this or should we go back and work with an employer provided plan?"

The ACA has turned into this motivator for entrepreneurial spirit and start-up businesses and innovators. Exactly the kind of thing we want to do, so, separate and apart from all the health care benefits, which are fantastic—that's reason enough to fight for them—the ACA has also given people who have a dream to start their own business, to start their own nonprofit the ability to do it, and have health insurance if they do it.

It's interesting, Senator Stabenow, the number of stories I've gotten on my website of people who have come up to me and mention this aspect of the Affordable Care Act, even though sometimes that's not the story they're telling me. Something about their child who has a special need, but they're telling me they're able to have health insurance as an entrepreneur, as a small business owner, as a startup or nonprofit because of the ACA.

So I'm seeing this really positive economic effect and I imagine that again, that was in Alyce and Holly's stories. It might not have been the main theme of the

story, but it was an element in both your stories. And I think that's something we have to fight to protect. I'd be interested in hearing your thoughts.

Ms. ORNELLA. I'll just give an example. Before the ACA was passed, my husband and I, who were both self-employed, went without insurance, because in Maine the quote for what was available to us, and we were two adults under the age of 35, was \$1,200 a month. And that was a huge part of our income. We've not ever been people who have made a lot of money so we went without insurance. And then when we were able to sign on to the ACA plan we paid \$200 a month.

So, for that reason, we were able to continue our small business activities for longer than we would have otherwise and we supported ourselves for a number of years that way. Obviously priorities change when you have a child and if you have a child that has complex medical needs you start to assess whether or not you can—especially when there's talk of repealing the ACA and protections for people with preexisting conditions you start to rush into thinking, "I need to work for someone else now."

Senator KAINE. But if we stabilize this and get over this rushed, this foolish rush to repeal—

Ms. ORNELLA. Yes.

Senator KAINE. We have something that we think we need in place for people like you, the chance again to say, "Hey I want to be my own boss and start my own business."

Ms. ORNELLA. Oh yes, absolutely.

Ms. JENSEN. I've actually never had health insurance from my employer. I went without it for a long time until the ACA and eventually Medicaid. It is absolutely essential to my business. My well-being is the cornerstone of it. It's more important than my credit line, it's more important than tax rates. Nothing gets done when I'm unwell. And we can't claim to support small businesses if we don't support small business owners. Yes, my business would probably not exist without Medicaid at this point to be honest. And in the larger picture, I worry about how that will dampen America's innovation and entrepreneurship. If it becomes an unbearable risk to start your own business, guess what? We're losing a lot of small business owners in America.

Senator KAINE. Thank you. I appreciate it.

Senator STABENOW. Thank you so much. And, Senator Kaine, I have heard the same thing from so many people who have been able to go into small business and their life's dream because they've been freed from that chain of having to be somewhere with insurance from their employer. So thank you so much for that. I know Senator Merkley has to leave at 1 and, to just briefly say something, we will let you jump in here to do that. I am going to step away to ask a question at the Finance Committee of Mr. Mnuchin—we're beginning a second round—and I will stop back, so we're doing our version of Beam Me Up, Scotty, as we're running back and forth between everything—but, Senator Merkley?

Senator MERKLEY. Inaudible 1:12:33–1:13:13. I think it's vetted in the issue of Medicare, Medicaid, and ACA. We have a health-care system that's just, when you need care, when you have that disease, that accident, you know you can access it, and then you pay more and you get the care that you need. So I just wanted to share that comment. [Inaudible comment] . . . have questions for Sue. Thank you for sharing your testimony. We need a health-care system. It gives peace of mind to Americans, not distress of whether you'll be able to get care, not go bankrupt, and that's what we're fighting for. Thank you.

Senator HASSAN. Well, thank you. I want to thank Senator Stabenow more—you really were the driving force in organizing this. I also just really want to thank all five of you for being able to be here to tell us your experiences, because change occurs when people are willing to stand up, especially in a democracy, and not only talk about ideas, but talk about real life experiences so that policy makers understand what the impact of their ideas and philosophies are and really can be informed as we work to make sure that things work for the American people. I am struck by the themes that your combined testimony have raised for today's panel, and I hope for everybody who's watching and listening cause I think we really see and heard from you a wide range of experiences that really talks about the individual peace of mind, the physical health, and the economic health that comes with accessible, affordable, high quality health care. I want to touch on a particular sub-

set of what I've heard, just because I think given Congressman Price's, nominee Price's, record is important. But before I do that, a special shout out, Alyce, to you, we have something in common having had kids with special needs and it has its challenges but it has its good rewards too, so, thank you for what you're doing to raise Sam.

Ms. ORNELLA. Thank you.

Senator HASSAN. You're Welcome. And, Kanisha, I wanted to talk to you a little bit more about your experience. First of all, given Congressmen Price's record of repeatedly voting to defund Planned Parenthood, you talked about how important Planned Parenthood had been to your care at critical times in your life. Can you just tell us a little bit more about what your experience as a patient at Planned Parenthood was like and how it impacted your ability to do what you wanted to do with your life?

Ms. HANS. Sure. So, when I went to Planned Parenthood when I was in high school; it's because I had no other place to go. And now I go to Planned Parenthood by choice because I trust them with my health care. I've mentioned before I had a medical condition that went undiagnosed for a while. I'd gone to several different doctors before, and Planned Parenthood was the first one to diagnose me with my condition and was able to treat me. And thanks to title X funding, I was able to afford my care, and that's why I keep returning to Planned Parenthood, because I trust them.

Senator HASSAN. I take it would also concern you to know that Dr. Price voted as a Congressmen against a District of Columbia law that would prohibit employers from discriminating against employees with the decisions they make about their reproductive health and birth control. Is that something you're aware of and does it concern you?

Ms. HANS. Yes it does concern me. I'm 23 years old and I am employed so I am worried about getting kicked off my parent's insurance, and if I do go on my employer's insurance, it's not my boss's business about my health care and it is something that is very concerning, and having grown up most of my adult life with the Obama administration, I never imagined I would have to worry about this. And it's kind of really throwing me for a loop.

Senator HASSAN. Right; well, thank you. I too am going to have to leave; this is what happens. Senator Kaine, you can sit right here.

Senator KAINES. I do have other questions, but I wasn't planning on sharing. I may have to go too. I'll keep it rolling.

Senator HASSAN. What I hope you all know, again, is how grateful we are to you for telling your stories. Each and every one of you has been willing to talk about something that used to be very hard to talk about, and particularly Holly, as I just ended my term as Governor of New Hampshire, and I'm dealing with an opioid crisis, as many States are. We also know that behavioral health challenges and substance use disorder sometimes co-occur, and so the importance of people with behavioral health challenges and/or substance misuse speaking up for themselves, the same way it's important for women who need access to strong and good reproductive health care speaking up for themselves, for people with disabilities, or parents for people with disabilities, the willingness to speak up about the need to be included is just critical, and in a democracy, where every single one of us counts, you guys have done us all proud today reminding us of that, so thank you so much, and let's keep at it because this rush to repeal is so misguided, and with regard to Congressman Price's nomination, I hope very much, at the very least, that he will understand and reflect on your testimony should he become confirmed. Thank you.

Senator HIRONO. Senator Kaine, you have one question to ask?

Senator KAINES. I do, I do, thank you, Senator Hirono. I'm so glad that we got into the reproductive health issue. This week, there was an amazing announcement, and it didn't get enough attention and that's the unwanted pregnancy rate in the United States, it's at its lowest ever since history has been able to record that rate. What a great thing. The Affordable Care Act and the fact that Planned Parenthood has not been defunded is one of the reasons—two of the reasons why unwanted pregnancy rates has come down. This is not really a question, it's an editorial comment. I am stunned at the number of individuals who take policy positions that would suggest they're very much against unwanted pregnancies who want to repeal the Affordable Care Act. I'm stunned at institutions that have taken an anti-ACA position who are institutions that would suggest production of the unwanted pregnancy rate.

I can't imagine anybody in society who would look at the reduction of unwanted pregnancy and say that's a bad thing. I think virtually everybody in society, regardless of politics, political party or political at all, regardless of region, regardless of race, regardless of anything, would look at reductions in unwanted pregnancy and say "that's a good thing." And yet some of the people who are the most claiming to be forward are the ones trying to undo the very health-care safety that has been able to bring down the rates of unwanted pregnancy. If they are successful in that, the unwanted pregnancy rates will go back up. That's one of the many things I have a hard time figuring out. And I will turn it back to my colleague, Senator.

Senator HIRONO. Thank you now that everybody has left, not you folks, but Mahalo for being here, and you know that we were joined by so many of our Senate colleagues today to hear your stories, and I know you understand that we are in the midst of confirmation hearings for many of President-elect Trump's nominees, and so I know you understand why people are going in and out.

We have a nominee for HHS Secretary who wants to privatize Medicare, who wants to dismantle Medicaid, who wants to defund Planned Parenthood, and you have come in today to tell us your own experiences and stories about how these programs have literally saved your families, saved you and allowed you to go forward and thrive. So, I will join my colleagues in fighting tooth and nail against the voucherizing of Medicare and the privatizing of these kinds of programs that really are the lifelines for millions of people in our community.

I think that finally, with the potential demise or repeal of the Affordable Care Act and voucherizing of Medicare and the huge cuts to Medicaid, the defunding of Planned Parenthood, it is finally, I think, sinking into our country what these kinds of actions would mean to them.

I was a member of the United States House of Representatives when we were working on the Affordable Care Act, and I remember, sadly, how many people on Medicare, including people from the state of Hawaii who were on Medicare, who came to me and called me and said, "Don't touch Medicare but don't pass the Affordable Care Act." These seniors are going to find out that with the repeal of the Affordable Care Act, they will end up paying more for drugs because the Affordable Care Act was the prescription drug donut hole. They will not be able to access the kind of preventative care that allows them to age in place and maintain their lives with the repeal of the Affordable Care Act.

This is sad, that so many people who came forward to say that we shouldn't pass the ACA will be among the millions who will be hurt with the repeal of the ACA. So, we have a President-elect who recently said that "my health-care plan will cover everyone." Did you . . . he said that. There will be health care for everyone. How do you all think that is supposed to happen? How is that supposed to be implemented with Secretary Price at the helm? Anybody? It's more than just a rhetorical question.

I would like you all to say that on the record what you all think will happen to President-elect Trump's pledge that his health care plan will cover everyone.

Ms. JENSEN. It does not seem logical to me if he is making that statement and he is nominating or choosing someone who, in what touches me personally, says he does not believe that preexisting condition should be considered as an accommodation or a protection, and I'm thinking of my own child who was born that way. He didn't acquire them through any of his own choices in life, or anything that he did. There's millions of children and individuals who are in way worse position than Sam is. So how does that add up if you say you want to have coverage for everyone but then the person you pick to be in charge is already excluding individuals before their record is of exclusion. I don't understand how that makes sense.

Senator HIRONO. Thank you. With the other people who have come forward, would you like your comments to this question to be on the record?

Ms. FLEMING. Yes, I'd like to comment. Obviously, the President-elect has not really looked at Representative Price's record in voting the things that he has voted against, so I think that hopefully, he will take a look at his record in what he has done in the past and give him some new ideas that this is not good in what you're planning to do.

Senator HIRONO. Ms. Serafin?

Ms. SERAFIN. I think that if he is chosen, he will decimate Medicare and Medicaid as we know it. I believe that his stance will be "you can go out and figure out how

to take care of yourselves on your own. We'll give you the costs, we'll give you the money for whatever else we need the money for." It will be chaos, I believe it will be complete chaos.

Ms. HANS. Yes, I would like to go in everyone else's comments in that I don't think the President-elect has really done his homework in who he's been nominating and that's been made very clear by Tom Price's record. And it doesn't seem like Tom Price doesn't really care about the health of the citizens of the United States. And therefore, it makes no sense that he should be at the helm of HHS. His record has consistently shown that he doesn't care about people who rely on these health programs the most.

Senator HIRONO. Ms. Jensen, would you like to add to this?

Ms. JENSEN. Yes, I would. Thank you for the opportunity. I very much agree, it's like Trump hasn't met Price. For instance, one of the ideas thrown around about employment requirements for Medicaid seem counter intuitive for me. I feel like it's the law makers' job to represent the caring majority, not the minority of the wealthy, and I feel like we're going in that direction. Yes, and I don't know how we're supposed to reconcile these two entirely exclusive plans that we have on the table. Yes, I believe that lawmakers need to work to protect the vulnerable, nurture small business, and save the taxpayers money.

Senator HIRONO. Thank you. Senator Blumenthal, we can proceed to you with your question.

Senator BLUMENTHAL. Thank you Senator. Thank you all of you for being here today. Your stories, as Senator Warren said, have really given us a face and a voice to this somewhat abstract issue to many Americans. People take their health for granted until they don't have it and then it becomes the most important thing in the world as each of you know from your personal experience. All of us know it because we've all had bad health, it's not like wealth gives you immunity, but it enables you to do a lot of preventive care, and that's what I want to focus on is the prevention. Cause just as we ignore the economic impact of small businesses as Holly has said so well, we also ignore the increased cost of health care if preventive steps aren't taken. At a very early age, Sam's age, to forestall diabetes and obesity and smoking and even opioid prevention because preventing addiction is so much more cost effective than treating it later. You mentioned, Anne, that the cost of your medicine is \$75,000 a year; do I have that right?

Ms. SERAFIN. It would be, for the one drug I talked about, it would be \$84,000 a year. As it is now, the Gilenya I'm on is \$6,000 a month, so that is \$72,000 a year.

Senator BLUMENTHAL. So, you can see just the cost of that one medication and your medical cost may not be preventable in the same way but we can really save a lot of money through prevention and we can bring down the cost of medication. One area that I think perhaps in this conversation that has not been emphasized is the effects and the goals of the Affordable Care Act in restraining and diminishing the growing cost of health care. That was one of the objectives, not just create more demand for it and put more money into the health-care system, but also try to make it more efficient and effective. So I don't know whether any of you any have observations on that aspect of it, I would welcome.

Ms. HANS. Yes, I think that a lot of people have kind of lost sight that that was the goal of the ACA: when more people have coverage, it actually drags cost down. When people don't have coverage, they keep putting off care. I know—I personally had to put off care because I couldn't access it, and when you keep delaying care, it's more costly in the end. And in the end, the taxpayers are still paying for it, they're just paying a lot more.

Ms. FLEMING. My view is that preventive care is necessary. This is a good thing, we're becoming a healthier society with this, and if you eliminate some of the preventive care, the early exams that you can have, which we cannot do before, because of the cost, you can really target if there is an issue, you can target right away and take care of it which in the long run will cost us a lot less than someone that has to have really severe care, so the preventive part of it is from early childhood all the way up, to us older folks. Thank you.

Ms. ORNELLA. I'll just quickly add with Sam's conditions, he requires regular monitoring to ensure that no further problems arise or if they do, they are caught in a timely manner. So I don't know if we want to consider that, I guess we'd consider it because by doing monitoring, which can range from minor tests that cost a few

hundred dollars to tests that cost a few thousand dollars, it's heading off any problems be exacerbated but, you know, especially with a young child that cannot really communicate what's going on in their body, so being able to access that kind of care is important to maintaining a stable health condition.

Ms. SERAFIN. I just want to add that the disease modifying drugs that are there for multiple sclerosis are there to retard any advancement. So even though they are costly, hopefully they're actually lessening your chances of developing a more severe disease and more costly problems.

Ms. JENSEN. And I'd like to add specifically for mental health and behavioral health, preventative care in that world is kind of a new frontier. I definitely had that attitude of "I can handle this. I can do this. I can dig my way out of this." I didn't want to ask for help. Maybe that's a very American thing: "I can do it myself." And that is what the preventative care is coming up against a lot of times. And I would say that education about mental health and behavioral health, the idea that was raised before that mental health and behavioral health are part of health care. So education about that could be very effective. And also reducing the stigma, even by covering these things we do a little bit to reduce the stigma. You're saying, you're a person worth care. You're not disposable, you're not discardable. And also reducing the stigma about asking for help which I hope I can do in a tiny way today.

Senator BLUMENTHAL. Just so you know Holly, for, I think it's more than 8 years, there's been a law on the books that requires, it's called, parity. In other words insurance companies are required to cover mental health care in the same way that they cover physical healthcare. That's a matter of Federal statute but there was a delay in adopting regulations to implement the statute. That delay occurred under both the Bush and Obama administrations and I was involved in helping to advocate that law. We did it in Connecticut which is my State, and then that law became a model for the Federal statute but only recently has it been implemented and even now it's not fully enforced. So my colleague Chris Murphy and I, we're both from Connecticut, we've both advocated that there be enforcement of that statute in part to deal with the stigma that you mentioned which is still a major obstacle.

Ms. JENSEN. You can't ask for help if you don't think there's anyone out there to help you.

Senator BLUMENTHAL. Well said. Thank you all.

Senator HIRONO. Thank you, Senator Blumenthal. I'm going to ask Senator Casey to wrap up, but before I do that I want to thank all of you once again. You represent millions and millions of affected people in our country and I think our voices, and I say "our" because you know we are with you, need to be heard. As we say in Hawaii, "Mahalo nui loa." And thank you, Ms. Jensen, for pointing out the importance of mental health services because, as Senator Blumenthal has pointed out and many of us know, there has been a lack of parity as to the treatment and the access to care for the mental health side which can be just as debilitating if not more so than physical injuries, so, Senator Casey, thank you very much. Mahalo.

Senator CASEY. Senator Hirono, thank you very much, and Senator Blumenthal and all those who are here. I'm the last one; because I am, I won't ask questions. I just wanted to make a comment about your testimony, maybe a comment about the process, and give you the last word if you so choose. We've been here a while.

One thing I want to say at the outset is, both Alyce and Diane, I'm using your first names even though we don't know each other, I don't know who to commend more on multitasking with Sam, but that's a pretty good tag team. I don't know if you practiced that this morning but it sure looked seamless. But we're grateful for your testimony.

I want you to know something and I say this in a very serious way, not just as a way to say thanks for making the trip here. We live in a society where on an hourly basis it seems, the lives of movie stars or athletes or even politicians or wealthy people, depending on what category someone's in, their lives are always chronicled, always on the news, always a subject of interest and debate and coverage so to speak. Every once and awhile the lives of real people are put up with the same degree of prominence but frankly not enough. And in this debate, right now it's more than just a debate, it's a fight.

Chapter 1 is stopping the repeal of the Affordable Care Act, and that's a fight we're in right now. Chapter 2, in my judgment, would be if they're successful in Chapter 1, fighting like hell to make sure whatever they replace it with, and no one's been able to find it—we might want to hire a private investigator to find it

in the replacement bill, but it doesn't seem to have surfaced yet; I'm hoping it does—but to fight like hell to make sure that whatever is in the replacement bill is substantial enough to meet all of your needs and the needs of lots of other people.

But your stories are not stories that are customarily on display in Washington; yours are the stories of people that have lived quietly triumphant lives. You've had to triumph over things that I've never had to worry about and a lot of people in this building have not had to worry about. Not everyone, but a lot of us haven't had those same worries. So in your own way, in a very quiet way, you've been triumphant in a way most of us haven't been able to appreciate. And that story that you told is both inspirational but also instructive and even instrumental. And I say that because the process. If you take your stories out of the debate, years ago when we were trying to pass the ACA and I was here and played a role in that, but even more so now if you took your stories out of this debate to stop repeal and to make sure we get the right result down the road, we lose.

Because if it's just a bunch of Senators rattling off numbers—and they're great numbers to talk about: 20 million people insured and all of that. We've got to keep using numbers; they're important. But what is indispensable in winning this battle is how often we tell your story, how often we excerpt from it in a floor speech, and how often we use a 20-second sound bite in an interview or back home or on the road or in debates in committee. All of those stories are going to be indispensable to that.

So this isn't just a nice thing to do today. You're contributing to the effort to win the battle. Your stories are persuasive, numbers once and awhile can help you persuade, your stories are persuasive. So it's up to us to make sure that we keep telling your stories, and stories like yours all across the country. So you're playing a big role in this debate and in so many ways that's doing something for your country.

You've come here to talk about your life which isn't easy to do. And politicians like me, we talk a lot and we talk about issues but rarely we don't talk about our own personal lives. That is much more difficult than what we do every day. To tell a story, to admit that things weren't going well in your life or that the struggles you had or that the suffering you or your family endured. That's not easy to do for anyone and we appreciate you doing that.

So that effort, that sacrifice, that commitment to going beyond yourself is very, very meaningful to the debate. So I hope you understand that and that you don't ever get dispirited in this fight because we need you very much in this fight and you've already been willing to sign up and not only put your hand up but walk towards the goal that we're trying to achieve.

Holly, one of the best lines today is yours: "It feels good to pay my bills, but more so to be part of something." And not just the kind of care that saved your life but gave your life back. So the measure of our success will be how often we can put your stories on the record in the interview. So I just want you to know how much we appreciate you. Secondly in the process, today I'm going back and forth between the hearing from the Finance Committee—we have Mr. Mnuchin for Treasury Secretary. That's what we're doing today, we're asking him a lot of questions about tough topics like mortgage foreclosures and things like that. But we're going to finish that hearing today; obviously it'll go for a while more, and we'll vote on that nomination.

But we're kind of in the middle of the Representative Price nomination. I'm on both committees that he testified in front of, but only the Finance Committee will be where the vote is. So he'll appear there in front of our committee where we're doing Treasury today, and that's where the vote will be. And because of your testimony today, you've given me more, I won't use the word ammunition, but you've given more information for us to be able to present in questions or comments in that hearing on Representative Price.

And obviously we can't just do a good job in these hearings, we have to do a lot more on the road back in our States. So that's the process and we're going to continue to fight very hard to give meaning and value and really to validate what you've told us today.

This is critically important, that we preserve all these protections. And absent any other comments, we can wrap up, but I just want to give you the last word. You traveled and took time to be here, so if anyone wants to make any final comments, and then we'll gavel out with the gavel. We actually have a gavel; I'll do that.

Ms. SERAFIN. Thank you for this opportunity. It has helped me personally to be able to share this story and feel like I'm part of what's going on and it's helped me to live with the next 4 years.

Senator CASEY. Ann, thank you very much. We're grateful. Anybody else?

Ms. FLEMING. I just want to thank everyone. It's good to put faces to it all with you all as well and I think one of the things that's missing is the eye to eye contact that you're, you know, going to implement something but you can't look me straight in the face or straight in the eye and tell me what you're going to take away and not give me anything else. This is good to be able to, the empathy that you have and that you have all presented in front of us today, which I don't see that happening in the next round of people. There's no compassion—where is it? It's missing. So thank you all.

Senator CASEY. We'll do a better job on our end. If we're in the middle of a debate, figuratively speaking and sometimes literally, we say, "Well, I know you don't like what I said, but answer Diane's question. How can you help her? How can you make sure she doesn't have a circumstance that's unimaginable and will have the help that she needs?"

Ms. FLEMING. I wanted to say, I live right across the bridge, so any time, just give me a call.

Senator CASEY. You're close.

Ms. FLEMING. I'll come in.

Senator CASEY. Thanks. Anybody else?

Ms. HANS. Yes, I would like to echo Diane's comments. It was really great meeting everyone. After everyone's questions and comments, I feel hopeful, and I haven't since November.

Senator CASEY. Good; thank you. Well, absent any other comments, I get to—this is really amazing that I get to hit this gavel. I just want to make it official. We are adjourned.

Anna Isis-Brown

Caring Across Generations activist

Los Angeles, CA

January 2017

Attn: Members of Congress and fellow Americans

Every member of my immediate family has benefitted from the Affordable Care Act (ACA). I am a 30-year-old newly-wed. I applied for individual health insurance in 2010, before the ACA went into effect. At the time, I was working full-time at a university bookstore, but the job did not offer me health insurance. I was denied coverage due to my pre-existing conditions—which included various allergies, minor dermatologic issues (eczema, acne), and depression. I went without an EpiPen (a lifesaving emergency medication for my most severe food allergies) and stopped taking my antidepressant medication for the 2 years that followed because I didn't have health insurance. I have health insurance through my employer now, but it is very important to me to know that if I ever lost my employer-sponsored health insurance in the future, the ACA would protect me from being excluded from the individual insurance market again.

Last year, at age 60, my father was diagnosed with two types of skin cancer. He lost his job about 2 years before the diagnosis. After he lost his job, he paid for COBRA for a while, but its high cost became completely unaffordable for him. He didn't seek treatment for the suspicious-looking patches of skin on his face, ears, and back because he was frankly afraid to find out what they were and how much they would cost to treat. He eventually applied for insurance through the Arizona state exchange, on the assumption that it would be cheaper to pay for the plans available on the exchange than it would be to keep paying for COBRA. When he finally applied to the exchange, he learned that, due to his income and Arizona's Medicaid expansion, he was actually eligible to get coverage for free. With his new coverage, he finally got a diagnosis and treatment. His doctor told him that without treatment, his face could have been disfigured by the basal cell carcinoma, and if the patches of squamous cell carcinoma had just spread unchecked, they could've become much more serious. My dad is still with us today because his cancer was caught and treated early enough.

My sister is 27 years old and has a mental health condition. She works full-time as the General Manager of a movie theater that is part of a small local chain. Until December 2016, her job did not offer health insurance. They just began offering her a plan last month, and she is now on it. For about the past 2 years, she purchased her health insurance through the California state exchange. The ACA allowed her to have coverage she could afford, and get treatment for her mental health conditions, when her company didn't offer any coverage.

My husband also works full-time as the Operations Manager for a small company in the film industry here in Los Angeles. He is the company's only full-time employee. The company does not offer health insurance. Until we got married in August 2016, he purchased his health insurance through the California state exchange. For about a year, when his income was lower, he got a small subsidy to help pay for the insurance. The ACA is the only option for many working people whose jobs simply do not offer insurance.

The ACA has made a difference in each of our lives, and for that, I am very grateful. I have such a sense of security knowing that, whatever happens in my career path in the future, I will always be able to get the Epi-pens that have saved my life once already. I am grateful for my time with my father, knowing that he was able to access the care he needed to treat his cancer before it got too advanced, and that he will be able to treat it again if it ever returns. And I felt enormous peace of mind that my sister and husband have been able to get the coverage they needed when they couldn't obtain it through their employers. In a time when many people need more help, it is not right to be offering less and to get rid of the only affordable option that many have. The ACA has been a lifeline for my family, as I'm sure it is for so many others.

Carol Gloor

Savanna, IL

In 2015, after several years of chronic pain, MRI's, and cortisone injections, I was finally told I needed to have my left hip replaced. I have always been an active person and the gradual loss of the ability to walk long distances was devastating to me. Thanks to Medicare, I had my hip replaced over a year ago. The hospital bill alone was over \$50,000, not counting the cost of the physical and occupational therapy which followed. Medicare paid for most of it, my supplemental insurance paid for some, and I paid the balance. I am one of the lucky ones in that I have supplemental insurance and some liquid assets, but without Medicare I could never have afforded the operation. Being well and my quality of life would have come at the cost of my savings and my assets. I am sure there are many others in the same situation looking for assistance. Instead, some people want to take that away from the people who need it most. I am hiking again and volunteering in many ways to make my community and my state a better place. Thank you, Medicare.

Kim Thomas

Raleigh, NC

My name is Kim Thomas. I'm a home care worker from Raleigh, NC. I became a home care provider after caring for my terminally-ill mother. As a home care worker, I assist with activities of daily living—such as toileting, bathing, mobility, meal preparation, and medication reminders—that make it possible for seniors and people with disabilities to live at home with dignity and independence. I have a true passion for caregiving. I became a Certified Nursing Assistant. I obtained my LPN, with special certifications and training in Alzheimer's/Dementia care, Diabetes care, all stages of cancer, Parkinson's, end-of-life care, wound, and respiratory care. I have a genuine love for seniors and the elderly—that's why I work as hard as I do.

And I work *hard*. I work about 100 hours a week or more. I work 16-hour shifts Monday through Saturday and three 14-hour night shifts each week. I don't receive paid time off, holidays, vacation, sick time, health insurance, or retirement benefits. And still, my wages are so low, \$8 or \$9 per hour, that I struggle to get by.

Though my job is all about taking care of people, I found it hard to take care of myself before the Affordable Care Act. I have diabetes and had a hard time finding coverage because of this pre-existing condition.

I used to go to the Emergency Room and pay \$100 a visit for diabetes medication. But I wasn't getting the care I needed to stay healthy and work hard for my family. I determined to find insurance coverage.

After weeks of research and rejections, I was able to get a "high risk" plan for \$479 per month with huge deductibles.

Not long after that, I got really sick. I was vomiting and had diarrhea for more than 24 hours. I clearly needed to go to the hospital. But I was scared of using my insurance plan—scared they would take it away from me. I finally crawled across the floor to call 911.

Doctors at the hospital determined my gallbladder had erupted and I needed surgery. But I kept telling the hospital staff that I couldn't stay there because I couldn't afford it. And when I called in to work, they asked me if I was "really sick" and suggested I get a second opinion.

I was in the hospital for 5 days. I came home to a \$3,000 hospital bill and a note from my insurance company that my premium was being raised to more than \$800 per month. I had to let my life insurance plan go, because I couldn't afford both. I sometimes missed car insurance payments—and I need my car to get to work. When the Affordable Care Act went into effect, I decided to visit *HealthCare.gov* and see if I could do better than \$800 per month. I visited the website, then spoke with an agent who told me they could have me insured starting January 1 for \$73.28 per month. Now, I get my diabetes medication at the pharmacy for \$4, instead of haphazard \$100 ER visits.

Without the Affordable Care Act, I wouldn't be able to manage my diabetes and be as healthy as I am. If it goes away, I am scared of the impact it will have on my life, including my ability to work and support my family. When every dime goes to medication or insurance premiums, you can't afford your other bills.

I can't believe someone would want to take this healthcare away from the American people. As a home care worker, it's not just me who depends on Obamacare and other programs such as Medicaid, it's my consumers, too, who receive Medicaid coverage. Medicaid is largest provider of long term care coverage in the country and more specifically home and community based care. Many of my consumers would be unable to remain in their homes or get the life-saving care they need if it were not for Medicaid. In fact, one of my consumers had a massive stroke and lost his ability to speak. Without Medicaid coverage, he would be unable to afford his medications—putting him at risk for another stroke.

If I lose my health coverage, if I'm no longer covered because of a pre-existing condition, if I have to go back to paying \$800 per month for health insurance, it will cause chaos in my life. If the Medicaid program is cut and if I no longer have a job or my hours are reduced and my consumers don't have access to the care they need, it will not only cause chaos in my life, but chaos in their lives as well.

The Affordable Care Act and Medicaid have changed my life and the life of my consumers for the better. It has made me healthier and able to work hard to support my family. Please don't take that away.

Michael Lostutter

Bloomington, Indiana 47401

January 6, 2017

My wife Mary and I are both age 64, we have been married 43 years. We grew up in rural Indiana. We had one child, a daughter who passed away in 2010. She was a traumatic brain injury survivor due to an auto accident in 1996. We were her caregivers for 14 years as she was permanently disabled due to her injuries, confined to a wheelchair.

Mary and I both worked longer than we were married, her mostly part-time at various jobs, myself from several full time positions finally retiring as the administrator of a multi-employer pension plan.

Prior to our daughter's demise, we had no plans to retire early or otherwise as we had our daughter's economic future as our primary consideration. After her unexpected death, our world changed as did our expectations for the future. We decided to retire early.

Working full time provided Mary and I with group health insurance however, at retirement the employer sponsored group plan was no longer available. COBRA coverage also was not available due to the size of the employment group.

The Affordable Care Act (ACA) with its requirement to insure without regards to pre-existing conditions allowed us to secure affordable coverage at age 62. We have maintained coverage through 2016, as I have now become eligible for Medicare and Mary likewise will be eligible in February.

The ACA has allowed us to enjoy our early retirement. It also, has allowed deserving younger folks the opportunity to replace us in the workforce improving their lives as well.

Mikki Chalker

Binghamton, NY

Most people do not realize what a godsend the ACA has been for people with disabilities. Until the ACA, many people with disabilities were doomed to poverty. Private insurance was unaffordable, or simply unavailable. My daughter suffered a traumatic brain injury at birth, leading to severe spastic cerebral palsy, a lifelong condition which will require lifelong care. Until the ACA, private insurance simply would not cover her. People like my child, who need insurance to be able to live, were doomed to stay under the limits of poverty for life in order to qualify for Medicaid and Social Security. Removing the pre-existing conditions barrier allows my 13 year old daughter, and others like her, to have insurance and yet still become tax-paying citizens with full independent lives.

Also, Medicaid and the waiver services it provides have allowed millions of people to live and thrive in the comfort and dignity of their own homes. Medicaid waiver services have allowed my daughter to receive nursing care at home which makes a difference in how often she is hospitalized. It also means that we can have the equipment to give her the care she needs at home—wheelchairs, lifting equipment, suction machines, mobility aids, and bathing aids. My daughter needs almost 100 percent assistance with daily living activities. Having insurance to provide these means she lives at home, not in an institution. With me providing that care at home with help from a nurse means she is hospitalized less, improving not just her health and daily life, but also saving untold thousands in hospital care and additional medical costs. Most importantly, it allows her to be a 13-year-old girl, with hopes and dreams and ambitions, not just a patient, not just a body in a nursing home or institution. I can't imagine going back to life with less access to these services. Not only does my daughter deserve better, she deserves more.

These are not small things in our lives. I am grateful for the work of Caring Across Generations that allows me to share how critical the ACA has been for my life and my daughter's life.

Mina R. Schultz

Fairmont, WV

When I was 25, I was finishing my graduate program at the University of Missouri and preparing to enter the Peace Corps. I had student insurance, but it would end upon graduation, and I would have about 9 months without coverage before my Peace Corps service began. I didn't give it much thought; I was young, healthy, didn't go to the doctor much. My parents foresaw the gap in coverage and told me about a new law that would allow me to stay on their coverage until I turned 26. I said, sure, sign me up. Didn't really matter to me, but why not? So I joined their plan.

The pain started in April 2011, about a month before graduation. I wrapped my knee, iced it, and took a break from running for a while so it would heal. After graduation I was planning on taking a temporary job in rural Montana, to pay the bills until my Peace Corps service started. I was still having pain, and not wanting to end up in the middle of nowhere Montana with a torn ligament, I scheduled an MRI. I will never forget the MRI techs telling me, "You'll be glad you came in." I was sure I had torn something. I was on my parents' insurance at the time.

I will never forget the phone call, when the doctor said, "Ms. Schultz, it appears you have a tumor."

The tumor was osteosarcoma, an aggressive bone cancer usually found in children and adolescents. I endured 5 surgeries, including a total knee replacement, and 9 rounds of chemotherapy (each involving 3 doses of chemo, so 27 doses all together) over the course of a year. Most of my treatment was inpatient, though I also received at-home physical therapy and IV services. Just one of my post-chemo injections cost thousands of dollars. Because I had taken that insurance, most of my treatment was covered, and my parents avoided bankruptcy. I would not have qualified for charity care. I don't know how we would have afforded my lifesaving treatment had I chosen to forego coverage because I was 25 and thought I was healthy. I think about it every day.

Now I am an enrollment assister in rural north-central West Virginia. I help my community members navigate the Health Insurance Marketplace, expanded Medicaid, and the ACA in general, because I believe everyone has the right to the access and care that I received when I was sick. No one should have to experience what I did, but especially no one should go bankrupt because they want to survive an illness. I try to explain this to people on a daily basis, that it is a responsibility to get coverage to protect yourself from the exploding cost of health care in our country, because you truly never know when something catastrophic might happen. I carry coverage so that I can cover my own costs and remain a contributing member of society. While I am coming up on 5 years cancer free, I have secondary conditions as a result of treatment, and take medications to manage my health. Because of my previous diagnosis and resulting side effects, I would be considered uninsurable without the ACA requirement to cover those of us with pre-existing conditions.

I am a contracted worker. I purchase my own insurance through the Marketplace exchange and receive a subsidy to help me afford this coverage. Because of the threat to the law, I am having to look for a new job, one that will offer me benefits so that I can't be denied coverage, and hopefully one that won't cap my benefits. I love my current job, but I won't be able to afford high risk pool coverage should the ACA be repealed and replaced. I take pride in being able to cover my own expenses, and I fear that I will have to rely on my community to care for me if I no longer have the ACA to protect me. I'm just trying to do my best, but I feel like my congressmen and women are trying to take away my autonomy by taking my care. I thought government was supposed to protect its people. Please protect me by keeping the ACA in place, so I can continue to have access to the care I need to maintain my health and contribute to my community.

Risa Morimoto

Caring Across Activist

New York, NY

January 2017

Attn: Members of Congress and fellow Americans

Without Medicare, Medicaid, and the Affordable Care Act, health care would be much more difficult for my family. Like many others, my family is pressed between providing care for our parents and for ourselves too. These programs are what make it possible for all of us to access the different kinds of care that we all need.

My mother had just turned 65 when she had a stroke in 2001. She was covered by Medicare and spent 3 months receiving care in the hospital. Ten years later, she was diagnosed with Parkinson's disease and needed 24/7 care. She refused to go into a nursing home and insisted that she be cared for in her own home.

Until her stroke, my mother was a hardworking small business owner—she opened up the first Japanese restaurant in Long Island. When she got sick, we had to sell her business, the thing she had worked so hard on for most of her life, and that was difficult for all of us. That left her with her house, but she didn't have many assets beyond that. We are Japanese, and taking care of our parents is a very big deal in Japanese culture. My brother and sister and I did our best. At the time, we weren't aware that my mother was eligible for Medicaid, and we could not afford to pay out of pocket for in-home help. Even with taking turns, after 10 years, my siblings and I were both completely burned out from our own full-time work and full-time caregiving. It really started to tear our family apart, both financially and emotionally.

Now she is covered by Medicaid, and we've been able to hire aides through the community-based Medicaid program. My mother is eligible to receive 106 hours of in-home care per week, but Mom is very particular about who spends time in her home

with her. We were able to hire Japanese caregivers, which helped us transcend some of these cultural and language barriers and made her feel much more comfortable. Living with the effects of a stroke and Parkinson's for 16 years shows what a strong person my mother really is, and my siblings and I are happy we get to support her. It's not easy—she cannot really do anything without assistance, but she knows she wants to be in her home where she is most comfortable and everything is familiar. Community Medicaid is what keeps her safe and comfortable at home, keeps her out of a nursing home, and we know it saves the state money.

My brother moved into my parents' home, and my sister lives next door. I make the trip out to Long Island every weekend from my home in New York City to help out. Even with the three of us sharing the responsibility of caring for her, we could not do it if it weren't for the caregivers who come to her home to take care of her. This is what allows my brother and sister and I to continue our full time jobs and maintain our own lives as well as pitch in to help with Mom. Without these aides, she would lose everything and I have no idea where she would live.

My husband and myself are small business owners, and insurance has never been easy or inexpensive for us without the benefit of receiving coverage through an employer. So when the Affordable Care Act was announced, we thought this would finally be something where we'd have a real option for substantial health care. Before the ACA, we had health insurance through Freelancers Union. I was always trying to cobble something together for both of us, or thinking we'd have to just rely on a catastrophic plan. Last year was stressful and frustrating—mid-year our insurance company cut my doctor and hospital out of the network. One example is that my husband and I needed to get physicals and blood work in September so I had to find a new doctor who turned out to be one of the worst doctors we had ever been to. The doctor's office mistakenly sent our bloodwork to the wrong lab (even though we explicitly told them they had to go to Quest Lab to which they answered they knew).

Even though they said they would fix the error, they didn't. Their mistake cost us \$500. I don't know why our doctor and hospital dropped our insurance coverage mid-year, and while I understand that there have been some problems since the ACA rolled out, I don't believe the answer is throwing it all out. The solution is to improve it and make it stronger. Getting more people covered through the ACA will help stabilize it. Having coverage that we can afford through the ACA is a huge relief. I have a close family friend who for many years could not afford insurance. When he finally had to drop his coverage, he was diagnosed with leukemia shortly afterwards. He lost his house, his business—everything. I get such peace of mind knowing that my coverage provides preventative care, and knowing that if some unexpected emergency arises, we will be covered and we will be okay.

My family has been able to afford the care we need because of Medicare, Medicaid, and the Affordable Care Act, and I think we as a country can do even better to make sure that everyone is able to get the care they need. Cuts and defunding these programs would make things much more difficult for many Americans—and no one says that it should be easy, or that the government should do it all, but where we can make things better, why wouldn't we? I am proud of these programs that help people get the help they need.

I am happy to be an advocate for better care with Caring Across Generations as part of the Caring Majority, and to be able to tell my family's story. Supporting these programs is bigger than politics—it is about people's lives. This is a moment when we need to take steps forwards, not backwards. I hope Congress does what the majority actually wants—it's their job.

Rita Morris

Birmingham, Alabama

I am Rita Morris of Birmingham, AL and proud daughter of Mrs. Katie. I thank you in advance for your valuable time in allowing me to share my personal experience as a family member and consumer of nursing home care with Medicaid. At some point in our lives we will be a caregiver or in need of a caregiver. I ask of you today to consider your family as I share a glimpse of ours. I ask that you recognize your partnership with us. As Mother's caregiver of 14 years, an only child, wife, cancer survivor and mother, my hope was for quality of life, quality of care and peace of mind for all of us. Nursing home care directly affects our loved ones as well as our families. My mother became a widow at the age of 45; I was 16. Out of neces-

sity I quickly learned about our family finance needs and importance of health care. Years later as a Registered Nurse, I was well aware that health care is driven by federal and state regulations. When my Mother was diagnosed with vascular dementia, her life and our family's life changed. At that time, I was a stay at home mom with a child in kindergarten. Our journey started at that time. We had many partners in caring for Mother along the way—the Grace of God, family, friends, faith, Medicaid, Medicare, Social Security, and many wonderful health care providers—but our journey would have been completely different if not for Medicaid.

As Mother's dementia advanced, her physical, mental and spiritual needs increased. She was able to live in her home for 2 years with assistance, in our home for 1 year with sitters, for 4 years in specialty assisted living, and for 7 years in a nursing home. After 4 years in assisted living, the dementia had progressed and she required pureed food and more care. When this occurred, we were no longer eligible for assisted living. The next transition was to the nursing facility. I researched the regulations (OBRA) for nursing homes and Medicaid before we moved in. We were prepared. The rules and regulations of Medicaid, Medicare, and Social Security are clear in purpose and process. They served our family as intended and were greatly needed.

In 2007 we were told that Mother could possibly live 6 months in the nursing home. We recognize and respect that the decisions for our federal funded health insurance programs are in the hands of our legislative partners. Medicaid was the most life-enriching benefit that Mother received at her most vulnerable time. She moved into the nursing facility in August of 2007. Her financial assets were depleted, her dementia had advanced, and she required care around the clock. Dementia symptoms were not limited to the hours of 8 am to 5 pm; they were around the clock for 24 hours. I completed the Medicaid application with the online form and directions. I submitted the form personally to our local office and received a follow-up call 3 weeks later. She moved into the nursing home in August 2007 and was approved by Medicaid retroactively in October 2007.

As a cancer survivor, my biggest fear was that I would no longer be there to care for her. I often asked myself: Who would care for her in my absence? My hope was to be able to care for her as she did for me, my father, and my family: simply with love. Her focus was always on us; she did not focus on finances, insurance or direct care. Medicaid provided Mother with the 24 hour a day care that she needed, the necessities that she required, and a state surveyor to monitor the care and assure that the facility was in compliance with the regulations. As an only child, I had peace of mind knowing that in the event of my absence, her care would be paid for and she would get the care she needed, with protection and oversight.

As a result of the necessities and protections Medicaid provides, my Mother lived an additional 7 years with respect, dignity, and quality of care and quality of life. Her wishes were simple. She used to say, "I don't want to be the one someone would see and say 'that poor thing'" and "I don't want to be a burden on you." She was never in a situation of being neither "that poor thing" nor a burden. In those 7 years she was admitted to the hospital only one time for a fractured hip. She had no skin breakdown, limited contractures, and was treated in her own bed for pneumonia and urinary tract infections over the years. She was provided care by loving caregivers, and she was loved by many. The staff of the two sister facilities that she called home became our extended family.

I was able to be a partner, assist in her care, be an involved mother in after school activities, help my son with his homework, and serve as room mom at his school. I was able to be present in our home as wife and mother in our family commitments. Our one income family was able to provide for our immediate needs and to save for our son's college needs. This was not always easy, but it was our new "normal" and we did the best we could. The stress of caregiving is tremendous. It takes a village to raise our children and it takes a village to care for our vulnerable loved ones of all ages and needs in all settings. The nursing home setting had a profound impact on our family. Long-term care is the most precious, personal and spiritual time for transitions in roles and in preparation for the final transition to Glory.

I would like to take a moment to share with you a glimpse of what our lives could have been without our Medicaid partner. In 2007 the potential of living 6 months could have been a reality. We would have had two options if we had to leave the assisted living without Medicaid. One would have been to care for Mother in our home, a home with a then 13 year old still needing to be driven to school and activities, increased homework, wife to prepare meals and provide 24 hour care during a time that Mother was still walking and wandering. The focus was caring for Moth-

er and family. When Mother was in our home, she found it to be stressful living with us before she chose to move to the assisted living. She wanted to be with friends her own age in her own "home." In our home, she had the constant reminder of her losses and her dependence on us. We required sitters in my absence along with medical equipment. If we continued to care for Mother in our home, she may not have received the highest quality of care that she deserved and she may never have achieved a high quality of life.

Our second option without Medicaid would have been to pay privately for the nursing care that she needed 24 hours a day. As an estimate in 2007, the private rate for the nursing home was \$5,000 per month or \$60,000 a year. Over a period of 7 years the total would have been a minimum of \$420,000. Our family would have required loans to meet those needs. We were and still are a one income family. We would have done everything needed to care for Mother. However, as parents to our only child, we also had to anticipate his college needs. This would have been an overwhelming situation and limited at best.

These are two very different options both affecting our family and most importantly the quality of care and the quality of life that Mother would have experienced. There would have been no peace of mind for any of us with either of these two options. In closing I would like to express my thanks to you and to ask for your continued support of Medicaid as an essential way to meet our medical needs and financial support not only for our loved ones, but for families as well. As the generation before us, we have contributed to our Social Security and have anticipated having Medicare and Medicaid in place as our needs arise. It has been a privilege and an honor to walk with Mother as her partner on this journey. Mother's last transition occurred on September 1, 2014 when she was called home to Glory. As my husband and I walked with Mother out the front door in the early hours we left with no regrets. It was well with my soul. I hope that our experience with Medicaid can relay the profound impact that the decisions made with a vote can have on the lives of those you serve. The photo of my hand with Mother's reflects my commitment of love and care and her fragile dependence and trust.

With our Medicaid partner, Mother was afforded quality of care and quality of life while I was afforded the peace of mind to continue to serve in my proudest role, Daughter.

Sincerely,
Rita Morris
Daughter of Mrs. Katie

Susan Flashman

Mt. Rainier, MD

My name is Susan C. Flashman, and I have been on Social Security since I became disabled following brain surgery in 2011. And 2 years later I was eligible for Medicare coverage. My husband, Richard A. Bissell, has been on Medicare for 12 years. We are both retired and live on a fixed income made up of Social Security and our retirement pensions from our years of Union employment with the International Brotherhood of Electrical Workers. We pay monthly for our Medicare coverage, as well as our supplemental insurance offered through our UNION.

Because we have Medicare coverage, we have been able to repair injured and worn parts of our bodies through surgery. The repairs have helped us to maintain an active life with minimal pain. Following my brain surgery, and as soon as I was well enough, I could have a breast biopsy performed to make certain that a mass seen during my annual mammogram was not the start of cancer.

This peace of mind following brain surgery was priceless. Since then, Medicare has helped to pay for the repair of my left wrist, and my broken toe. Both important to keep me living a full and independent life. In this same manner, my husband had surgery to repair a torn rotator cuff in his shoulder. Without such surgery, the pain would have incapacitated him.

The importance of Medicare to us is that we can stay healthy enough to continue to contribute to our community in voluntary activities, as well as maintain an independent life in our own home. In doing so, we do not burden our families, or the long-term care system.

If we were unable to have Medicare help maintain our health through regular doctor's visits and medical tests, we might become less healthy more quickly as we age. The enormous cost of health care for those who are no longer able to earn additional funds is critical.

If Medicare were to become part of the insurance business, I am afraid that I and every subscriber would have to hire a lawyer to be certain that these companies fulfilled their legal obligations of coverage. I have personally encountered this type of dilemma following my brain surgery. In order to receive the benefits I deserved from a catastrophic medical insurance plan, I had to rely on legal counsel. What is even worse than having to fight for what is due, is to have to fight when you are least able. The insurance industry counts on this to help reach their profit margin.

While we were working, we contributed to Social Security and Medicare and now the Congress thinks privatizing care for seniors should be profitable. Hogwash!

It is time to expand Social Security—so that everyone in this country has the basics they need to live a decent life, not just those lucky enough to have inherited wealth.

Sincerely Submitted by Susan C. Flashman on January 16, 2016.

Lezrette Hutchinson

Bronx, NY

My name is Lezrette Hutchinson. I live in the Bronx, NY, and I am 60 years old and a mother of three. Thank you for convening a public forum to give voice to American families who would be harmed by proposals that would make people with Medicare and Medicaid pay more for their care. Please accept this letter as formal comment for the forum record.

In 1999, after years of working at New York's Board of Education, I was diagnosed with sarcoidosis. Sarcoidosis is an inflammatory disease that affects my lungs, which makes me depend on oxygen. With little information about the disease, I became extremely ill.

Two years later, I became homeless for a time after a fire burned down my home. The side effects of the disease and my medications made me depressed. This was because I didn't know where to go for proper treatment, and I was prescribed the incorrect medications. I was unable to go to work nor to take meaningful part in my children's lives as they grew into adulthood.

My health turned around once I found a sarcoidosis clinic at Mount Sinai Hospital, which accepts both my Original Medicare and fee-for-service Medicaid coverage. After receiving the care I desperately needed, I was able to become an activist and participate in a support group for those with sarcoidosis. Later, I joined the board of my medical center to implement changes that my fellow advocates and I knew would improve patients' quality of life. I also attended a recreational support group called the 50s-plus Program, and then joined the Workgroup for People with Medicare and Medicaid, part of the Duals Coalition of New York's Medicare Rights Center.

If I didn't have my original Medicare, I would need to find a plan that would cover me best, knowing that I have a serious, rare disease. I would need to make sure I found a way to continue to receive the care I need with the right doctors who can service my chronic disease. This would be a challenge for me since not many doctors specialize in my illness, and if I couldn't continue to see them my illness would take a turn for the worse.

With my current income, by the time I pay my rent and bills, I do not have much left. If my Medicare costs increased that would be a big financial hardship for me. Thanks to my Medicare and Medicaid, I am provided with affordable, vital services that enhance my life. I would love to continue to get the quality of care that I am getting now. Yes, I am ill but I don't want that to stand in my way. I recently found out I am going to be a grandmother and I want to take part in my grandchild's life and make up for the years I was unable to be in my own children's lives due to my illness.

Theresa Maguire

Queens, NY

My name is Theresa Maguire. I live in Queens, NY, and I am a mother of two and recently became a grandmother. Thank you for convening a public forum to give voice to American families who would be harmed by proposals to repeal the Affordable Care Act (ACA) and undo the Medicare and Medicaid guarantee. Please accept this letter as formal comment for the forum record.

On December 28, 2010, I received a fully favorable (100% disabled) decision in connection with my Social Security Disability Insurance Benefits application. At 57 years old, I had been a grammar school teacher consecutively for the previous 26 years. I am disabled from Chronic Interstitial Cystitis (IC) with Hunner's Lesions. I also have Pelvic Floor Dysfunction, Pudendal Nerve Involvement, hypertension, tachycardia, IBS, and anxiety.

Since 2010, I have been treated by Dr. Robert Moldwin for my IC condition and its related issues. Dr. Moldwin is one of the leading specialists in the United States for IC and is the author of "The Interstitial Cystitis Survival Guide." He has played a primary and pivotal role in my treatment. I first saw Dr. Moldwin in May of 2010 and I continue to visit his practice generally on a weekly/bi-weekly basis.

In June of 2010, Dr. Moldwin ordered me to begin bladder installations. Each installation lasts approximately 1 hour and consists of 15 steps. I must undergo these treatments on a semi-weekly, and often weekly, basis. On several occasions, the installations will puncture one of my Hunner's lesions which causes five or more hours of steady bleeding. During this time, I am forced to stay in or near a bathroom and drink copious amounts of water. With time, the bleeding subsides. In addition to the installation procedures, I receive "internal nerve block injections" into the walls of my pelvis. I also endure "internal physical therapy." This is to assist with the pain associated with my conditions.

All efforts at relieving my pain thus far have been only temporary in nature. After suffering from the pain and devastating change of lifestyle brought about by my condition, I began to see a mental health specialist in October of 2010, and my treatment with her has been ongoing since. My pain is moderate to severe, and occurs on a daily basis. This is exacerbated by my particularly small bladder which causes further pain. This also causes my frequency of urination to increase along with the increased pain.

I wake up multiple times a night. I live with fatigue, loss of sleep, and bladder spasms, among other symptoms. My experience of pain or other symptoms is severe enough to interfere with attention and concentration on a frequent basis, and I am incapable of even a low stress job. I can only sit continuously for 20 minutes, stand for 20 minutes, and total sit, stand, or walk less than 2 hours in an 8-hour period.

My condition dictates bathroom visits that can be 20 times in a 24-hour period. Urinating is a burning painful experience for me a majority of the time. I suffer the inability to sit at times due to the excruciating pain of my condition. I have a prescription from my neurologist that allows me to be in a kneeling position in the car when I cannot transfer to a sitting position due to temporary paralysis of my pelvic floor. All together, I need 10 prescription medications, 5 to regularly manage my conditions and an additional 5 for bladder installations.

I had to wait 2 years to receive Medicare. For those 2 years, I needed to pay COBRA premium payments. The burden of my illness exacerbated and strained my ability to meet even the simplest daily tasks. Furthermore, the emotional and psychological strain and stress of medical insurance payments and medical co-payments while waiting for Medicare was enough to push me over the edge. Since I was a teenager, I worked diligently as a tax-paying citizen and continued to do so my entire adult life. Here I was at 57 years old sinking with a monetary situation that added to my already debilitated medical condition. If I were to get sick now, I would have the ability to shop for other, potentially less expensive, insurance options than that COBRA coverage through New York State's health exchange—thanks to the Affordable Care Act (ACA).

Since I began receiving Medicare, I have been privileged with being treated by the same doctors as prior to my Medicare coverage, and I have been comfortably reassured with my present Medicare coverage that I can continue to receive the cutting edge treatments available to me. I pay \$104 per month for Medicare (which is deducted from my Social Security Disability Benefit), and I do not have any other medical insurance coverage. I cannot take on the burden of paying for additional coverage. I receive a Social Security Benefit of \$1,550 per month, and I receive a disability insurance check for \$775 per month. My out-of-pocket co-pays for 2016 were slightly more than \$3,215 in addition to my Medicare premiums.

I hope my story conveys the fragile, debilitating situation one is put in when one can no longer function as a productive member of society and can therefore no longer earn a living. Medicare needs to remain with its benefits, at the very least, intact. I cannot endure the thought of elected officials dictating changes in Medicare that determine not only my quality of life, but my life itself. I deserve to have a fighting chance, and I need my Medicare benefits to remain stable to be granted that fighting chance. With your help, your actions, your foresight, and your good consciences, you can save lives. I hope all members of Congress will step up to the challenge and battle for what is a human right—the right to decent medical benefits for the disabled.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The American public heard a lot of promises about health care from the new administration. No cuts to Medicare or Medicaid. Nobody hurt by ACA repeal. “Insurance for everybody . . . much less expensive and much better.” Congressman Price’s own record undercuts those promises, and this morning I’ll get to those issues.

But first I’m going to start with questions about ethics and undisclosed assets. Congressman Price owns stock in an Australian biomedical firm called Innate Immunotherapeutics. His first stock purchase came in 2015 after consulting Representative Chris Collins, the company’s top shareholder and a member of its board. In 2016, Congressman Price was invited to participate in a special stock sale called a private placement. The company offered the private placement to raise funds for testing on an experimental treatment it intends to put up for FDA approval. Through this private placement, Congressman Price increased his stake in the company more than 500 percent. He has said that he was unaware he paid a price below market value.

That claim doesn’t pass the smell test. Company filings with the Australia Stock Exchange clearly state that this specific private placement would be made at below-market prices. The Treasury Department handbook on private placements says they are “. . . offered only to sophisticated investors in a nonpublic manner.” Congressman Price also said last week that he directed this stock purchase himself, departing from what he said was his typical practice.

Then there’s the issue of what was omitted from the Congressman’s notarized disclosures. Congressman Price’s stake in Innate is more than five times larger than the figure he reported to ethics officials when he became a nominee. He disclosed owning less than \$50,000 of Innate stock. At the time the disclosure was filed, by my calculation, his shares had a value of more than \$250,000. Today his stake is valued at more than half a million dollars. Based on the math, it appears that the private placement was excluded entirely from the Congressman’s financial disclosure. This company’s fortunes could be affected directly by legislation and treaties that come before Congress.

It also appears Congressman Price failed to consult the House Ethics Committee following trades of several health care stocks, as they were directly related to two bills he introduced and promoted. Even if some of those trades were not made at his direction, he would have been aware of them as soon as he filed his Periodic Transaction Reports with the House of Representatives.

Set aside the legal questions. It’s hard to see how this can be anything but a conflict of interest and an abuse of his position.

Finally, one of the most important questions on the Finance Committee’s biographical questionnaire is whether nominees have been investigated for ethics violations. Congressman Price has been the subject of two investigations stemming from fundraising practices. This too was not disclosed.

I believe this committee needs to look into these matters more thoroughly before moving ahead with this nomination.

Let’s turn now to policy, starting with the Affordable Care Act and the scheme known as “repeal and run.” The secret Republican replacement plan is still hidden away, but already the administration is charging forward with a broad executive order endangering people’s health care. As the Budget chairman, Congressman Price is the architect of repeal and run.

If his repeal bill became law, 18 million Americans would lose their health-care plans in less than 2 years. In one decade you'd go from 26 million people without insurance to 59 million. Repeal and run would raise premiums 50 percent in less than 2 years. Costs would continue to skyrocket from there. The market for individuals to buy health insurance would collapse. No-cost contraceptive coverage for millions of women—gone. By defunding Planned Parenthood, nearly 400,000 women would lose access to care almost immediately. Hundreds of thousands more would lose their choice to see the doctors they trust.

The Price plan takes America back to the dark days when health care worked only for the healthy and the wealthy.

Congressman Price's other proposals don't offer much hope that the damage will be undone. By the Trump rubric of "insurance for everybody," "great health care . . . much less expensive and much better," the Congressman's plans get a failing grade.

In another bill, the Empowering Patients First Act, the Congressman Price brought back discrimination against people with pre-existing conditions such as pregnancy or heart disease. It gave insurers the power to deny care and raise costs on people with pre-existing conditions if they didn't maintain coverage. In effect, the bill said insurance companies could take patients' money and skip out on paying for the care they actually need.

His bill also gave insurers the green light to reinstate lifetime limits on coverage and charge women higher rates just because they're women. It gutted the tax benefits that help working people afford high-quality health-care plans. It slashed the minimum standards that protect patients by defining exactly what health plans have to cover. All this from a proposal called the Empowering Patients First Act. It'd be a stretch to find a bill with a more ironic title, considering how much power it handed to giant insurance companies.

If there's a theme developing, it's that the Congressman's proposals push new costs onto patients. The massive cuts to Medicare proposed in Congressman Price's budget are another prime example. In my view, the Congress has a duty to uphold the promise of Medicare—the promise of guaranteed benefits.

Congressman Price advocated privatizing Medicare and cutting it by nearly half a trillion dollars. After his nomination, he said he wants to voucherize Medicare within the first 6 to 8 months of the administration.

He also supports "balance billing." That means seniors could be forced to cover extra charges above what Medicare pays for the services they receive in the doctor's office. So in this case, it's extra costs pushed onto elderly people who live on fixed incomes.

Congressman Price has also called for block granting and capping Medicaid, a plan that would shred the safety net for millions of America's most vulnerable patients.

Medicaid insures 74 million people. More people rely on Medicaid to help pay for nursing home care and home-based care than any other program. The program pays for nearly half of all births and covers millions of children. It's a critical source of mental health care and substance use treatment, which is vital at a time when communities nationwide are battling the opioid epidemic. But Congressman Price's most recent block grant proposal cut Medicaid by a trillion dollars.

Setting that huge cut aside, there's also a concerning pattern to the way some lawmakers look at programs that have undergone this kind of transformation. At first it's a block grant, a few years later it's declared a slush fund, and then it gets slashed to the bone.

Unfortunately, that pattern has also defined Congressman Price's approach to other areas that would be within his jurisdiction as Secretary. His budget called for trillions of dollars in cuts to programs that support millions of vulnerable people—everything from job training to housing assistance to child nutrition. He also voted no on the reauthorization of the Violence Against Women Act when it sailed through the House on a bipartisan basis.

As I wrap up, I want to return to health care. The Congressman and many others say patients should be at the center of care, and nobody would dispute that idea. When I look at Congressman Price's proposals, I don't see the patient at the center of health care. I see money and special interests at the center of health care.

His plans would tell vulnerable Americans that their health care will go only as far as their bank accounts will take them. The well-to-do might be able to afford Congressman Price's proposals and the costs they push onto patients, but millions of working Americans cannot.

Congressman, I thank you for joining the committee today and I appreciate your willingness to serve. I look forward to your testimony.

MEMORANDUM FOR FINANCE COMMITTEE MEMBERS

From: Senate Finance Committee Staff
Date: January 23, 2017
RE: Nomination of Dr. Thomas E. Price

This memo describes the Senate Finance Committee staff review of the 2013, 2014, and 2015 tax returns, and other documentation of Dr. Thomas E. Price in connection with his nomination to be the Secretary of the Department of Health and Human Services (HHS).

Background

Finance Committee staff conducted a review of Dr. Price's Senate Finance Committee (Committee) Questionnaire, tax returns for 2013, 2014, and 2015, and financial disclosure statements. As part of this review, a due diligence meeting was held with the nominee and his legal representation on January 16, 2017. His accountant participated via telephone. In addition to the due diligence meeting, staff submitted multiple rounds of written questions to the nominee.

At the conclusion of this process, three issues have been identified that have been deemed appropriate to bring to the attention of committee members.

Senate Finance Committee Questionnaire—Ethics Investigation and Late Property Tax Payments Omitted

All nominees referred to the committee are required to submit the Senate Finance Committee Statement of Information Requested of Nominee ("Questionnaire").

Part D. Legal and Other Matters, Question 1, asks nominees: "Have you ever been the subject of a complaint or been investigated, disciplined, or otherwise cited for a breach of ethics for unprofessional conduct before any court, administrative agency, professional association, disciplinary committee, or other professional group?"

In his response, submitted December 21, 2017, Dr. Price responded, "No." However, in 2010, the Office of Congressional Ethics (OCE), an independent office of the House of Representatives, conducted an investigation into Dr. Price's 2009 fund-raising activities. OCE voted 4–0–1 to refer the case to the House Ethics Committee, which, after conducting a second investigation, ultimately found no wrongdoing in 2011.

In written questions submitted to Dr. Price on January 6, 2017, committee staff requested an explanation for the omission of the ethics investigation. Dr. Price stated it was an inadvertent omission and that the majority of activities investigated related to his authorized campaign committee, rather than him personally. The information pertaining to this investigation has been and continues to be available on the web page of the House Ethics Committee.

Part F. Financial Data, Question 10, asks nominees: "Have you paid all Federal, State, local, and other taxes when due for each of the past 10 years?" Dr. Price responded, "Yes." However, upon examining Washington, DC and Nashville, Tennessee real estate tax records, Committee staff determined late tax payments had been made in relation to rental properties owned by Dr. Price, totaling \$1,583.45 for late payments made over the past 7 years.

In written questions submitted to Dr. Price on January 6, 2017, Committee staff requested an explanation for the omission of the late tax payments. Dr. Price stated that, regarding the DC property, he believed that "late fees and penalties derived from not receiving timely property tax notices." Regarding the Tennessee property, the nominee noted that "notices regarding property taxes for this rental property . . . were either not being received or being wrongly mailed to the tenant at the property and not reaching the nominee and his spouse."

Depreciation of Land Value and Miscellaneous Employment Deductions

Committee staff received 2013, 2014, and 2015 tax returns from Dr. Price on December 21, 2016. In addition to the written questions submitted on December 28, 2016 and January 6, 2017, Committee staff spoke with Dr. Price's accountant on January 9, 2017. Following the due diligence meeting with Dr. Price, Committee staff then submitted an additional round of written questions to the nominee on January 16, 2017.

Improper Inclusion of Land Value in Depreciation Calculations

Taxpayers who own rental property are generally allowed to deduct depreciation expenses associated with the wear and tear of those buildings. Taxpayers are not, however, allowed to include the value of land in the depreciable amount.

Dr. Price owns rental condominiums in Washington, DC and Nashville, Tennessee, and claimed depreciation expenses associated with those properties for years 2013, 2014, and 2015. It appears these values included depreciation for the value of the land. According to property tax records, the land value of Washington, DC condominium was listed as \$95,640, and the land value of his Nashville condominium was listed as \$30,000.

Under current tax rules,¹ these values are not allowable for depreciation expenses. Committee staff asked for clarification on this issue in the due diligence meeting with Dr. Price and sent written follow-up questions on January 16, 2017.

In his response to the committee, received on January 23, 2017, Dr. Price's accountant stated he had taken the position that the land had a fair market value of zero. However, given the lack of another valuation besides the property tax assessments, Dr. Price has committed to address the discrepancy by filing a Form 3115 to adjust the depreciation and account for the improper deductions on his 2016 tax returns, though adjustments may be spread out over 4 years.

Absence of Documentation of Employment Deductions

In 2013, 2014, and 2015, Dr. Price claimed miscellaneous employment deductions, totaling \$19,034. Dr. Price, and his wife, also a medical doctor, both list their occupations as "PHYSICIAN" on the second page of their Form 1040s. Neither Dr. Price nor his wife actively works as a physician, though Dr. Price has noted he has maintained his medical license. Committee staff requested substantiation and further explanation of the deductions in written questions submitted December 28, 2016.

Committee staff spoke with Dr. Price's accountant on this matter on January 9, 2017, and again during the due diligence meeting on January 16, 2017. In those discussions, Dr. Price's accountant noted that Dr. Price and his wife, Elizabeth, would compile a variety of expenses, including vehicle expenses, and discuss with the accountant what portion of those expenses would be appropriate to deduct as employment expenses, frequently settling on an amount equal to roughly 60 percent. Though the Prices no longer actively work as physicians, their accountant believed that the deductions were appropriate, and were reflective of expenses incurred by Mrs. Price. After the January 16, 2017, due diligence meeting, staff suggested that in the absence of full documentation of the deductions, that the returns be amended.

In a response, received January 23, 2017, Dr. Price's accountant noted that proper documentation could not be located. Dr. Price's 2013, 2014, and 2015 tax returns will be amended to remove the \$19,034 of deductions. Since Dr. Price was subject to the Alternative Minimum Tax (AMT) in each of those years, the changes will not result in any change to tax liability.

Asset Values

In separate financial disclosure filings to the House of Representatives, to the committee, and to the public through the Office of Government Ethics (OGE) Form 278, the nominee reported ownership of stock in an Australian pharmaceutical company—Innate Immunotherapeutics Ltd. The nominee purchased these shares in two tranches: one in 2015 valued at \$10,000 at the time of purchase, but was valued at between \$15,000 and \$50,000 on December 20, 2016, the date of filing. A second tranche was purchased in August 2016 of 400,613 shares, through a private placement offering, and was listed on the committee questionnaire as being valued between \$50,000 to \$100,000, which was based upon the purchase price. An analysis done by multiplying the number of shares by the market price on December 20, 2016 demonstrates a value higher than that reported by the nominee. The nominee

¹ Treasury Reg. § 1.167(a)-5, T.C. Memo. 1982-51, *Meier v. Commissioner*.

noted that the amounts reported to the committee were a good faith valuation. The nominee agreed to recalculate the value of the shares based on the market value at the time the committee Questionnaire was completed. The revised value of the second tranche was between \$100,000 and \$250,000 when filed.

The nominee and committee staff also agreed that the tranche of shares acquired in August 2016 was not accounted for on the OGE Form 278, and the nominee told staff that income attributable to his holding in the company reported on OGE Form 278 was incorrect. The nominee noted that it is unclear how information related to his holding in this stock was misstated on the published form. The nominee agreed to contact OGE to correct the form.

Senate Finance Committee—Bipartisan Vetting Process
January 24, 2017

The Finance Committee has a long, bipartisan tradition of engaging in a very thorough process for vetting nominees. It has served the committee well and it has served the country well.

It has several steps. First, we review the paperwork, consisting of the committee questionnaire, financial disclosure (OGE Form 278), ethics agreement, ethics letters, and 3 years of tax returns. Frequently, there have to be several rounds of written, follow-up questions before the paperwork is satisfactorily reviewed.

Next, we have three staff meetings; one to complete the due diligence review (financial), one to discuss policy with the chairman and ranking member's staff, and one with the staff of committee members. Only after all of these steps have been completed do we notice a hearing, seven days prior to the hearing's date.

The two nominations that we are considering so far each raise issues that have taken some time to review. In the case of Mr. Mnuchin, he has very complicated financial affairs, with partnerships embedded within other partnerships. It took some time just to get a good understanding of his financial affairs. In the case of Dr. Price, it has been difficult to value his stake in an Australian drug company. In fact, Dr. Price revised his committee questionnaire just yesterday, January 23, 2017, to correct inaccurate information about the ownership of this stock.

Below is an overview of the dates of meetings, materials received, rounds of questions asked, and responses received between committee staff and the nominees through the bipartisan vetting process.

Mr. Steven T. Mnuchin

Materials Submitted

- December 16: Tax Returns
- December 19: Questionnaire; Interim OGE Form 278
- January 10: Revised Questionnaire; OGE Ethics Materials; OGE Form 278
- January 15: 2nd Revised Questionnaire

Meetings

- January 13: 1st due diligence (financial)
- January 17: 2nd due diligence (policy)
- January 17: 3rd due diligence (Committee Member staff)

Rounds of Questions

- December 23: Initial Tax Compliance
 - Responses received: December 30, January 4, January 6
- January 4: Follow-up Tax Questions and due diligence matters
 - Responses received: January 6, January 9, January 13
- January 10: Follow-up Tax Questions and due diligence matters
 - Responses received: January 12, January 18
- January 13: Tax and Non-tax follow-up questions, following 1st due diligence meeting
 - Responses received: January 18

The Honorable Thomas E. Price

Materials Submitted

- December 21: Questionnaire; Tax Returns

- January 11: OGE Ethics Materials; OGE Form 278
- January 23: Revised Questionnaire

Meetings

- January 16: 1st due diligence (financial)
- January 17: 2nd due diligence (policy)
- January 17: 3rd due diligence (Committee Member staff)

Rounds of Questions

- December 28: Initial Tax Compliance
 - Responses received: January 4
- January 6: Due diligence matters
 - Responses received: January 12
- January 10: Additional Tax Compliance
 - Responses received: January 12
- January 16: Tax follow-up questions, following 1st due diligence meeting
 - Responses received: January 23
- January 17: Non-tax follow-up questions, following 1st due diligence meeting
 - Responses received: January 22

The Washington Post, January 23, 2017

**HHS NOMINEE'S MIX OF INVESTMENTS, DONATIONS, LEGISLATION
KEEP RAISING QUESTIONS**

By Kimberly Kindy and Amy Goldstein

Representative Tom Price, the Georgia Republican nominated by President Trump to lead the Department of Health and Human Services, is under increasing scrutiny for a trifecta of financial, campaign and legislative activities that some longtime ethics lawyers describe as “extremely rare” and revealing “an extraordinary lack of good judgment.”

In recent years, Price has repeatedly traded stock in dozens of health-related companies while pushing bills that could have benefited many of them. At the same time, he has been uncommonly reliant on campaign contributions from the health-care industry, accepting more than \$700,000 from physicians, hospitals, drug companies and insurers during his 2016 run for a seventh congressional term, according to the Center for Responsive Politics.

“I haven’t seen anything like this before, and I’ve been practicing and teaching about securities law for 30 years,” said Richard W. Painter, who was chief White House ethics lawyer for President George W. Bush from 2005 to 2007.

Given that Price has some influence legislatively over the health-care sector, his volume of trades in related companies is unusual, according to a former chief counsel to the House and Senate ethics committees. In the past few years, more lawmakers have moved away from investing in individual stocks, opting instead for mutual funds, Treasury bills or municipal bonds as investments.

“They are allowed to do this type of trading, but I would advise against it,” said Rob Walker, who served in the bipartisan counsel positions from 1999 to 2008. “The level of scrutiny he is facing goes along with the territory of making these kinds of investments.”

Price’s investments and donations coincide with a pattern, dating back to his years as a state senator, of strenuously promoting legislation that advances the interests of the medical profession. An orthopedic surgeon for 20 years before he entered politics and still an active member of the American Medical Association, he has sought as both a Georgia legislator and congressman to make it more difficult for patients to win medical malpractice lawsuits and to limit certain damage awards in such cases.

“Whether it be liability or any policy issues about how health care is delivered, how it is paid for, how it is accessed, it is doctors all day every day,” said longtime critic Mark Taylor, a Democratic lieutenant governor in Georgia during most of Price’s tenure in the state Senate and first years on Capitol Hill.

And while Price speaks often of pursuing a patient-centered health-care system, he rails against what he calls an excessive federal role in health care, voting at one point against an expansion of the Children’s Health Insurance Program. “The desire

of those on the left to gradually move every American to Washington-controlled bureaucratic health care is so strong they will stop at nothing," he said before casting that vote in 2007.

In Congress, he has been one of the most ardent opponents of the Affordable Care Act, sponsoring the only bill to repeal the sprawling health-care law that passed Congress. Then-President Barack Obama vetoed it early last year.

Price's investment and legislative records are central themes that Democrats plan to pursue in his confirmation hearing Tuesday before the Senate Finance Committee. During a "courtesy" hearing last week before a different Senate panel, he faced sometimes-heated interrogation by Democrats over the timing of stock purchases and the extent of his involvement in them.

The nominee has said he would divest financial interests in any companies that could pose a conflict of interest for him as HHS secretary. But some lawmakers, as well as the advocacy group Public Citizen, are calling for an investigation by the Office of congressional Ethics. They also have filed complaints against Price with the Securities and Exchange Commission.

A congressional probe would cease if he were to become HHS secretary. An SEC investigation would continue.

An HHS spokesman reiterated Monday that Price had no knowledge of any trades in his financial portfolio, with the exception of those in one company. The spokesman declined to provide the name of Price's broker or to share a copy of his written agreement with the investment firm. Price's legislative office did not respond to repeated requests for comment over several days.

If confirmed, the 62-year-old congressman, who chairs the House Budget Committee, would run one of the biggest federal agencies and its \$1.1 trillion budget. Supporters suggest a doctor best understands what the nation's health-care system needs, with Senator Orrin G. Hatch (R-Utah) describing Price as "very upfront and very straightforward, very honest, and somebody who really understands the health-care system of this country."

Price has largely defended his investment activities by saying his broker made nearly all of the stock purchases without his knowledge. Brokers cannot make securities trades for clients without their expressed permission in writing, and Senators Patty Murray (D-WA) and Ron Wyden (D-OR) sent a letter Friday asking Price for such proof. Aides in their offices said Monday that he has not responded.

And regardless, said Painter, now a law professor at the University of Minnesota, "It's a pretty weak defense since he could have gone online at any time and seen the trades that were being made on his behalf."

Representative Louise M. Slaughter (D-NY), the co-author of the 2012 Stop Trading on Congressional Knowledge (STOCK) Act, shares that sentiment. The law passed after media reports on the close ties between lawmakers' stock portfolios and legislative actions. It requires that trades be publicly reported within 45 days instead of annually—the sole reason Price's stock activity last year has come to light in the midst of his confirmation.

"The weakest link here is this notion that some broker bought all these things without his knowledge," Slaughter said.

A spokesman for the Trump transition countered on his behalf last week, although Phil Blando addressed only the issue of campaign fundraising. "Any effort to connect campaign contributions to Dr. Price's policy positions is an increasingly stale and desperate Democratic talking point," he said.

Of particular concern to Slaughter and her Democratic colleagues is Price's largest stock buy last year—between \$50,000 and \$100,000—in an Australian biomedical firm, Innate Immunotherapeutics. Price acknowledged last week that this purchase, and several smaller ones made in the company in 2015, occurred without a broker's aid. He told members of the Senate Health, Education, Labor and Pensions Committee that he learned of the company from Representative Chris Collins (R-NY), who serves on Innate's board, and then did his own research on it and the multiple sclerosis drug it was developing.

The 2016 investment was done through what's known as a "private placement offering" made by a company to a select group of potential investors. Price contended that he received no insider information ahead of time.

Price's denial didn't satisfy Murray, who also pressed him on the timing of the trades. They coincided with final negotiations on the sweeping 21st Century Cures bill, aimed in part at helping to accelerate clinical trials and approval of drugs like Innate's.

Simon Wilkinson, Innate's chief executive, told *The Washington Post* that about 640 investors purchased stock through the special offer. The company did not directly approach Price, he said.

According to David Blake, an Australian securities analyst, the shares the lawmaker purchased in the special offering are now worth between \$337,500 and \$675,000—a 575 percent increase.

Another trade in the spotlight involves Zimmer Biomet, a major manufacturer of orthopedic and dental implant devices.

CNN was the first to report financial disclosure records showing that Price bought between \$1,001 and \$15,000 worth of Zimmer Biomet shares last March. A week later, he introduced legislation to delay a new payment model that industry analysts said could have serious financial implications for the company.

The HHS regulation carried "tremendous risk and complexity for patients and health-care providers," Price said when he introduced his bill. "Rushing its implementation would be unreasonable and potentially detrimental to patients and their quality of care."

Federal Election Commission records show Price received \$2,000 in campaign donations from the company's political action committee in November 2015 and June 2016.

In a statement, Zimmer Biomet spokeswoman Monica Kendrick said it "did not support" Price's legislation and was unaware of his investment in the company. She said the company had long backed efforts such as the payment model Price sought to block.

Price also purchased stock in three pharmaceutical companies in the months leading up to his introduction last June of a bill that would have provided the businesses with massive tax breaks for their manufacturing and production activities in Puerto Rico, records show. Amgen, Eli Lilly and Bristol-Myers Squibb gave a combined \$20,000 to his 2016 reelection campaign, according to filings with the Federal Election Commission.

The bill ultimately did not pass the House. Blando stressed last week that Price had "no say or input into these trades" and that to insinuate a connection "is insulting."

Overall, Price is far more reliant on donations from health professionals than other lawmakers in comparable positions in the House. Since he was first elected to Congress in 2004 from an affluent, conservative district in northern Atlanta, they have given more than \$3.5 million in campaign contributions, more than any other donor sector, according to data from the Center for Responsive Politics.

In contrast, the previous chairman of the House Budget Committee, Speaker Paul D. Ryan (R-WI), has received \$1.3 million in contributions from health professionals since 1998.

While Price resembles many House Republicans in his zeal for dismantling the ACA, his focus on medical malpractice lawsuits is distinctive.

Starting in 2009, he has four times introduced the Empowering Patients First Act, with the most recent three bills seeking to repeal the ACA. All would have weakened patients' hand in medical malpractice cases by setting \$250,000 caps on non-economic damages, creating clinical guidelines to protect doctors from liability or both. And he sponsored two separate bills aimed at creating such guidelines for use in malpractice lawsuits.

None got out of House committees.

Julie Tate, Alice Crites, and Matea Gold contributed to this report.

COMMUNICATIONS

AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS (AAHKS)
OFFICE: 847-698-1200 • FAX: 847-698-0704 • WEB: aahks.org
9400 W. Higgins Road, Suite 230 • Rosemont, IL 60018-4976

The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The American Association of Hip and Knee Surgeons (AAHKS) strongly supports the nomination of Congressman Tom Price, MD as Secretary of the United States Department of Health and Human Services (HHS). AAHKS is the foremost national specialty organization of 2,900 physicians with expertise in total joint arthroplasty procedures. The mission of AAHKS is to advance hip and knee patient care through education and advocacy, and we look forward to working with federal officials to improve our health care system.

Prior to entering public service, Congressman Tom Price practiced medicine as an orthopaedic surgeon. He spent nearly two decades in private practice caring for patients and their families. Dr. Price's experience as a physician gives him a critically important perspective on the real-world impact of health policy including the importance of access, coverage, the doctor-patient relationship, clinical decision making and challenges of navigating a complex health care environment. Most importantly, we have confidence that as a physician, he will seek to put patients first in his role as HHS Secretary.

Dr. Price was also an educator. He was an assistant professor at Emory University School of Medicine and Medical Director of the Orthopedic Clinic at Grady Memorial Hospital, a public hospital serving the greater Atlanta area. His contributions to the education of resident physicians under his tutelage are a testament to his commitment to secure a healthy future for all Americans.

AAHKS respectfully urges the Senate to confirm Dr. Price's appointment as Secretary of HHS.

Sincerely,

William A. Jiranek, M.D.
President

Michael J. Zarski, J.D.
Executive Director

ASSOCIATION OF WEB-BASED HEALTH INSURANCE BROKERS (AWHIB)

Introduction

The Association of Web-Based Health Insurance Brokers (AWHIB) appreciates the opportunity to provide comments on the nomination of The Honorable Thomas Price to be Secretary of the Department of Health and Human Services. AWHIB is a trade association of web-broker entities (WBEs) that have signed agreements with the Centers for Medicare and Medicaid Services (CMS) and are currently leveraging the Federally Facilitated Marketplace's (FFM) direct enrollment application programming interfaces (APIs). Our members include brokerage firms that sell health insurance online directly to consumers, private health insurance exchanges, and technology companies that support individual agents and brokers. AWHIB seeks to

collaborate with consumers, issuers, regulators, lawmakers, and other industry groups to continually develop technologies and enrollment strategies that provide Americans with the greatest access to health insurance products and services.

AWHIB members have played a significant role in enrolling consumers in individual market health insurance policies. During the plan year 2016 annual open enrollment period, AWHIB members alone facilitated nearly 1 million initial enrollments and active reenrollments, or over 12% of initial enrollments and active re-enrollments by consumers in the Federally-facilitated Marketplace states and states using the Federal platform. This amount is in addition to the hundreds of thousands of off-exchange individual market enrollments facilitated by AWHIB member companies. Our web broker technology is used by tens of thousands of independent health insurance agents nationwide, and AWHIB member companies have partnerships with the world's largest health insurance brokers, tax preparation firms, and health insurance technology firms, including Jackson Hewitt; Tax Act; Mercer; Buck (Xerox); Lockton; Bankrate; NFP; SummaCare Inc.; HealthSpan Inc.; HealthSpan Integrated Care Inc.; H&R Block; Walgreens; Working America; CUNA Mutual Group; Benaissance; Direct Health; and Assurex Global.

AWHIB offers its support for Congressman Price to be the next Secretary of HHS based upon his significant experience in the House of Representatives, including his role as Chairman of the House Budget Committee during the 114th Congress, as well as 20 years as a practicing orthopaedic surgeon. If confirmed by the Senate, AWHIB looks forward to working with Secretary Price to improve the health of all Americans.

Principles for Stabilization and Reform of the Individual Health Insurance Market

The nation's individual health insurance market is at a critical juncture as it enters its fourth year following the full implementation of the Affordable Care Act. AWHIB recognizes that the Administration, along with many members of Congress, intend to take steps to modify and/or replace many of the elements implemented under the Affordable Care Act, including potentially the health insurance Exchanges. As key players in assisting consumers make an informed choice of insurance products, AWHIB's members want to offer their perspectives and recommendations regarding the individual health insurance market for consideration by an incoming Secretary of HHS.

To promote the availability of coverage, AWHIB recommends that an incoming Secretary consider the following six key tenets to help guide changes to the individual health insurance market:

- *Expand Consumer Choice of Enrollment Venue*—Provide consumers with choices on how to enroll in health insurance and support multiple channels for enrollment, including private sector channels. Private health insurance exchanges and WBEs have enrolled consumers in health insurance products prior to the ACA, and as part of the ACA both on and off the exchanges. They also have extensive third party partnerships with retailers, tax preparation firms, unions, employers and other organizations that could be leveraged to reach consumers “where they are.” Despite this experience, private sector enrollment channels have been highly underutilized by the Exchanges to date.
- *Provide for Versatile Eligibility Determination Regardless of Enrollment Channel*—Whether the ACA Exchanges continue or are replaced, Federal and state governments should provide simple and versatile approaches to render eligibility determinations, such as a standalone eligibility service (SES), that can interact with a variety of enrollment channels. This would enable health insurance enrollment efforts to leverage a variety of private and public sector based enrollment channels.
- *Promote Innovation*—One of the core strengths of private health insurance exchanges and WBEs is their ability to use technology innovations to meet the needs of their consumers. While AWHIB recognizes the need for robust consumer protections, WBEs and private exchanges also need flexibility to take full advantage of innovation. To achieve this balance, Federal and state governments should focus on defining the overall policy aims, while permitting flexibility for innovation within defined policy guardrails.
- *Strengthen Support for Continuous Coverage*—Improve the health of the insurance risk pool by implementing enrollment policies emphasizing continuous coverage. This includes improving the administration of special enrollment periods

and making changes to the annual open enrollment process. If the individual mandate is removed, AWHIB supports guaranteed renewability and other incentives to further continuous coverage.

- *Use Refundable Advanceable Tax Credits to Further Insurance Accessibility*—Base tax incentives for health coverage on refundable advanceable tax credits rather than tax deductions. Refundable advanceable tax credits are versatile and can be used by consumers to lower the cost of monthly health insurance premiums, making health insurance accessible to more consumers than tax deductions and non-refundable credits.
- *Improve the Overall Health of the Insurance Market*—Implement policies that would support a more healthy insurance market that is sustainable for health insurance carriers and affordable for consumers. Congress and HHS should consider implementing risk mitigation strategies such as a revised reinsurance program or national high-risk pool, as well as allowing for greater availability and incentives for health savings accounts.

Near-Term Changes to Strengthen the Current Exchange Market

Based upon the above principles, AWHIB recommends the following near-term actions should the ACA Exchanges remain in place for the near term or an indefinite period of time:

- *Implement Enhanced Direct Enrollment for the FFM for PY 2018*—Federally-facilitated Exchanges and state Exchanges that use the Federal enrollment platform permit WBEs to enroll consumers into Exchange coverage using a so-called “direct enrollment process.” However, the current process is not consumer friendly and requires the consumer to be redirected to *HealthCare.gov* before being redirected back to the WBE website to select a plan. This experience is jarring and confusing to the consumer, rendering it nearly non-functional.

HHS has proposed to replace the current direct enrollment process with an enhanced direct enrollment process, which would permit the consumer to complete the Exchange application and select a plan on the WBE platform, however, has not firmly committed to a timeframe for fulfilling those original intentions. AWHIB strongly recommends that HHS implement enhanced direct enrollment for PY 2018, as this would permit WBEs to significantly increase the number of consumers that could enroll in coverage through the Exchanges. Furthermore, this could also be used to support eligibility determination for refundable advanceable tax credits under future replacement plans.

- *Strengthen Special Enrollment Periods*—To improve the health insurance risk pools, HHS should require full verification of eligibility for special enrollment periods. In addition, Congress and HHS should shorten the 3-month grace period for non-payment of premiums by consumers receiving advance premium tax credits, and prevent such consumers from taking advantage of enrollment rules to drop and reenroll in coverage. These changes would help to stabilize the individual market, providing greater predictability for carriers and reducing the potential for adverse selection.

Long-Term Changes if the Role of Public Exchanges Is Altered Significantly

If the public exchanges’ role in facilitating consumer shopping is significantly altered or replaced, consumers will still need tools to help them understand, compare, select and enroll in available health insurance products. WBEs and private exchanges are well positioned to fill this void as a private sector alternative to the public exchanges, as they already provide consumers with online shopping platforms designed to help consumers understand, compare and select available health insurance products. Furthermore, they have extensive experience, having served as an additional channel for consumers to shop for and enroll in public exchange coverage (specifically with respect to Federally-facilitated Exchange), and as a shopping and enrollment portal for off-exchange health insurance products.

AWHIB recommends the following changes to promote broad access in a reformed market:

- *Promote Consumer Choice in Enrollment Venue*—AWHIB recommends that consumers be able to shop for and enroll in health insurance coverage in any online portal that meets Federal or state requirements, including a public exchange, WBE/private exchange or carrier portal. This will provide consumers with greater choice according to which type of portal best suits their needs, as each type of portal may provide value to different types of consumers.

- *Implement Refundable Advanceable Tax Credits*—As noted above, AWHIB recommends that tax incentives in a reformed marketplace be structured as refundable advanceable tax credits, as this will enable consumers to use their tax credits to lower the cost of health insurance premiums. Refundable advanceable tax credits help make health insurance more accessible for consumers than tax deductions.
- *Seamlessly Verify Tax Credit Eligibility*—If tax credits are refundable and advanceable, consumers need to know whether they are eligible for the tax credit when shopping for a health plan. To support broad access to insurance, HHS should provide WBEs, private exchanges and carriers with access to a stand-alone eligibility service (SES). With SES, a WBE, private exchange or carrier would be able to submit tax credit application data to the Federal government (IRS or HHS on behalf of IRS), and then receive an official Federal eligibility determination—all through back-end web-services. As a result, the consumer could obtain a tax credit eligibility determination as part of the WBE, private exchange or carrier's consumer shopping and enrollment experience, making it easier for consumers to access health insurance coverage.
- *Transact Enrollment Directly With Carrier*—Permit WBEs and private exchanges to enroll consumers directly with the health insurance carrier, unless otherwise specified by a state. ACA enrollments are currently processed through the Exchange, even if plan selection takes place on a WBE/private exchange or carrier shopping platform. A more efficient and seamless process would allow for WBEs, private exchanges and carriers to enroll consumers directly with the carrier, with the carrier transmitting enrollment information with HHS for purposes of tax credit administration once the consumer has effectuated enrollment with the carrier.
- *Maintain Guaranteed Renewability; Implement Incentives for Continuous Coverage*—Should the individual mandate be eliminated, maintain guaranteed renewability provisions in order to encourage consumers to maintain coverage and avoid enrolling in coverage only when needed. Also implement clear disincentives for incurring gaps in coverage, including late enrollment fees or waiting periods for consumers who do not maintain continuous coverage and otherwise qualify for a special enrollment period. Such measures would help to mitigate adverse selection and support risk pool health in place of an individual mandate.
- *Improve the Overall Health of the Insurance Market*—Consider changes to improve the overall health of the insurance market, including risk mitigation strategies such as revised reinsurance, risk adjustment, risk corridor, and/or national high-risk pool programs. Also consider options to promote a broader range of health insurance products, including the expanded availability of health savings accounts.

Conclusion

The individual health insurance market is at a critical moment—one that will require strong leadership from HHS. AWHIB believes that short-term action is needed to help bring greater stability to the market and offers specific recommendations if broader reforms are undertaken. AWHIB looks forward to working with Congressman Price to improve the health of all Americans if confirmed by the Senate as the next Secretary of HHS.

LETTER SUBMITTED BY STEVEN P. BRASCH, M.D.

January 26, 2017

Senate Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Dear Senators:

I hereby file my OPPOSITION to the confirmation of Representative Tom Price for Secretary of Health and Human Services.

Because of many of Dr. Price's views on matters of public health, the ACA, medical and social services to the poor, underserved, gay, and disenfranchised citizens of America, I believe he is poorly qualified to serve as our next Secretary of HHS.

Please contact me if you have any questions.

LETTER SUBMITTED BY LESLI CHOAT, MT (ASCP)

January 24, 2017

U.S. Senate
 Committee on Finance
 Dirksen Senate Office Bldg.
 Washington, DC 20510-6200

I would like to express my opposition to the Nomination of Tom Price for HHS Secretary.

My health care career has spanned 32 years and I continue to function as STD Counseling and Testing Coordinator in an STD program. I was working in health care before HIV and hepatitis C (HCV) were identified. I am a scientist who has seen the great strides the United States and the world have made to test and treat for HIV, HCV and other infectious diseases. I saw so many die in the beginning of the AIDS epidemic and I am proud to see so many live healthy lives with the advances we have made in HIV care. I serve on my local HIV planning group to advance HIV prevention and care in my community. I support Planned Parenthood and the services they provide to so many that have no other access to health care. I see HCV as a looming public health threat that must be addressed. My voice should be heard as a citizen who works every day on the front lines of American Public Health!

I oppose Representative Tom Price as HHS Secretary. I do not feel Tom Price has the expertise or background knowledge to run such a vital department overseeing so many branches of American health care. Representative Price has spent the last 8 years undermining efforts aimed at providing health care and social services to communities both living with, and vulnerable to, HIV/AIDS and other health conditions. These actions include voting to repeal the Affordable Care Act (ACA) multiple times, pushing for the privatization Medicare, supporting to defund Planned Parenthood, pledging cuts to social service and safety net programs—all while demonstrating a hostile voting record on lesbian, gay, bisexual, transgender and queer (LGBTQ) issues. Throughout the recent hearing before the Senate Committee on Health, Education, Labor and Pensions (HELP), Price made several indications to continue a trend to dismantling existing systems, without details of a replacement that sustains access to health care and social services.

At a time when we are at the forefront of new and exciting science to deliver better antiretroviral therapies for HIV, breakthroughs in cures for HIV, and pathways for making TB treatments shorter and more tolerable, the nomination of Tom Price threatens to impede the progress of both scientific research and its implementation. Upon confirmation, I feel Tom Price will, as promised, oversee the dismantling and overhaul of health care systems that are responsible for delivering many of these medical advances to people in the United States, particularly those communities impacted by health, social, and economic disparities as well as stigma.

HHS is not just the department that oversees our health care system, but also governs our public health, research, and regulatory agencies, such as the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the Food and Drug Administration (FDA). The recent revelation of ethics violations and refusal to clearly answer questions on these issues during the Senate HELP hearing clouds my trust in Price to ensure the sanctity and impartiality of these agencies. Trust in HHS leadership is needed in prioritizing pressing public health challenges and countering emerging threats such as Zika, Ebola, drug-resistant TB and antimicrobial resistance through robust R&D, proactive epidemiology, pharmacovigilance, and accelerated research and response.

Price's worrisome background as a member of the American Academy of Physicians and Surgeons—an organization that promotes and endorses the theory that HIV does not cause AIDS, despite a substantial evidence base to the contrary—puts into question his capabilities to end an epidemic. Health conditions like HIV thrive on stigma. Price has only perpetuated stigma and marginalized vulnerable communities by voting against bills that afford protections to the LGBTQ community. With attention needed for other neglected populations, such as prisoners impacted by HIV and HCV, it becomes less likely under a Price-led HHS that key populations will be able to access needed health care and treatment.

With Price's support of the repeal of ACA and efforts to defund Medicaid, the hopes and vision of providing health care that include ending the HIV epidemic and curtailing HCV transmission among the poorest and most vulnerable Americans will vanish.

Sincerely,
Lesli Choat

LETTER SUBMITTED BY RICHARD AND JILL CLAYBOUR

January 25, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Honorable Chairman and Members of the Committee:

We are private citizens writing to beg that you oppose confirmation of Tom Price as the new Secretary of Health and Human Services.

His history of support for views with little or no foundation in science, his apparent willingness to leave needy sick citizens without health care and a reasonable transition to a supposed "much better" program are in themselves sufficient reasons in our eyes to disqualify him. We are shocked, however, at the continued revelations of his conflicts of interest and believe that in no way should these matters be swept under the rug. At a time when Americans have sent a clear signal of their distrust in Washington, we look to you to make sure that our leaders are setting an example of probity and conformance to the highest ethical standards.

Thank you for your consideration.

Sincerely,
Richard and Jill Claybour

LETTER SUBMITTED BY ROBERT K. DARROW

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

January 27, 2017

Senators:

I am writing to you as a 32-year survivor, thriving and living with AIDS, and in opposition to President Trump's nomination, Tom Price, for Secretary of HHS. Tom Price's questionable fitness to head a multi-agency cabinet-level department charged with the health of U.S. residents can simply be ascertained from his own record as a Congressional representative to parts of Atlanta's northern suburbs—a district and metro area with extremely high rates of HIV and a flourishing opioid epidemic. Despite the abundance of epidemiological data illustrating the impact of the HIV epidemic in his own district and in the southeastern United States, Representative Price has spent the last 8 years undermining efforts aimed at providing health care and social services to communities both living with, and vulnerable to, HIV and other health conditions. These actions include voting to repeal the Affordable Care Act (ACA) multiple times, pushing for the privatization of Medicare, threatening to cap and block-grant Medicaid, supporting to defund Planned Parenthood, pledging cuts to social service and safety net programs—all while demonstrating a hostile voting record on lesbian, gay, bisexual, transgender and queer (LGBTQ) issues. Throughout the recent hearing before the Senate Committee on Health, Education, Labor and Pensions (HELP), Price made several indications to continue a trend to dismantling existing systems, without details of a replacement that sustains access to health care and social services.

At a time when we are at the forefront of new science to deliver better antiretroviral therapies for HIV, breakthroughs in cures for HCV, and pathways for making TB treatments shorter and more tolerable, the nomination of Tom Price threatens to impede the progress of both research and implementation. Upon confirmation, Tom Price will, as promised, oversee the dismantling and overhaul of health care systems that are responsible for delivering many of these medical advances to people in the United States, particularly those communities impacted by health, social and economic disparities as well as stigma.

Before the ACA, hundreds of people every year were waitlisted for the AIDS Drug Assistance Program (ADAP). People living with HIV (PLHIV) would need an AIDS diagnosis to be eligible for Medicaid. Pre-existing conditions would also disqualify many PLHIV from gaining insurance. While the ACA is not perfect, thousands of PLHIV have been transitioned onto insurance through marketplaces and have become eligible for Medicaid benefits. This has provided many with access to comprehensive health care for the first time, with profound effects on public health and prevention outcomes. Much of the success we're seeing in increasing viral suppression rates and reducing the number of diagnoses annually will be put in jeopardy if the ACA is repealed without replacement. Without replacement and stewardship by the incoming Secretary of Health and Human Services, access to treatment, prevention and other services will remain out of reach for many of these communities.

HHS is not just the department that oversees our health care system, but also governs our public health, research, and regulatory agencies, such as the Centers for Disease Control and Prevention (CDC), Indian Health Services (IHS), National Institutes of Health (NIH), and the Food and Drug Administration (FDA). The recent revelation of ethics violations and refusal to clearly answer questions on these issues during the Senate HELP hearing clouds any trust in Price to ensure the sanctity and impartiality of these agencies. Trust in HHS leadership is needed in prioritizing pressing public health challenges, ensuring drug and device safety, and countering emerging threats such as Zika, Ebola, drug-resistant TB, and antimicrobial resistance through robust R&D, proactive epidemiology, pharmacovigilance, and accelerated research and response.

Price's worrisome background as a member of the American Academy of Physicians and Surgeons—an organization that promotes and endorses the theory that HIV does not cause AIDS, despite a substantial evidence base to the contrary—puts into question his capabilities to end an epidemic. Health conditions like HIV thrive on stigma. Yet, Price has only perpetuated stigma and marginalized vulnerable communities by voting against bills that afford protections to the LGBTQ community. With attention needed for other neglected populations, such as prisoners impacted by HIV and HCV, it becomes less likely under a Price-led HHS that key populations will be able to access health care and treatment.

Now more than ever, ending the epidemics of HIV, TB, and HCV requires a combination of bipartisan federal and state leadership, evidence-based policies, and adequate resources in proper alignment to deliver the promise of biomedical and public health advances. Efforts to lower drug prices for HIV and HCV while sustaining U.S. leadership in R&D for TB and other neglected diseases remain inevitable challenges to the successor of HHS and the Trump administration. Tom Price, however, remains a concerning and unqualified candidate to lead HHS given a track record that only marginalizes communities, raises questions on his ethics and integrity to run an expansive \$1 trillion department, and putting forth policy proposals that seek to fast-track the loss of lifesaving health care for 18 million Americans. Ending the epidemics remains impossible by destroying access to health care and treatment. With Price's support of the repeal of ACA and efforts to defund Medicaid, the hopes and vision of providing health care—including ending the HIV epidemic, curbing HCV transmission, eliminating TB—among the poorest, sickest, most disenfranchised, most vulnerable Americans will vanish.

Respectfully,

Robert K. Darrow, executive director emeritus
The Philadelphia Center—Shreveport

LETTER SUBMITTED BY ANGELA WILSON GYETVAN

January 19, 2017

U.S. Senate

Committee on Finance
 Dirksen Senate Office Bldg.
 Washington, DC 20510-6200

Dear Committee Members:

I am writing in regards to the Full Committee Hearing for the Nomination of Tom Price to serve as Secretary of Health, held January 18, 2017.

I object to Mr. Price's nomination on the following grounds:

- (1) Potential ethics violations: There is evidence that Mr. Price invested in at least one health-care company, then introduced legislation favorable to the company after he made the investment. At the very least, this is a violation of House ethics rules. At the most, it is insider trading—and must be investigated before any confirmation.
- (2) Conflicts of interest: Price holds positions in multiple healthcare companies, and must divest or put those holdings into a blind trust prior to any confirmation. He also has ties to the tobacco industry—smoking is the leading cause of preventable death!—and has consistently voted against tobacco regulation as a result.
- (3) Non-support for social safety net and general lack of compassion: Price supports the roll-back of Medicare and Medicaid, the repeal of the Affordable Care Act, and blocked the expansion of the Children's Affordable Health program. He even voted to block medical treatment if a Medicare co-pay is not available: a position that is directly opposed to the Hippocratic Oath he took when he became a doctor.
- (4) Track record on women's and LGBTQ rights: Price supports overturning *Roe v. Wade* and has voted against legislation that prevents discrimination based on sexual orientation.

The Health Secretary needs to be a representative for all of us. Mr. Price is not that person.

Thank you.

Angela Wilson Gyetvan

HUMAN RIGHTS CAMPAIGN
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Written Statement of David Stacy
 Government Affairs Director

I submit this testimony on behalf of the Human Rights Campaign's 2 million members and supporters. As the nation's largest organization advocating for the civil rights of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, I raise severe concerns regarding the ability of Representative Tom Price to serve and represent the health and well-being of all Americans as Secretary of the Department of Health and Human Services (HHS). Representative Price has developed a lengthy public record attacking LGBTQ people and every hard-fought victory that we have achieved as a community in recent years. He has used his position as a Congressman elected to represent Georgia voters as a national platform to deny federal rights—including protection from violence—for LGBTQ people nationwide.

Representative Price has consistently voted against critical pieces of legislation that would protect LGBTQ people including the Employment Nondiscrimination Act (ENDA), the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act, and the 2013 reauthorization of the Violence Against Women Act (VAWA). Beyond these votes, Representative Price has publicly spoken against equality, regularly partnering with groups known for promoting anti-LGBTQ views—using the privilege of his position to spread intolerance and misinformation. He has even argued that legislation like ENDA, designed to protect vulnerable workers and promote equal opportunity, would have “remarkably negative” consequences and should be evaluated for the medical and health-care costs of “promoting a homosexual lifestyle.” I must clarify that the real impact of nondiscrimination provisions on health

and well-being of LGBTQ people are remarkably positive, to use Representative Price's descriptor.

We know that systemic discrimination in employment, housing, health care, and education increases the risk of poverty and compounds the health disparities already facing our community. Fear of discrimination deters many LGBTQ people from seeking necessary and important preventative health care, and when they do enter care, studies indicate that the respect that LGBTQ people receive is not consistent with the respect that all patients deserve. Recent studies have shown that transgender people are particularly at risk for discrimination—especially in the health-care setting. One third of transgender people seeking care reported experiencing discrimination, harassment, assault, or even denial of care simply because of their gender identity. One in four transgender people avoided care altogether fearing discrimination. Nondiscrimination provisions provide individuals and families with the security they need to lead full and productive lives. They also increase access to insurance coverage and reduce incidents of arbitrary denial of care based on bias.

It is critical that healthcare facilities treat every patient with respect, recognize patients' gender identity, and provide equal access to gender appropriate facilities while providing treatments. This basic standard of care is embraced by major medical establishments and organizations including the American Academy of Pediatrics and the American Counseling Association. These groups have made it clear that this access is not just an issue of civil rights, but also public health. However, Representative Price has directly attacked transgender people's rights to access appropriate facilities calling this most basic right "absurd." This dismissal of basic rights and welfare is deeply disturbing.

Since joining Congress, Representative Price has failed to adequately represent the nearly 10,000 LGBTQ Georgians living in his district. He has consistently refused to recognize them as deserving constituents and has failed to represent even their most basic needs to Washington. Representative Price's repeated choice to place his personal anti-LGBTQ ideology ahead of this significant portion of his own Congressional district calls into question his ability and true willingness to serve all Americans as Secretary of HHS. This role demands a public servant dedicated to improving health-care coverage and outcomes for all people, not a culture warrior with an outdated and dangerous agenda.

We are also concerned by Representative Price's longstanding opposition to the Affordable Care Act (ACA). The ACA is a critical tool to combat the stark disparities facing our community by expanding access to coverage and ensuring that everyone—regardless of who they are or who they love—has access to the care they need. The federal government has published regulations implementing the nondiscrimination provision of the ACA to explicitly protect individuals on the basis of gender identity or sex stereotyping. These protections are critical for some of the most vulnerable members of our community. This rule also makes clear to providers that transgender patients must be treated consistent with their gender identity, including with respect to facilities and patient rooms. The regulation also prohibits the categorical exclusions in insurance coverage that have plagued the transgender community for so long and have put basic transition related care out of the reach of so many.

Because of the ACA, many LGBTQ people have access to comprehensive health-care coverage for the first time. This security and assurance of quality care without discrimination can be life changing. Representative Price's clear commitment to dismantling the ACA and his hostility towards nondiscrimination provisions generally could seriously undermine the health-care outcomes for our community for years to come.

Finally, as Secretary of HHS, Representative Price will be charged with leading one of the world's largest medical and health research organizations—overseeing the Centers for Disease Control and Prevention as well as the National Institutes for Health. He will also lead administrations and sub-agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) that has published cutting edge research impacting the LGBTQ community including a report addressing the well-established medical harms of so-called "conversion therapy." However, Representative Price has done little throughout his career as a Congressman or as a physician to prove his commitment—or even belief—in evidence based science.

Representative Price is a longstanding member of the Association of American Physicians and Surgeons, a fringe organization that publicly questions well-established

public health concepts including childhood vaccination and the safety of abortion. Perhaps most troubling for our community is the organization's suggestion that HIV does not in fact lead to AIDS. Although Representative Price has stated that he does not personally hold this view regarding HIV/AIDS, his continued association with an organization that is so clearly anti-science is deeply disturbing. As Secretary of HHS Representative Price will be called on to be a research visionary, committed to science and to pursuing answers to the nation's most complex health questions with dedicated compassion. Absolutely nothing in Representative Price's record shows that he is up to this job.

LEADINGAGE
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January 24, 2017

Dear Senator:

LeadingAge is a nonprofit aging services association. Our 6,000+ members and partners include nonprofit organizations representing the entire field of aging services, 39 state partners, hundreds of businesses, consumer groups, foundations, and research partners. Among our members, we count more than 2,000 nonprofit nursing homes, either as free-standing nursing homes, or as a component of a multi-level community. According to GAO, nonprofit nursing homes tend to have higher staffing ratios and are more likely to be higher quality as rated by the CMS 5-star system.

CMS recently issued a final rule implementing new requirements for participation for nursing homes in the Medicare and Medicaid programs. This 105-page rule adds new requirements, mandates previously voluntary provisions such as corporate compliance programs, and revises requirements currently in effect.

As you consider the nominations of Representative Tom Price for Secretary of HHS and Seema Verma for Administrator of CMS, we urge you to address the following concerns.

LeadingAge strongly supports high quality for nursing homes and transparent standards. Our community based, nonprofit providers are a vital element of the post-acute and long-term care continuum, and are often recognized as exemplars of person-centered care and quality. We support many aspects of these new regulations, including the focus on person-centered care. In fact, prior to the enforcement date of the new regulations, our members were actively engaged in the process of integrating the components of Compliance and Ethics, and Quality Assurance Process Improvement (QAPT) into their day-to-day operations.

However, we are gravely concerned about the broad scope of these new regulations (stated by CMS to be the most significant changes to nursing home regulation since 1991), as well as the incredibly short time frame by which providers must comply. We submitted extensive comments to CMS during the regulatory comment period on the content of the regulations including a particular concern about having sufficient time to implement. We are also participating as stakeholders in the various meetings and calls conducted by CMS. To date, the agency has not been responsive.

Specifically, we have particular concerns about the following aspects:

- (1) **Workforce:** Many sections of the regulations require new staffing or changes to the training and competencies of existing staff. Some of these went in to effect November 28, 2016 less than 2 months after the final rules were published. Providers were expected to comply immediately with the requirements, but given little guidance as to these competencies. This left insufficient time for providers to develop the necessary skills training and assessments to comply with the new requirements. And lastly, many rural communities have a workforce shortage and simply do not have sufficient numbers of workers to employ to meet these regulations.
- (2) **Delayed Guidance:** CMS normally develops written guidance explaining the regulations, provides definitions and instructions for implementation, and identifies resources for training. However, it has failed to do so for many of the new policies and procedures that went into effect in November, or for the new systems that must be in place later this year.

- (3) **Guidance Going Beyond Regulatory Language:** Where draft guidance has been shared with stakeholder groups, there is considerable concern that this guidance goes well beyond the scope of the actual regulations and thus creates a whole new set of compliance requirements for enforcement that are not defined in regulation. Guidance that exceeds the regulations but is enforced like regulations should not be enforceable.
- (4) **Timing:** As stated above, the extremely short time frames required for compliance create impossible burdens for many providers, particularly for those smaller and rural providers. The risk is therefore that many of these vital community-based homes will close, rather than face severe enforcement penalties. When these homes close, the negative impact on the community is widespread: Vulnerable residents often are displaced and providers—who are often the primary employer in that community—lose their jobs.

Implementation of broad regulations that impose unrealistic time frames, fail to recognize the negative impact in a challenging workforce environment, and for which guidance and resources have not yet been thoroughly considered or shared with the very providers who will be expected to comply, can only set up providers for failure. This will negatively impact patients and communities for years to come.

We ask for a thoughtful evaluation of these new regulations and a realistic time frame by which providers are able to comply.

Thank you for your consideration.

Sincerely,

Katie Smith Sloan
President and CEO
LeadingAge

LETTER SUBMITTED BY DEBBIE MURZYN

January 24, 2017

Dear Senate Finance Committee:

I oppose the nomination of Tom Price for the Secretary of Health and Human Services. I request that you oppose President Trump's pick and challenge his nomination. Tom Price's questionable fitness to head a multi-agency cabinet-level department charged with the health of U.S. residents can simply be ascertained from his own record as a Congressional representative to parts of Atlanta's northern suburbs—a district and metro area with extremely high rates of HIV and a flourishing opioid epidemic. Despite the abundance of epidemiological data illustrating the impact of the HIV epidemic in his own district and in the Southeastern United States, Representative Price has spent the last 8 years undermining efforts aimed at providing health care and social services to communities both living with, and vulnerable to, HIV and other health conditions. These actions include voting to repeal the Affordable Care Act (ACA) multiple times, pushing for the privatization Medicare, threatening to cap and block-grant Medicaid, supporting to defund Planned Parenthood, pledging cuts to social service and safety net programs—all while demonstrating a hostile voting record on lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues. Throughout the recent hearing before the Senate Committee on Health, Education, Labor and Pensions (HELP), Price made several indications to continue a trend to dismantling existing systems, without details of a replacement that sustains access to health care and social services.

At a time when we are at the forefront of new science to deliver better antiretroviral therapies for HIV, breakthroughs in cures for HCV, and pathways for making TB treatments shorter and more tolerable, the nomination of Tom Price threatens to impede the progress of both research and implementation. **Upon confirmation, Tom Price will, as promised, oversee the dismantling and overhaul of health care systems that are responsible for delivering many of these medical advances to people in the United States, particularly those communities impacted by health, social and economic disparities as well as stigma.**

Before the ACA, hundreds of people every year were waitlisted for the AIDS Drug Assistance Program (ADAP). People living with HIV (PLHIV) would need an AIDS diagnosis to be eligible for Medicaid. Pre-existing conditions would also disqualify

many PLHIV from gaining insurance. While the ACA is not perfect, thousands of PLHIV have been transitioned onto insurance through marketplaces and have become eligible for Medicaid benefits. This has provided many with access to comprehensive health care for the first time, with profound effects on public health and prevention outcomes. Much of the success we're seeing in increasing viral suppression rates and reducing the number of diagnoses annually will be put in jeopardy if the ACA is repealed without replacement. **Without replacement and stewardship by the incoming Secretary of Health and Human Services, access to treatment, prevention and other services will remain out of reach for many of these communities.**

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Price's worrisome background as a member of the American Academy of Physicians and Surgeons—an organization that promotes and endorses the theory that HIV does not cause AIDS, despite a substantial evidence base to the contrary—puts into question his capabilities to end an epidemic. Health conditions like HIV thrive on stigma. Yet Price has only perpetuated stigma and marginalized vulnerable communities by voting against bills that afford protections to the LGBTQ community. With attention needed for other neglected populations, such as prisoners impacted by HIV and HCV, it becomes less likely under a Price led HHS that key populations will be able to access health care and treatment.

Now more than ever, ending the epidemics of HIV, TB, and HCV requires a combination of bipartisan federal and state leadership, evidence-based policies, and adequate resources in proper alignment to deliver the promise of biomedical and public health advances. Efforts to lower drug prices for HIV and HCV while sustaining U.S. leadership in R&D for TB and other neglected diseases remain inevitable challenges to the successor of HHS and the Trump administration. Tom Price, however, remains a concerning and unqualified candidate to lead HHS given a track record that only marginalizes communities, raises questions on his ethics and integrity to run an expansive \$1 trillion department, and putting forth policy proposals that seek to fast-track the loss of lifesaving health care for 18 million Americans. Ending the epidemics remains impossible by destroying access to health care and treatment. **With Price's support of the repeal of ACA and efforts to defund Medicaid, the hopes and vision of providing health care—including ending the HIV epidemic, curbing HCV transmission, eliminating TB—among the poorest, sickest, most disenfranchised, most vulnerable Americans will vanish.**

Thank you for your time.

Debbie Murzyn

NATIONAL CENTER FOR LESBIAN RIGHTS (NCLR)
1100 H Street, NW, Suite 540
Washington, DC 20005

January 25, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Lamar Alexander
Chairman

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member

U.S. Senate
 Committee on Health, Education, Labor,
 and Pensions
 455 Dirksen Senate Office Building
 Washington, DC 20510

U.S. Senate
 Committee on Health, Education, Labor,
 and Pensions
 154 Russell Senate Office Building
 Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Chairman Alexander, and Ranking Member Murray:

The National Center for Lesbian Rights (NCLR) writes to oppose the nomination of Representative Tom Price as Secretary of Health and Human Services (HHS). We have grave concerns that Representative Price will not work toward HHS's goal of enhancing and protecting the health and well-being of all people.

It is imperative that the person chosen to lead the Department of Health and Human Services demonstrate a commitment to health-care access and science-based public health and health-care policy. This important federal official must also be free from discriminatory or hostile attitudes toward minority and vulnerable groups, and administer our critical health-care programs free from ideological bias. Representative Price's record as a legislator casts serious doubt on his ability to perform this role.

Representative Price's Opposition to LGBT Equality

Representative Price has espoused negative views of LGBT people, who have only in recent years begun to achieve critical protections for our health and relationships. In 2013, on a conference call, Representative Price was asked if Congress should be required to consider the "fiscal impact" of legislation involving LGBT people because of the supposed health and economic costs of LGBT people's so-called "lifestyles." He stated that was "absolutely right," and that "the consequences of activity that has been seen as outside the norm are real."¹ Representative Price is also a member of the Association of American Physicians and Surgeons, which supports conversion therapy and calls transgender identity a pathology.

In May of 2016, the Departments of Justice and Education issued guidance to schools on title IX clarifying that the law protects transgender students and requires that they be treated consistent with their gender identity in schools. Representative Price responded with a Facebook post that the guidance was "absurd."² Such an attitude calls into question his ability to enforce essential health care non-discrimination protections. In a 2015 national survey,³ 3% of transgender people who had gone to a doctor or a hospital had been turned away because of who they are. In that same survey, 23% of transgender people nationally said they had avoided getting care when they were sick or injured because they were afraid of that kind of discrimination. Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health-care programs or activities on the basis of race, color, national origin, sex, age, or disability. This is the first time that federal law has broadly prohibited sex discrimination in health care. Health insurers, hospitals, clinics, and any other entities that receive federal funds are covered by this law. Prior to section 1557, there were no broad federal protections against sex discrimination in health care or health insurance. The regulations implementing this important provision that were issued last year state that prohibited sex discrimination includes discrimination based on gender identity and sexual orientation. These critical protections would not exist if the ACA had not been enacted or were repealed, as Representative Price has repeatedly voted to do. Representative Price's plan to replace the ACA, the Empowering Patients First Act, did not include a similar prohibition on discrimination in health care programs on the basis of sex.

Representative Price has also co-sponsored the "First Amendment Defense Act," considered by many to be the most sweeping anti-LGBT bill in Congress as it would establish sweeping new religious accommodations that would seriously harm legal rights and protections for millions of Americans and permit unprecedented types of discrimination against LGBT individuals, same-sex couples, and others. Its aim is to enable a wide range of "persons"—defined in the bill to include government employees, recipients of government grants and contracts, and even for-profit businesses—to violate constitutional or statutory law so long as the violation is based on a sincerely held religious belief about marriage or sexual relationships.

¹<http://www.rightwingwatch.org/post/rep-tom-price-fears-negative-health-and-economic-impacts-of-gay-rights-bills/>.

²<https://www.facebook.com/reptomprice/posts/10154118633590421>.

³<http://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>.

In 2007, Representative Price offered an amendment to Federal Housing Finance Reform Act that required all adults in a household to present specific forms of identification before they could receive assistance through affordable housing grants.⁴ Such a law presents a significant barrier to homeless persons because they often lack these types of identification.⁵ Given that homelessness has become a critical issue for those in the LGBT community,⁶ we cannot support a nominee who actively works to build barriers to safe shelter for those in need.

We are further concerned by Representative Price's record of opposing the repeal of Don't Ask, Don't Tell,⁷ legislation that would ban employment discrimination on the basis of sexual orientation, and LGBT hate crimes protections, as well as his continued opposition to the Supreme Court's recognition that the Constitution requires equal protection of LGBT people, including with respect to marriage.⁸

Representative Price's Opposition to Reproductive Health Care

Representative Price's consistent opposition to reproductive health care for women also raises serious concerns. Despite access to birth control being widely recognized as one of the most important public health achievements of the 20th century, resulting in improved health and safety for millions of women, Representative Price has consistently opposed the publicly funded family planning network, the title X program, the contraception benefit under the Affordable Care Act, and the Medicaid program's family planning freedom-of-choice provision, while seeking to bar Planned Parenthood from receiving critical federal funding even for health care services entirely unrelated to abortion and despite the dependence of millions of low-income women on those services.

Representative Price has co-sponsored legislation that would define life at conception, which would outlaw abortion entirely, along with several of the most effective and widely used forms of birth control, and prohibit in vitro fertilization. Representative Price also sponsored legislation in Georgia that would require health-care providers to give medically inaccurate information to patients seeking abortion.

Ideological opposition to contraception and abortion, and the use of misinformation to reduce access to these essential reproductive health-care services, renders Representative Price unfit to hold the position as the head of our nation's public health care infrastructure.

Representative Price's Opposition to Protecting Access to Healthcare

As a member of Congress, Representative Price has proposed a "replacement" for the ACA that would strip coverage from millions of Americans, including LGBT people and their families. Under Representative Price's plan, LGBT people would lose not only nondiscrimination protections (described above) but also health-care coverage they can only afford because of the law.

Representative Price's alternative legislation would allow insurers to dramatically raise premiums for some people with pre-existing medical conditions, including HIV/AIDS, which would have a dramatic impact on gay and bisexual men. His plan would also fully repeal the Medicaid expansion, a provision of the ACA that extended Medicaid coverage to people making less than approximately \$16,000 per year. Because of employment discrimination that pushes many LGBT people into unemployment or low-wage jobs that do not offer health insurance, LGBT people are disproportionately likely to need alternatives such as Medicaid. Representative Price's ACA alternative would also decimate federal funding for HIV/AIDS treatment.

For the foregoing reasons, we oppose the nomination of Representative Tom Price to lead the Department of Health and Human Services.

Sincerely,
National Center for Lesbian Rights

⁴<https://www.congress.gov/crec/2007/05/22/CREC-2007-05-22-pt1-PgH5560.pdf>.

⁵https://www.nlchp.org/documents/ID_Barriers.

⁶<http://williamsinstitute.law.ucla.edu/wp-content/uploads/Durso-Gates-LGBT-Homeless-Youth-Survey-July-2012.pdf>.

⁷<https://www.congress.gov/crec/2010/12/15/CREC-2010-12-15.pdf>.

⁸<https://tomprice.house.gov/press-release/price-responds-scotus-marriage-ruling>.

LETTER SUBMITTED BY MARILYN D. QUINN

January 24, 2017

Re: The potential appointment of Tom Price to be Secretary of HHS

Dear Committee Members,

As a citizen and a woman who will soon be 70, I want to tell you what I think about the nomination of Congressman Tom Price for Secretary of HHS and some of the health-care issues that are important to me, my family, my friends, and to all Americans. I was able to watch some of his hearing, and I have read some of his statements concerning health care and health insurance.

(1) Obamacare:

My 36-year-old working daughter was **finally able to get health insurance due to Obamacare**. As a resident of New York State, she was also able to pick her coverage from a state-endorsed exchange. I tried to help her get insurance before Obamacare, I called health insurers who would have charged twice the amount she finally paid for a policy after passage of the ACA. She also has a pre-existing condition (asthma), and her employer does not offer health insurance.

We are afraid of a future without the ACA. I believe that the ACA was damaged by two actions during its enactment: (1) the removal of **the coverage mandate** and (2) the removal of **the “public option.”** These would have created a bigger pool of insured and would have provided insurance for those who are too poor to pay the coverage fees. These two provisions were **killed by the Republicans** (and a few misguided Democrats under pressure from people with the wrong information).

I say, “Fix it.” Don t kill it.

This country would be spending less on health care if it considered it to be **a right for all American citizens**, as it is in many other nations. I believe that single-payer Medicare for all would create the kind of broad pool necessary **to keep costs down** for patients and providers alike, as it does in most other developed countries. Imagine how much less time and money it would take for the government and the nation’s medical offices to administer the policies. Imagine how much less it would cost if everyone had access to **affordable preventive care**. I keep hearing that the potential problem with “single payer” is the ensuing difficulty for many doctors and hospitals to make more money off their patients. (Why not reward those who successfully improve their patients’ lives or fill the needs of the under-served and those who are unlucky enough to live in impoverished urban deserts?)

I believe firmly also that many of the people I know who would love to change jobs, or love to move to another state for work or study, or want to start their own business, perhaps by working from home as entrepreneurs, would also benefit by having a policy that is **affordable and portable**. My best friend started a business in Europe where health care was available for everyone, regardless of employment, place of domicile, and income.

Too much time, stress, and money go into the intricacies, changes, and details regarding insurance, which consume and direct the courses of our lives. This is a waste for all citizens and ultimately for our government.

It is advantageous for citizens to learn the truth about all of this. People should know that if they help pay for the health care of everyone else, not just themselves, both the country and themselves will benefit.

(2) Access to affordable contraception and legal abortion:

I need only point out how these benefits to women have **saved many lives** and **improved the health** of women and their families. Pregnancy and childbirth wreak many changes on a woman’s body, some of them deadly. Illegal abortion, of course, is dangerous. The protection of the right to a safe abortion should not be weakened by those who follow religious dogmas or unscientific views of pregnancy and the medical procedures used in modern America. I know women who suffered great indignities in the 1960s (e.g., transport in the trunk of a car) and dangers (e.g., inserting sharp objects into the vagina or ingesting poison) before the passing of *Roe v. Wade*. Women will always be willing to do these things in order to control their destinies.

For many years, I have been protecting access to clinics and doctors who bravely give women the service they need to reduce their family’s size, or to complete a col-

lege education, or to take a job that would be impossible without affordable quality childcare. This country was **founded on freedom of and from religion**. We need to respect that right, which formed the basis of our country's beginnings. Someone's religious beliefs should not be used to deny another woman even minimal access to these basic needs. **The lives of individual women and of their family members should be respected no matter how much their religious belief differs with regard to definitions of life, personhood, female versus male, sexual preferences and activities, and health conditions.** There is no 100% effective form of birth control, but many of them work well enough to permit modern women sexual fulfillment, wider career choice, and a healthier body for starting a family when she is ready and willing.

One other aspect of reproductive choice should be included in the work of the HHS. The United States **must cooperate with organizations and help other nations in need of assistance to provide contraception, childcare, health care, and safe abortion access.** When women have these benefits, they become more economically productive, better mothers, and better able to counter the actions of autocratic or theocratic governments. The world's environment would also benefit from the amelioration of the effects of overpopulation, the resulting pollution, and increasing warfare over necessities for life.

Thank you for listening. I was one of those many, many individuals, along with my husband and daughter, who marched in Washington on January 21st. If I must, I will return, and I will march, write, and put my money toward keeping women's healthcare and reproductive choices free from misinformed or misogynistic people in power. I will speak out against anyone who tries to take away any person's right to affordable health care and reproductive choice.

Sincerely,
Marilyn D. Quinn

LETTER SUBMITTED BY STACEY RAVANESI

To: Senate Finance Committee

Date: January 24, 2017

I am in deeply concerned about the nomination of Representative Tom Price (R-GA) for Secretary of Health and Human Services (HHS). As a matter of fact I am intensely opposed to his nomination. I strongly request the Senate Finance Committee to challenge his nomination to helm an agency that plays an exceedingly important and complex role in ending the certain epidemics in the United States and around the world. Individuals impacted by HIV, tuberculosis (TB), hepatitis C (HCV), and other infections; their families and their communities could face serious and often deadly consequences if someone with Representative Price's agenda leads this vital multi-agency cabinet-level department.

Representative Price's questionable suitability to head HHS and be ultimately responsible for policies that directly affect the health of U.S. residents can simply be ascertained from his own record as a congressional representative to parts of Atlanta's northern suburbs—a district and metro area with extremely high rates of HIV and a flourishing opioid epidemic. Despite the abundance of epidemiological data illustrating the impact of the HIV epidemic in his own district and in the South-eastern United States, Representative Price has spent the last 8 years undermining efforts aimed at providing health care and social services to communities both living with, and vulnerable to, HIV and other health conditions. These actions include voting to repeal the Affordable Care Act (ACA) multiple times, pushing for the privatization of Medicare, threatening to cap and block-grant Medicaid, supporting to defund Planned Parenthood, pledging cuts to social service and safety net programs—all while demonstrating a hostile voting record on lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues. Throughout the recent hearing before the Senate Committee on Health, Education, Labor, and Pensions (HELP), Price made several indications to continue a trend to dismantling existing systems, without details of a replacement that sustains access to health care and social services.

At a time when we are at the forefront of new science to deliver better antiretroviral therapies for HIV, breakthroughs in cures for HCV, and pathways for making TB treatments shorter and more tolerable, the nomination of Representative Price threatens to impede the progress of both research and implementation. Upon con-

firmation, Representative Price will, as promised, oversee the dismantling and overhaul of health-care systems that are responsible for delivering many of these medical advances to people in the United States, particularly those communities impacted by health, social, and economic disparities.

HHS is not just the department that oversees our health-care system, but also governs our public health, research, and regulatory agencies, such as the Centers for Disease Control and Prevention (CDC), Indian Health Services (IHS), National Institutes of Health (NIH), and the Food and Drug Administration (FDA). The recent revelation of ethics violations and refusal to clearly answer questions on these issues during the Senate HELP hearing clouds any trust in Representative Price to ensure the sanctity and neutrality of these agencies. Trust in HHS leadership is needed in prioritizing pressing public health challenges, ensuring drug and device safety, and countering emerging threats such as Zika, Ebola, drug-resistant TB, and Gonorrhea, infant mortality increases from infections such as congenital Syphilis, and antimicrobial resistance through robust R&D, proactive epidemiology, pharmacovigilance, and accelerated research and response.

Representative Price's worrisome background as a member of the American Academy of Physicians and Surgeons—an organization that promotes and endorses the theory that HIV does not cause AIDS, despite a substantial evidence base to the contrary—puts into question his capabilities to end an epidemic. Health conditions like HIV thrive on stigma. Yet Price has only perpetuated stigma and marginalized vulnerable communities by voting against bills that afford protections to the LGBTQ community. With attention needed for other neglected populations, such as prisoners impacted by HIV, HCV, and TB; it becomes less likely under a Price-led HHS that key populations will be able to access health care and treatment.

Now more than ever, ending public health epidemics requires a combination of bipartisan federal and state leadership, evidence-based policies, and adequate resources in proper alignment to deliver the promise of biomedical and public health advances. Efforts to lower drug prices while sustaining U.S. leadership remain inevitable challenges to the successor of HHS and the Trump administration. Representative Price, however, remains a concerning and unqualified candidate to lead HHS given a track record that only marginalizes communities, raises questions on his ethics and integrity to run an expansive \$1 trillion department, and putting forth policy proposals that seek to fast-track the loss of lifesaving health care for 18 million Americans. Ending the epidemics remains impossible by destroying access to health care and treatment. With Representative Price's support of the repeal of ACA and efforts to defund Medicaid, the hopes and vision of providing health care among the poorest, sickest, most disenfranchised, most vulnerable Americans will vanish.

The practice of slashing proven best public health practices from the most helpless Americans is shameful and morally horrendous, while also stigmatizing populations that have been historically marginalized throughout American history. Therefore, I am begging please do NOT confirm Representative Price for Secretary of HHS.

Thank you.

Stacey Ravanesi

LETTER SUBMITTED BY INDU SUBAIYA, M.D., MBA
 CEO, Health 2.0
 350 Townsend Ave.
 San Francisco, CA 94107

U.S. Senate
 Committee on Finance
 Dirksen Senate Office Bldg.
 Washington, DC 20510-6200

January 30, 2017

Honorable members of the Senate Finance Committee:

My name is Indu Subaiya, M.D., MBA, and I am Co-Chairman and CEO of Health 2.0, the largest health care innovation conference and network in the world. I submit this letter to oppose Tom Price's nomination for Secretary of Health and Human Services.

We know that the ACA reduces barriers to health care for millions of Americans, but what many don't know is that it also fuels a vibrant segment of the private sector, the health technology innovation economy.

In a decade of working alongside thousands of health-care innovators globally, and in chapters in over 40 U.S. cities from Nashville to Boston, Dallas to Chicago, we have never seen our health-care system adapt so beautifully to reward private enterprise while saving lives and taking care of our most vulnerable without the heavy hand of government.

Dr. Price appears to be a well-intentioned, educated man, but he has been out of both the practice of medicine and a transforming health-care industry for too long to lead us in this dynamic market. Appointing him to architect a replacement plan for the ACA would be like hiring a dinosaur to build a space station.

What health care needs today is a pragmatic voice who can put pedal to metal on the progress that's begun, who can work on reforming the ACA dispassionately with business leaders, entrepreneurs and patients represented in equal proportions, and who understands the health care innovation economy.

But Dr. Price is far too polarizing in his politics to be taken seriously by the diverse and moderate mainstream on both sides of the aisle. Those of us fixing health care on the ground have blasted silos, left partisanship at the door and figured out how to advance a common interest. Ask Republican Governor Charlie Baker, Republican former Head of the ONC, Dr. David Brailer, Chelsea Clinton of the Clinton Foundation, Mark Bertolini, CEO of Aetna, Bernard Tyson, CEO of Kaiser all of whom we've warmly welcomed on stage at Health 2.0 not just as speakers but as partners in the work of transforming health care.

Dr. Price on the other hand has never reached out to our community, and he's had a decade to do so. Instead he has represented the Association of American Physicians and Surgeons, seen as a fringe group promoting self-interest, technophobia, and a "doctor knows best" philosophy. That era in medicine is over. The era of shared decision-making, data transparency, evidence-based medicine and providers as partners in care and innovation is here. Our era needs a Secretary of HHS who will command the respect of the brightest lights in the health care innovation economy and Dr. Price is just not that person.

What do I mean by the innovation economy in health care? I am not referring to the old generation of electronic medical record companies (EMR) that indirectly received incentives under the HITECH act. I'm referring to the more than 4,000 new companies and many more thousand jobs that were created in response to the ACA's imperative to make health care more accountable for its outcomes. These companies have applied the best of American business and technological ingenuity to support doctors in their workflow and decision-making, to promote collaboration among caregivers, to avoid redundancy in testing, to improve patient safety and to allow patients to take more responsibility for their health and care.

As a sector, they've raised over \$19.8 billion in venture capital since 2011 because investors could bet on the momentum of a system aligning around the best interests of patients for the first time in history. What happens when you leave the doctor's office or hospital has always mattered to individuals and families; but now it made business sense.

All this capital isn't just lining the pockets of Silicon Valley startups. Economic development corporations in New York City, Massachusetts, Detroit, and Louisiana are making long-term, strategic investments in the health technology innovation economy to attract innovative companies to set up shop in their cities to provide badly needed solutions and to be powerful engines of job growth.

That's great you say. We'll keep this thriving and virtuous economy alive, we're just going to get rid of the individual mandate, some nasty corporate penalties and poorly run exchanges that limit choice and raise premiums for patients and we'll handle pre-existing conditions with hiving off those patients into separate pools. But that's a fool's errand.

It was precisely because the ACA widened the tent of coverage that new private sector markets were created. It was precisely because of exchanges that Americans woke up to the fact that you need to take responsibility for your health and spend your pre-deductible dollars wisely, and private sector businesses rose to the occasion to build tools to educate consumers on managing health-care expenses and decision-making.

Overstretched health systems also see innovative technology as a way to do more for patients with less overhead, to reach people in rural areas and at home cheaply and effectively, to refer repeat visitors to the ER to a lower cost option in the community. Hospitals like Massachusetts General in Boston, Cedars Sinai in Los Angeles, Dell Medical Center in Texas, UPMC in Philadelphia and New York Presbyterian in New York City all have either started their own or participated in health technology innovation programs to test new models of care delivery in partnership with the entrepreneurial community in health care.

It was the ACA's imperative to take care of a wider and more diverse population that created demand for new products to address the social determinants of health that are killing our small towns: caregiving burden, mental health, substance abuse, food insecurity, health literacy, social support for the elderly and so much more. These social ills normally depend on inefficient government programs. But thanks to the ACA, for the first time entrepreneurs have paying customers for solutions to these issues. Customers like public health departments, community clinics and hospitals. At the national conference we run on health innovation, the session on "Community Health" normally draws a handful of do-gooders. This past year you couldn't get in the room if you tried; it was packed with entrepreneurs. The ACA had created a market for doing well by doing good.

The train of progress toward a healthier America and a more efficient health-care system has left the station. If confirmed, Dr. Price would waste time trying to run after it only to get run over by it. We have better Republican candidates to choose from who have worked shoulder to shoulder with patients and innovators, who've been part of the transformation of American health care on the ground, not in DC and not in the ivory tower.

Don't appoint him because you are comfortable with him as a congressman and a doctor. Neither role prepares him for this job. Don't appoint him because the AMA endorsed him. The AMA is a friend to the innovation community but it speaks for a minority of physicians. You have already heard from thousands of doctors who aren't involved in politics who oppose this nomination. Take your time and don't rush this vote. Let's fix what's broken together without taking a wrecking ball to progress. On behalf of those of us with real experience making positive change in the trenches of health care, I ask you to vote "no" on Tom Price.

Thank you for your consideration.

Sincerely,

Indu Subaiya, M.D. MBA
CEO, Health 2.0

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January 24, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Dear esteemed members of the Senate Finance Committee:

Treatment Action Group (TAG) submits this statement for the record in strong opposition to the nomination of Representative Tom Price (R-GA) for Secretary of Health and Human Services (HHS). We urge critical community action and implore the Senate Finance Committee to challenge his nomination to helm an agency that plays an exceedingly important and complex role in ending the HIV, tuberculosis (TB) and hepatitis C (HCV) epidemics in the United States and ultimately around the world.

TAG is an independent, science-based research and policy think-tank fighting for better treatment, vaccine and a cure for HIV/AIDS, TB, and HCV. We work closely and interface extensively with U.S. health care, research, and regulatory institutions to support expanded access to health care, centralize community engagement and ethically accelerate vital research.

Tom Price's questionable fitness to head a multi-agency cabinet-level department charged with the health of U.S. residents can simply be ascertained from his own record as a Congressional representative to parts of Atlanta's northern suburbs—a district and metro area with extremely high rates of HIV and a flourishing opioid epidemic. Despite the abundance of epidemiological data illustrating the impact of the HIV epidemic in his own district and in the Southeastern United States, Representative Price has spent the last 8 years undermining efforts aimed at providing health care and social services to communities both living with, and vulnerable to, HIV and other health conditions. These actions include voting to repeal the Affordable Care Act (ACA) multiple times, pushing for the privatization of Medicare, threatening to cap and block-grant Medicaid, supporting to defund Planned Parenthood, pledging cuts to social service and safety net programs—all while demonstrating a hostile voting record on lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues. Throughout the recent hearing before the Senate Committee on Health, Education, Labor and Pensions (HELP), Representative Price made several indications to continue a trend to dismantling existing systems, without details of a replacement that sustains access to health care and social services.

At a time when we are at the forefront of new science to deliver better antiretroviral therapies for HIV, breakthroughs in cures for HCV, and pathways for making TB treatments shorter and more tolerable, the nomination of Representative Tom Price threatens to impede the progress of both research and implementation. Upon confirmation, Representative Price will, as promised, oversee the dismantling and overhaul of health-care systems that are responsible for delivering many of these medical advances to people in the United States, particularly those communities impacted by health, social, and economic disparities as well as stigma.

Before the ACA, hundreds of people every year were waitlisted for the AIDS Drug Assistance Program (ADAP). People living with HIV (PLHIV) would need an AIDS diagnosis to be eligible for Medicaid. Pre-existing conditions would also disqualify many PLHIV from gaining insurance. While the ACA is not perfect, thousands of PLHIV have been transitioned onto insurance through marketplaces and have become eligible for Medicaid benefits. This has provided many with access to comprehensive health care for the first time, with profound effects on public health and prevention outcomes. Much of the success we're seeing in increasing viral suppression rates and reducing the number of diagnoses annually will be put in jeopardy if the ACA is repealed without replacement. Without replacement and stewardship by the incoming Secretary of Health and Human Services, access to treatment, prevention and other services will remain out of reach for many of these communities.

HHS is not just the department that oversees our health-care system, but also governs our public health, research, and regulatory agencies, such as the Centers for Disease Control and Prevention (CDC), Indian Health Services (IHS), National Institutes of Health (NIH), and the Food and Drug Administration (FDA). The recent revelation of ethics violations and refusal to clearly answer questions on these issues during the Senate HELP hearing clouds any trust in Representative Price to ensure the sanctity and impartiality of these agencies. Trust in HHS leadership is needed in prioritizing pressing public health challenges, ensuring drug and device safety, and countering emerging threats such as Zika, Ebola, drug-resistant TB, and antimicrobial resistance through robust R&D, proactive epidemiology, pharmacovigilance, and accelerated research and response.

Representative Price's worrisome background as a member of the American Academy of Physicians and Surgeons—an organization that promotes and endorses the theory that HIV does not cause AIDS, despite a substantial evidence base to the contrary—puts into question his capabilities to end an epidemic. Health conditions like HIV thrive on stigma. Yet Representative Price has only perpetuated stigma and marginalized vulnerable communities by voting against bills that afford protections to the LGBTQ community. With attention needed for other neglected populations, such as prisoners impacted by HIV and HCV, it becomes less likely under a Price-led HHS that key populations will be able to access health care and treatment.

Now more than ever, ending the epidemics of HIV, TB, and HCV requires a combination of bipartisan federal and state leadership, evidence-based policies, and adequate resources in proper alignment to deliver the promise of biomedical and public health advances. Efforts to lower drug prices for HIV and HCV while sustaining U.S. leadership in R&D for TB and other neglected diseases remain inevitable challenges to the successor of HHS and the Trump administration. Representative Tom Price, however, remains a concerning and unqualified candidate to lead HHS given

a track record that only marginalizes communities, raises questions on his ethics and integrity to run an expansive \$1 trillion department, and putting forth policy proposals that seek to fast-track the loss of lifesaving health care for 18 million Americans. Ending the epidemics remains impossible by destroying access to health care and treatment. With Representative Price's support of the repeal of ACA and efforts to defund Medicaid, the hopes and vision of providing health care—including ending the HIV epidemic, curbing HCV transmission, eliminating TB—among the poorest, sickest, most disenfranchised, most vulnerable Americans will vanish.

In summary, we urge the Senate Committee on Finance to challenge the nomination of Representative Tom Price as he is unqualified and unfit to lead HHS in a critical juncture to end the HIV/AIDS, TB, and HCV epidemics. Should you have any questions or concerns in regards to our statement of opposition to the nomination of Representative Tom Price for HHS Secretary, please contact TAG policy staff Kenyon Farrow at (202) 236-3274 or via email at kenyon.farrow@treatmentactiongroup.org, and Suraj Madoori at (917) 530-5996 and suraj.madoori@treatmentactiongroup.org.

Thank you.

Mark Harrington
Executive Director
Treatment Action Group

LETTER SUBMITTED BY ELIZABETH VALLANCE

January 25, 2017

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

To the committee members:

I write in strong protest of the nomination of Tom Price to head the Department of Health and Human Services.

Nothing in Representative Price's record suggests that he is fit to hold this position. Nothing in his record suggests an understanding of the public health issues faced by people of limited incomes, by the elderly, by people with AIDS or addiction problems, by people in minority communities including the LGBTQ community. He has repeatedly fought efforts to provide women's health through Planned Parenthood, has fought to cut desperately needed social services and safety-net programs which are effective and solvent, including (they work, though he disdains them) the Affordable Care Act, Medicare, and Medicaid.

My mother was a proud nurse practitioner in a public clinic in Appalachian Pennsylvania for many years before she died (of cancer—we need that cancer research!) in 1997, and her stories of the many women (anonymous of course)—young women, poor women, women without health plans, women who were alone and frightened by symptoms they couldn't understand, many with their male partners, women new to the area who had no other resources—were extremely moving tales of gratitude for the compassionate care they received. It was clear to her, and it is clear to me, that providing professional health care was critical to the health of these women and the well-being of their families, their children, and the community. Surely all existing programs can be improved upon, and I would welcome genuine improvements—in accessibility and efficiency—in any of them. But Representative Price has offered no solutions, only his intentions to reduce important national programs without a clue as to what might replace them. The women my mother treated in those years before the Affordable Care Act were fortunate to have that clinic, but that was not typical and her clinic couldn't reach everyone.

Donald Trump seems bent on destroying much of what we as a nation have so painstakingly created over the past decades, programs that might begin to bring this country a bit higher in the lists of international rates of healthiness and longevity. The Programs under HHS are the most crucial to this slow progress we have made. HHS needs a leader who understands, respects, and wants to improve on them, not someone whose only interest in the job seems to be to wreck the department and its critical programs.

There are thousands of FAR better candidates out there, responsible health-care and health-policy professionals whose commitment to the health and well-being of our citizens is clear. Reject this terrible choice and let's find someone more qualified than Tom Price to head the programs that the health and well-being of so many millions of Americans depends on.

Thank you for your consideration,
Elizabeth Vallance,
Citizen and voter.

