EXAMINING THE POLICIES AND PRIORITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MAY 15, 2024

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C O N T E N T S

EXAMINING THE POLICIES AND PRIORITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Wednesday, May 15, 2024

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND THE WORKFORCE,
Washington, DC.

The Committee met, pursuant to notice, at 10:16 a.m., in Room 2175, Rayburn House Office Building, Hon. Virginia Foxx, (Chairwoman of the Committee) presiding.

Present: Representatives Foxx, Thompson, Walberg, Grothman, Allen, Banks, Owens, Good, Miller, Kiley, Bean, Burlison, Moran, Chavez-DeRemer, Williams, Houchin, Scott, Courtney, Bonamici, Takano, Adams, DeSaulnier, Norcross, Jayapal, Wild, McBath, Hayes, Omar, Leger Fernandez, and Manning.

Staff present: Cyrus Artz, Staff Director; Nick Barley, Deputy Communications Director; Mindy Barry, General Counsel; Isabel Foster, Press Assistant; Daniel Fuenzalida, Staff Assistant; Sheila Havenner, Director of Information Technology; Amy Raaf Jones, Director of Education and Human Services Policy; Alex Knorr, Legislative Assistant; Georgie Littlefair, Clerk; CJ Mahler, Professional Staff Member; John Martin, Deputy Director of Workforce Policy/Counsel; Hannah Matesic, Deputy Staff Director; Audra McGeorge, Communications Director; Rebecca Powell, Staff Assistant; Ian Prince, Professional Staff Member; Heather Wadyka, Professional Staff Member; Seth Waugh, Director of Workforce Policy; Maura Williams, Director of Operations; Brittany Alston, Minority Operations Assistant; Ilana Brunner, Minority General Counsel; Theresa Tilling-Thompson, Minority Professional Staff; Scott Estrada, Minority Professional Staff; Stephanie Lalle, Minority Communications Director; Veronique Pluviose, Minority Staff Director; Andre Lindsay, Minority Professional Staff; Daniel Foster, Minority Senior Health and Labor Counsel; Dhrtvan Sherman, Minority Research Assistant; Ellie Berenson, Minority Press Assistant; Banyon Vassar, Minority Director of IT; Carrie Hughes, Minority Director of Health & Human Services Policy; and Jessica Schieder, Minority Economic Policy Advisor.

Chairwoman FOXX. Good morning. The Committee on Education and Workforce will come to order. I note that a quorum is present. Without objection, the Chair is authorized to call a recess at any time. Good morning again and welcome. Thank you everyone for joining us to conduct the Committee's yearly oversight of the budg-

et request for the Department of Health and Human Services, HHS.

I am pleased to note that this is the final Committee hearing with a cabinet level official slated for this Congress. At the beginning of the 118th when I took the gavel, I promised to make oversight a top priority. Over this time, the Committee has operated with the utmost respect and scrutiny toward every hard-earned taxpayer dollar spent by this administration.

Therefore, Secretary Becerra, it is only fitting that the committee's last cabinet level oversight hearing this Congress deals with one of the biggest department budget requests in history. For starters, this budget has an eye-popping top line of 1.84 trillion dollars.

When I saw the mandatory spending numbers of 1.7 trillion, I could not help but think of it as an albatross upon the necks of young Americans. I have been in Congress long enough to know that there are few things more permanent than mandatory spending. The proposed spending in this budget represents an 8-percent increase over the Fiscal Year 202024 enacted level, which more than doubles year-over-year inflation.

This unsustainable rate of spending is baked in as a function, a mandatory obligation, and the aging population. Today, there are more 64-year-olds than 4 year olds in this Nation. I think that is something worth repeating. Today there are more 64-year-olds than 4 year olds in this Nation.

Every day 11,000 more reach 65, with only 10,000 children born. These statistics are an anomaly that would be foreign to any other point in American history. What is more, the American healthcare system is too expensive, complex and inefficient for what we get. We spend nearly 18 percent of our GDP on healthcare, whereas other developed countries spend much less.

Rather than investing in innovation, and empowering employers to lower costs, this administration is hell bent on shouldering the employer sponsored health plans with burdensome and costly regulations. For these reasons, 1.84 trillion is not simply a number, it is a story.

It is a demographic and fiscal catastrophe smuggled into the enormous top line of this budget. It is the legacy of older generations, and it is the inheritance of younger ones. While unfathomable, it is not going to hold a candle to future HHS budgets if we do not get spending in check.

Furthermore, each dollar proposed in this budget represents a policy priority. Again, the burden of HHS's partisan agenda is going to fall heaviest on younger generations, which is made clear by some notable exclusions in the budget. Nowhere does the budget contain the word fentanyl, save one instance in a footnote. Fentanyl overdose is the leading cause of death for Americans 18 to 45.

More than car crashes, cancer, and suicides combined. The budget does nothing to address it. Nowhere does this budget mention the Biden border catastrophe that not only fuels the Fentanyl epidemic, but also child trafficking. Under your watch the Office of Refugee Resettlement transferred 85,000 unaccompanied minors to sponsors who were unable to be reached upon followup.

These migrant children are effectively lost. Nowhere does this budget support the longstanding Hyde Amendment, one of the greatest protections for America's youngest and most vulnerable. In forcing taxpayers to fund abortions, HHS is trampling on the rights of the unborn, and religious Americans.

Finally, nowhere does this budget contemplate the negative effects of transgender surgeries on minors. Instead, it funds them. In 2022, HHS issued guidance stating that "Gender affirming care," improves "physical and mental health," despite citing zero research or studies. The lack of scientific evidence supporting these procedures is an absolute scandal.

In an ideal world the HHS budget would represent a positive vision for a healthier country. Yours is a tax and spend monstrosity that papers over the numerous social pathologies inflicting our Nation. Fentanyl abuse, child trafficking, abortion on demand and genital mutilation, to name a few. Secretary Becerra, a chasm separates Republicans and Democrats on these issues, but I do not expect to reach an agreement today on many of them.

I propose we work together for the remainder of your tenure toward our shared goals. The Lower Cost More Transparency Act, which passed the House by a wide bipartisan margin of 320 to 71, would be a great place to start. Whereas, Medicare price controls are polarizing, we can find common ground in price transparency.

We should also work together toward expanding telehealth benefit access to Americans, especially those in rural areas. Although I appreciate the budget calling for a ban on facility fees in telehealth, it worries me that this administration has not made it a priority to restore employer's ability to offer telehealth accepted benefits.

Last, we can do better to coordinate the implementation of the No Surprises Act, to ensure it aligns with congressional intent. While the law has successfully protected millions of patients from receiving a surprise medical bill, the tri-agency's implementation of the independent dispute resolution process has been a disaster.

I worry it will only drive up healthcare costs further. It is my hope that Congress and the White House can come together and craft their responsible budget for Fiscal Year 202025 that addresses these concerns. As for my other concerns with the general direction of the HHS, you will get to answer for those today. With that, Secretary Becerra, I look forward to your testimony, and I yield to the Ranking Member for an opening statement.

[The statement of Chairwoman Foxx follows:]

COMMITTEE ON EDUCATION & THE WORKFORCE

COMMITTEE STATEMENT

Opening Statement of Rep. Virginia Foxx (R-NC), Chairwoman
Committee on Education and the Workforce
Hearing: "Examining the Policies and Priorities of the Department of Health and Human Services"
May 15, 2024

(As prepared for delivery)

Good morning, and welcome. Thank you everyone for joining me to conduct the Committee's yearly oversight of the budget request for the Department of Health and Human Services (HHS).

I am pleased to note that this is the final Committee hearing with a cabinet-level official slated for this Congress. At the beginning of the 118th, when I took the gavel, I promised to make oversight a top priority.

Over this time, the Committee has operated with the utmost respect and scrutiny towards every hard-earned taxpayer dollar spent by this administration.

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For starters, this budget has an eye-popping topline of $1.84 trillion. When I saw the mandatory spending number of $1.7 trillion, I couldn't help but think of it as an albatross around the necks of young Americans. I've been in Congress long enough to know that there are few things more permanent than mandatory spending.

The proposed spending in this budget represents an 8 percent increase over the FY 2024 enacted level, which more than doubles year-over-year inflation. This unsustainable rate of spending is baked in as a function of mandatory obligations and the aging population.

Today, there are more 64-year-olds than 4-year-olds in this nation. Every day, 11,000 more reach 65 with only 10,000 children born. These statistics are an anomaly that would be foreign to any point in American history.

What's more, the American health care system is too expensive, complex, and inefficient for what we get. We spend nearly 18 percent of our GDP on health care, whereas other developed countries spend much less. Rather than investing in innovation and empowering employers to lower costs, this administration is hellbent on shouldering employer-sponsored health plans with burdensome and costly regulations.

For these reasons, $1.84 trillion isn't simply a number. It's a story. It's a demographic and fiscal catastrophe smuggled into the enormous topline of this budget. It's the legacy of older generations, and it's the inheritance of younger ones. And, while unfathomable, it isn't going to hold a candle to future HHS budgets if we don't get spending in check.

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Nowhere does this budget support the longstanding Hyde Amendment, one of the greatest protections for America's youngest and most vulnerable. In forcing

taxpayers to fund abortions, HHS is trampling on the rights of the unborn and religious Americans.

And finally, nowhere does this budget contemplate the negative effects of transgender surgeries on minors. Instead, it funds them. In 2022, HHS issued guidance stating that "gender-affirming care" improves "physical and mental health" despite citing zero research or studies. The lack of scientific evidence supporting these procedures is an absolute scandal.

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Secretary Becerra, a chasm separates Republicans and Democrats on these issues. While I don't expect to reach an agreement today on many of them, I propose we work together for the remainder of your tenure towards our shared goals.

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Lastly, we can do better to coordinate the implementation of the *No Surprises Act* to ensure it aligns with congressional intent. While the law has successfully protected millions of patients from receiving a surprise medical bill, the Tri-Agencies' implementation of the independent dispute resolution process has been a disaster, and I worry it will only drive up health care costs further.

It is my hope that Congress and the White House can come together and craft a responsible budget for FY 2025 that addresses these concerns. As for my other concerns with the general direction of HHS, you will get to answer for those today.

Mr. SCOTT. Thank you, Madam Chair, Secretary Becerra, good morning. Thank you for being with us today. It is always a pleasure to welcome you back to the Committee. You are familiar with this room, not only from your previous appearances before as Secretary, but because you and I started our congressional careers right here in this room over 30 years ago.

It is great to see you back on Capitol Hill and I thank you for your dedication to public service. Under your leadership, the Department of Health and Human Services has made historic

progress in helping workers and their families access quality, affordable care. Last Congress, congressional Democrats passed the American Rescue Plan Act without a single Republican vote.

That law enhanced premium tax credits to lower monthly costs for low-income Americans, especially by eliminating the subsidy cliffs, so that more individuals could get coverage and get help getting coverage. We also passed the Inflation Reduction Act, which was enacted into law to extend the tax credit enhancements, cap the cost of insulin for people on Medicare, and for the first time ever, direct the Federal Government to negotiate lower prices for prescriptive drugs covered by Medicare.

These decisive actions yielded positive results. For example, during the 2024 open enrollment period a record 21.4 million Americans signed up for the Affordable Care Act coverage. That is not all, just last week the administration took further steps to improve access to coverage by announcing a final rule that would expand healthcare coverage to dreamers.

We also know that protecting our Nation's health goes beyond improving access to health insurance. Recently, the department updated several regulations that will improve the lives of workers and their families. For example, the updated Section 504 regulations will protect disabled individuals from discrimination in programs that receive Federal funding through HHS.

This will ensure that people with disabilities have equal access to quality care and are treated fairly in systems that are supposed to protect their health and welfare of all Americans. Additionally, the department issued a number of final regulations that support the healthcare workforce, seniors in nursing homes, and people with disabilities who rely on Medicaid.

Taken together, these rules will work to improve access to and quality of healthcare. Unfortunately, my colleagues on the other side of the aisle frequently talk about their commitment to our Nation's health and safety, but they have not backed up their words with actions.

For example, my colleagues may talk about the child labor problems today, however the reality is that Republican State legislators in many states across the country are working to reverse child worker protection laws, and despite our multiple requests for a hearing on this persistent and growing problem, the majority of this Committee has yet to schedule a hearing, or advance legislation to advance child labor violations.

Moreover, we have seen Republicans attempt to sabotage quality healthcare coverage and undermine access to healthcare and other services that our constituents need. They restrict or criminalize a woman's access to abortion, jeopardizing the health of women, and work against the necessary care that supports the health of transgender individuals.

Despite these efforts, congressional Democrats and the Biden administration will continue working to lower prescriptive drug prices, strengthen the ACA and improve transparency for healthcare consumers. Many Democrats remain focused on helping this administration build on our progress to expand access to care for our most vulnerable communities, lower the costs of quality

care, and meet the changing healthcare needs of workers and their families.

The Biden's administration's proposed investments underscore your commitment to protecting the health and well-being of every American, and so Secretary Becerra, thank you for your work, and thank you for joining us today, and I look forward to the discussion. I yield back.

[The statement of Ranking Member Scott follows:]

ED & WORKFORCE DEMOCRATS

OPENING STATEMENT

House Committee on Education and the Workforce
Ranking Member Robert C. "Bobby" Scott

Opening Statement of Ranking Member Scott (VA-03)
Full Committee Hearing
Examining the Policies and Priorities of the U.S. Department of Health and Human Services
2175 Rayburn House Office Building
Wednesday, May 15, 2024 | 10:15 a.m.

Thank you, Madam Chair.

Secretary Becerra, good morning, and thank you for being with us today. It is always a pleasure to welcome you back to the Committee.

You are familiar with this room, not only from your previous appearances before us as Secretary but also because you and I started our congressional careers right here in this room 30 years ago. It is great to see you back on Capitol Hill, and I thank you for your dedication to public service.

Under your leadership, the Department of Health and Human Services has made historic progress in helping workers and their families access quality, affordable care.

In the last Congress, Congressional Democrats passed the *American Rescue Plan Act* without a single Republican vote. That law enhanced premium tax credits to lower monthly costs for low-income Americans, especially by eliminating the subsidy "cliff" so that more individuals could get coverage and get help getting coverage.

We also passed the *Inflation Reduction Act*, which was enacted into law to extend these tax credit enhancements, cap the cost of insulin for people on Medicare, and—for the first time ever—direct the Federal government to negotiate lower prices for prescription drugs covered by Medicare.

These decisive actions yielded positive results. For example, during the 2024 open enrollment period, a record 21.4 million signed up for *Affordable Care Act* coverage. That's not all. Just last week, the Administration took further steps to improve access to coverage by announcing a final rule that would expand health care coverage to Dreamers.

We also know that protecting our nation's health goes beyond improving access to health insurance. Recently, the Department updated several regulations that will improve the lives of workers and their families. For example, the updated Section 504 regulations will protect disabled individuals from discrimination in programs that receive federal funding through HHS. This will ensure that people with disabilities have equal access to quality care and are treated fairly in systems that are supposed to protect the health and welfare of *all* Americans. Additionally, the Department issued a number of final regulations that support the health care workforce, seniors in nursing homes, and people with disabilities who rely on Medicaid. Taken together, these rules will work to improve access to and quality of healthcare.

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For example, my colleagues may talk about child labor problems today. However, the reality is that Republican state legislators in many states across the country are working to reverse child worker protection laws. And, despite our multiple requests for a hearing on this persistent and growing problem, the Majority on this Committee has yet to schedule a hearing or advance legislation to address child labor violations.

Moreover, we have seen Republicans attempt to:

- Sabotage quality health care coverage and undermine access to health care and other services that our constituents need;
- Restrict or criminalize a woman's access to an abortion, jeopardizing the health of women; and,
- Work against the necessary care that supports the health of transgender individuals.

Despite these efforts, Congressional Democrats and the Biden Administration will continue working to lower prescription drug prices, strengthen the ACA, and improve transparency for health care consumers.

Committee Democrats remain focused on helping this Administration build on our progress to:

- Expand access to care for our most vulnerable communities;
- Lower the cost of quality care; and,
- Meet the changing health care needs of workers and their families.

The Biden Administration's proposed investments underscore your commitment to protecting the health and well-being of every American.

So, Secretary Becerra, thank you for all your work and for joining us today. I look forward to our discussion.

Chairwoman FOXX. Thank you, Mr. Scott. Pursuant to Committee Rule 8-C, all members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically in Microsoft Word format by 5 p.m., 14 days after the date of this hearing, which is May 29, 2024.

Without objecting, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record. I now turn to the introduction of our witness. We have as our witness, Secretary Xavier Becerra, from the U.S. Department of Health and Human Services located in Washington, DC.

We thank you for being here today and look forward to your testimony. I'd like to remind the witness that we have read your written statement, which will appear in full in the hearing record. Pursuant to Committee Rule 8-D and Committee practice, I ask that you limit your oral presentation to a 5-minute summary of your written statement, and I would like to remind the witness to be aware of his responsibility to provide accurate information to this Committee. I now recognize Secretary Becerra.

STATEMENT OF HON. XAVIER BECERRA SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Secretary BECERRA. Chairwoman Foxx, Ranking Member Scott and members of the Committee, thank you for the invitation to discuss the President's 2025 budget for the Department of Health and Human Services. Let me place this 2025 budget in context.

When President Biden took office in January 2021, COVID was ravaging our families and our economy, Americans were dying at the rate of two or three 9/11s every day. Let me repeat that. Every day the sum total of two to three 9/11s was taking the lives of Americans in this country because of COVID.

In January 2021, the number of Americans with health insurance was, like our jobs and the economy, down and on the canvas. Prescription drug prices were skyrocketing, with patients and their pocketbooks at the mercy of big pharma and its profits. We changed that. Today, 3 years later, nearly 700 million shots of COVID vaccines have gone into the arms of Americans.

COVID is still around, but we can now manage it like the flu. Today more than 300 million Americans, a record number, can go to the doctor and hospital and not go bankrupt because they have their own health insurance. More than 46 million of those 300 million Americans count on the Affordable Care Act for their insurance, another record.

Today, while big pharma is still big, the President's new prescription drug law has brought down the price of insulin to $35.00 per month for Americans on Medicare. As we speak, we are in negotiations with those big drug companies to lower the prices of even more prescription drugs, even as they sue us to stop us.

The President's budget doubles down on the investments that made the comeback of our jobs, our economy, and our health possible. It does not just protect Medicare. It strengthens it beyond our lifetime. This budget lays out a vision for a nation that invests in its most vulnerable, fosters innovation, and protects every American's access to the care she needs.

Perhaps most importantly, it continues our shift from a health system that treats illness to one that sustains wellness. All told, the Fiscal Year 202025 budget proposes 130 billion dollars in discretionary, and 1.7 trillion dollars in mandatory funding to advance our mission and invest in key priorities. Let me share some of those highlights.

The budget provides Medicaid-like coverage to low-income individuals in the outlier states that have not expanded Medicaid under the Affordable Care Act. When that happens, another 1.5

million of our fellow Americans will secure healthcare coverage, and the peace of mind that comes with it.

This budget builds on the largest investment in behavioral health in a generation. It bolsters a 988 suicide and crisis lifeline. It gives young people support at home and in school. The President's investments in behavioral health workforce would add 12,000 new psychiatrists, psychologists, clinical social workers, marriage and family therapists, counselors, and peer support specialists at a time when their services are desperately needed.

Across HHS, the budget tackles the maternal health crisis by improving access to pre-and post-natal care, supporting emergency care services, and expanding maternal care in rural and underserved communities. We are also making childcare more affordable for working families, and more available where families live and work.

This budget would fund more than 750,000 slots for our children in Head Start and provide universal preschool for our Nation's four million 4-year-old children, and eventually include our 3-year-olds as well. Our budget grows and strengthens our cybersecurity initiatives to ensure patient safety and privacy, and to keep our hospitals and providers, especially smaller ones, those in rural communities, running and secure.

Finally, this budget further advances our preparedness efforts by investing in counter measures to combat biological threats, and antimicrobial resistant germs by expanding our monitoring of supply chains, and by improving information sharing across Federal, State and local governments.

We cannot reduce the health and well-being of Americans to a line on a budget spreadsheet, but we can transform the numbers on that balance sheet into real investments, and services that sustain health and promote wellness for all Americans. That is what this 2025 budget by President Biden does.

I thank you for the time, I look forward to taking your questions.

[The prepared statement of Secretary Becerra follows:]

TESTIMONY OF SECRETARY XAVIER BECERRA BEFORE THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE

MAY 15, 2024

Chair Foxx and Ranking Member Scott, and Members of the Committee, thank you for the opportunity to discuss the President's Fiscal Year (FY) 2025 Budget for the Department of Health and Human Services (HHS). I am pleased to appear before you today, and I look forward to continuing to work with you to serve the American people.

When President Biden took office, the number of Americans with health insurance was declining. We changed that. Over 300 million Americans now have health insurance – the most under any other Administration.

Until now, Americans paying far too much for prescription drugs haven't had any relief. We changed that. The Inflation Reduction Act, signed into law by President Biden in 2022, caps the price of insulin at $35 per month per insulin prescription for people with Medicare, and certain important vaccines, like the Shingles vaccine, are available for free. And now, for the first time, HHS is negotiating directly with drug companies to lower prescription drug costs for people with Medicare, and we're working to make health care markets more competitive across the board.

The Biden-Harris Administration has taken decisive action to protect access to reproductive health care, including abortion and contraception care. We are also fighting tooth and nail to stop the dismantling of the remaining rights and freedoms available to women across the country.

In three years, the Biden-Harris Administration has made the largest investment in behavioral health, which includes both substance use and mental health, in a generation. We are on the path to increasing the number of mental health counselors in schools, have improved support services for high-risk and underserved populations, and trained health care providers, families and school personnel on best practices for supporting young people with behavioral health needs, including those taking medications to treat opioid use disorder.

There are many, many more accomplishments that I could highlight – but, there is more work to be done. It is critical that we look forward to the challenges that lie ahead and take the actions that will ensure that we can continue to improve the health and wellbeing of all Americans.

This budget lays out a vision for a nation that fosters innovation, invests in health, and supports its most vulnerable.

HHS remains at the center of some of the most important issues for American families – including expanding access to care and lowering health care costs; protecting and strengthening Medicare, Medicaid, and the Marketplace; helping ensure access to reproductive health care; improving maternal health care; transforming the way we deliver behavioral health care, particularly for substance use disorders; improving care for older adults and people with disabilities; preparing for future public health threats; ending cancer as we know it; and ensuring access to high-quality education and support for children.

We also must continue to advance cutting-edge research, and meet the health needs of Tribal Nations and Native communities. And none of this would be possible without the resources to support our operations.

All told, the FY 2025 budget proposes $130.7 billion in discretionary and $1.7 trillion dollars in mandatory funding to advance our mission and invest in key priorities that will impact the lives of all Americans. We remain steadfast in our commitment to be good stewards of taxpayer dollars, and to continually improving the experience of the people whom our programs serve.

Expanding Coverage and Lowering Health Care Costs

Once again, a record-breaking number of Americans enrolled in the Health Insurance Marketplace in 2024—over 21.3 million people. That means more Americans are getting the health care coverage they need at an affordable cost. This is a testament to the success of the Affordable Care Act.

The FY 2025 budget continues to build on this success by making permanent the expanded premium tax credits that the Inflation Reduction Act extended and providing Medicaid-like coverage to low-income individuals in states that have not expanded Medicaid under the Affordable Care Act, along with financial incentives to ensure states maintain their existing expansions. For Medicaid and CHIP, the Budget allows states to extend the existing 12-month continuous eligibility for all children to 36 months, and allows states to provide continuous eligibility for children from birth until they turn age 6. Further, the budget prohibits enrollment fees and premiums in CHIP. It extends consumer surprise billing protections to ground ambulances, building on the No Surprises Act. The budget also advances the steps taken in the Inflation Reduction Act to improve access to affordable prescription drugs by further expanding Medicare's ability to negotiate prices directly with drug manufacturers, and expanding inflation rebates and the $2,000 out-of-pocket prescription drug cost cap beyond Medicare and into the commercial market.

Fundamental to our vision of affordable, accessible health care is ensuring Americans can rely on Medicare for generations to come. The FY 2025 budget proposes changes that indefinitely extends the solvency of the Medicare Hospital Insurance Trust Fund.

In addition, the budget continues on the path to doubling Health Center Program funding, which provides health care services to millions of Americans, particularly those in underserved communities. The budget provides $8.2 billion for Health Centers in 2025, allowing the program to serve approximately 3.9 million additional patients. This investment also supports the expansion of behavioral health services at Health Centers.

Transforming Behavioral Health

The FY 2025 budget proposes over $20.8 billion in investments to improve behavioral health across the Department. This includes $602 million, an additional $82 million, to the 988 Suicide and Crisis Lifeline for an expanded awareness campaign and increased technical assistance support and infrastructure. This investment in 988 also maintains specialized services for LGBTQI+ youth, Spanish speakers, and the Deaf and Hard of Hearing Community.

The budget seeks to expand access to high-quality mental health care, including through a $1 billion investment in the Community Mental Health Services Block Grant. The budget also improves behavioral

health benefits for people with Medicare and Medicaid and in the private insurance market, with an emphasis on improving access, promoting equity, and fostering innovation. In addition, the budget invests $1 billion in health information technology adoption for inpatient psychiatric facilities, as well as certain outpatient and residential behavioral health facilities. If we are serious about integrating behavioral health providers into the rest of the health care system, we must close the technology gap and advance better information exchange with other health care, public health, and community partners.

The budget also addresses the sobering impact of the behavioral health crisis on our nation's youth. National surveys of youth have shown significant increases in certain mental health symptoms, including depressive symptoms and suicidal ideation, compounded by the effects of the COVID-19 pandemic. The surveys underscore the urgency and importance of our commitment to equip our youth with the tools they desperately need to address these unique challenges. The budget expands mental health services in schools and bolsters youth mental health programs by investing an additional $50 million in Project AWARE (Advancing Wellness and Resiliency in Education) and an additional $50 million in Children's Mental Health Services. These programs provide services to states, tribes, and communities to support children with serious emotional challenges and their families. The budget also includes $30 million for the Centers for Disease Control and Prevention's (CDC) Essentials for Childhood: Preventing Adverse Childhood Experiences (ACEs) through Data to Action Program, which will increase the number of states, territories, localities, and tribes implementing ACEs prevention strategies and approaches in their communities.

In addition, the budget increases funding to states for overdose prevention and substance use disorders treatment. In January 2021, the overdose death rate was increasing 31% year-over-year. Today, the rate of increase has dropped to about 2% year-over-year. We're making great progress, but in the face of an increasingly dangerous drug supply, we need to do more. The budget provides an additional $20 million for the State Opioid Response program, which has provided treatment services to over 1.2 million people and has helped states to reverse more than 500,000 overdoses. It also includes a $5 million increase for the Tribal Opioid Response program to address the disproportionate impact of the overdose crisis on American Indian and Alaska Native people.

The FY 2025 budget also continues to invest in growing and diversifying the behavioral health workforce. The budget includes $254 million for the Health Resources and Services Administration (HRSA) for Behavioral Health Workforce Development Programs, including expanding the substance use disorder provider workforce. The budget also continues to expand key HRSA programs by providing $916 million for the National Health Service Corps and $320 million for Teaching Health Centers Graduate Medical Education programs in 2025 to ensure the continued growth of health care services and expand workforce capacity across the country, including for behavioral health. The budget also includes $20 million for the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Minority Fellowship Programs to reduce health disparities and improve behavioral health care outcomes for underserved populations.

Improving the Well-being of Children, Families, and Older Adults

The FY 2025 budget invests in the future of our nation's children through high-quality early childhood education. The budget proposes to guarantee affordable child care to low- and middle-income working families from birth until kindergarten and offer preschool to all four-year-olds, making early care and

education programs affordable and available where families live and work, and increasing wages for early childhood education workers. Under this proposal, preschool would be free and the average family would pay no more than $10 per day for child care until their child starts kindergarten, saving them over $600 per child, per month. This proposal will go a long way to support our most vulnerable children and their families.

The budget continues to bolster Head Start for children from birth to age five and requests a $544 million increase for the Head Start workforce, allowing wages to keep pace with inflation and for us to maintain a high-quality child care workforce. As child care continues to be unaffordable or unavailable for millions of Americans, the budget provides funding to Americans that desperately need it to continue to work and support their families. It also requests a $500 million increase for the Child Care and Development Block Grant to continue our progress in stabilizing the child care sector and helping more Americans afford child care.

The budget also invests in child welfare, with a package totaling $11.4 billion over 10 years. This funding expands services and supports to families at risk of child maltreatment or involvement with the child welfare system, increases funding for prevention services and kinship placements and supports for older youth, and increases and streamlines funding to tribes.

Finally, we are also investing in supports for older adults and people with disabilities to ensure they can participate fully in our communities. The FY 2025 budget provides $2.7 billion for Administration for Community Living programs—a $84 million increase above the 2024 Enacted level. This includes additional funds for nutrition programs, as well as funding for suicide prevention for older adults.

Enhancing Long-term Care in All Settings

HHS programs support the health and well-being of people with disabilities and older adults. The FY 2025 budget includes a 10-year, $150 billion proposal to expand Medicaid home and community-based services to allow more older adults and people with disabilities to receive care at home and in their communities. Recognizing that a strong, well-trained workforce is essential to delivering high-quality services, the budget initiative is designed to enhance the quality of these jobs. When older adults' support needs become so great that they must enter nursing homes, they deserve safe, high-quality long-term care. At the 2024 Enacted level, state survey agencies would complete just 65% of statutorily required nursing home surveys in FY 2024, down from 100% in FY 2022 and 75% in FY 2023. To address the increasing workloads and align with the Administration's commitments to improve the safety and quality of nursing home care, the budget requests an increase in funding to allow CMS to conduct 85% of the mandatory surveys, as well as legislative proposals that strengthen quality and care in long term care facilities for FY 2025. In addition, the Administration's proposal to shift survey and certification funding for nursing home facilities from discretionary to mandatory and increase that funding to conduct 100% of mandatory surveys, effective in FY 2026, would allow for sustained and reliable oversight and enforcement in the nation's nursing homes and ensure that Americans receive high quality, safe services within these facilities.

Strengthening Maternal Health Outcomes and Reproductive Health care Access

The budget reflects the Administration's commitment to address the U.S. maternal mortality rate, which is higher than all other developed nations and on the rise. The majority of these deaths are preventable,

and Black and American Indian and Alaska Native women are disproportionately affected. Across HHS, the budget invests in tackling this maternal health crisis, including $376 million focused on addressing maternal mortality and maternal health equity. This includes targeted funding within the Indian Health Service (IHS) to provide culturally-relevant maternal health care in Indian Country, additional funding for CDC to expand maternal mortality prevention, and continued support for the Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone (IMPROVE) initiative in the National Institutes of Health (NIH). It also includes $215 million in HRSA specifically for reducing maternal mortality and morbidity. This funding will improve access to pre- and post-natal care, including for behavioral health, provide access to emergency care services, expand maternal care in rural and underserved communities, and more.

To help improve maternal health coverage and prioritize person-centered care, the budget also includes an optional Medicaid benefit that expands coverage of maternal health support services across the prenatal, labor and delivery, and postpartum periods, with enhanced federal funding available for the first five years in which states take up the State Medicaid option. This includes coverage for a range of maternal health support workers, including doulas. With this benefit, we aim to bolster maternal health supports throughout the entire continuum of care and to demonstrate our dedication to supporting women at every stage of pregnancy and beyond.

Access to reproductive health care, including contraception, is a more urgent issue now than it has been in decades. The budget provides $390 million, a 36 percent increase, to the Title X family planning program to meet the increased need for family planning services, which are essential to ensuring women have control over personal decisions about their own health, lives, and families. Title X remains the only federal grant program dedicated solely to providing individuals with comprehensive family planning services in communities across the United States.

Preparing for Future Public Health Threats

While this Administration has made tremendous strides in preparedness capabilities since the pandemic, there are many public health threats beyond COVID-19. The budget therefore includes over $28.9 billion in total resources across the Department to support preparedness, including efforts to prevent future pandemics, in addition to response capabilities, consistent with the President's plan to prepare for and respond to biological threats, as outlined in the 2022 National Biodefense Strategy and Implementation Plan.

This includes $8.9 billion in discretionary funding for preparedness across the Department. The budget invests an additional $55 million for CDC for the Center for Forecasting and Outbreak Analytics as well as to manage the Response Ready Enterprise Data Integration platform.

Our nation continues to face emerging public health threats and it is important that we are well positioned to adequately respond. The budget continues to strengthen our domestic supply chain by investing $95 million to accelerate development and domestic production of medical countermeasures, and onshore production of active pharmaceutical ingredients and essential medicines through the Administration for Strategic Preparedness and Response. It also includes $12 million to support the Food and Drug Administration (FDA) in addressing medical and food shortages and $10 million for a new supply chain coordination office within HHS.

As a continuation of our work to treat and prevent infectious diseases, the budget also includes a new HHS-wide proposal to eliminate hepatitis C infections in the United States. This five-year program focuses on high-risk populations and will increase access to curative medications, and expand implementation of complementary efforts such as screening, testing, and provider capacity.

Advancing Health in Indian Country

HHS remains committed to addressing the significant health disparities faced by Tribal Nations and Native communities, and the chronic underinvestment in the Indian Health Service. The budget proposes $8.2 billion for IHS, a $1.1 billion increase above the 2024 Enacted Level. This includes the proposed reauthorization of the Special Diabetes Program for Indians. This will maintain direct health care service levels, address targeted public health issues, and advance critical operational efforts like Health Information Technology modernization.

Beginning in FY 2026, the budget proposes full mandatory funding for all IHS accounts, and automatically grows funding each year to account for factors like inflation and pay. This approach will address chronic underinvestment by ensuring funding grows along with IHS's needs. The budget also includes a dedicated funding stream for public health capacity and infrastructure needs in Indian Country, a key lesson learned from the pandemic.

This budget also addresses health care workforce needs across the Indian Health Service by providing hiring authorities to improve the recruitment and retention of providers in our system. Workforce challenges– including significant staffing needs in behavioral health fields, such as substance use disorder care – are one of the top concerns raised by tribes to HHS. Addressing these challenges is critical to providing better-quality health care to the people IHS serves and to continuing to fight the concurrent substance use and suicide crises tribes are currently facing.

The Department will continue to partner with Tribes and Congress to realize mandatory funding, and to ensure we can continue to provide advance discretionary appropriations so IHS can maintain critical health care services if there is a lapse in appropriations.

Advancing Science to Improve Health

Cancer impacts Americans of all ages and from all walks of life. Decreasing the cancer death rate and the number of loved ones we lose to the disease remains a top priority for the Administration. The Biden Cancer Moonshot set ambitious goals to cut the cancer death rate by 50 percent over 25 years, preventing more than 4 million cancer deaths by 2047, and to improve the experience of people touched by cancer. The FY 2025 budget invests $2.9 billion across the Department to make that possible, including $716 million in discretionary resources at the NIH National Cancer Institute to continue their efforts to speed delivery of cancer drugs and vaccines and ensure access to current and new standards of cancer care. An additional $100 million increase for CDC will support cancer prevention activities, including tobacco prevention and cessation. The Advanced Research Projects Agency for Health (ARPA-H) will also support Cancer Moonshot goals by investing in the development of unprecedented breakthroughs to prevent, detect, and treat cancer.

Additionally, ARPA-H will maintain its role as a catalyst for transformation in the health ecosystem—including through its recently-announced Sprint for Women's Health. With its $1.5 billion budget, the

agency will continue finding real-world solutions for real-world problems, driving biomedical innovation in a variety of arenas.

The budget continues the Administration's commitment to support scientific innovation. It includes $50.1 billion in total resources for NIH, prioritizing in particular women's health research and firearms and gun violence research with additional funds. The budget also continues to support Brain Research Through Advancing Innovative Neurotechnologies, All of Us, and important research on opioids and pain management, HIV/AIDS, and health disparities to improve American health outcomes.

To keep our nation at the forefront of scientific innovation, we must seize the promise of artificial intelligence—while also managing its risks. NIH is committed to harnessing the power of artificial intelligence to advance research, and has already launched ambitious initiatives to propel the fusion of biomedicine and artificial intelligence and machine learning. In addition, the FY 2025 budget provides resources to oversee artificial intelligence within the Department to advance its responsible use in public health and health care.

The FY 2025 budget also invests in scientific research that has resulted in significant improvements to American lives. CDC's overall budget—increased by $520 million—prioritizes investments in areas such as improving public health data, preventing and mitigating the impact of infectious diseases, reducing injury and violence, and protecting against environmental health hazards. The budget also provides a total of $513 million to the Agency for Healthcare Research and Quality to further invest in their mission to produce scientific evidence that makes health care better, more accessible, and more affordable.

Supporting Program Operations and Mission-Critical Infrastructure

HHS needs sufficient operational funding to fulfill our mission. This includes resources to allow the Office of the Secretary to oversee the federal government's largest budget. The budget makes badly needed investments in Centers for Medicare & Medicaid Services (CMS) Program Management to ensure CMS can carry out its core operations, such as surveying hospitals and nursing homes to ensure quality care is being delivered to millions of Medicare and Medicaid enrollees. It also invests in FDA to support the agency's expert staff that ensures the safety of our food supply, guarantees the effectiveness of our medicines, and that conduct rigorous and transparent scientific reviews.

The Nonrecurring Expenses Fund is a key source of funding for Departmental operations. The Fund permits HHS to transfer unobligated balances of expired discretionary funds into an account for necessary information technology and facilities infrastructure acquisitions. Since FY 2013, the fund has allocated over $6.5 billion in capital investment projects across the Department. HHS's proposed FY 2025 projects will address aging systems and facilities, including at IHS, NIH, and CDC. These improvements are integral in improving the health and well-being of the American people.

A fundamental component of HHS's infrastructure is its cybersecurity capabilities. We have seen a dramatic rise in large data breaches reported to HHS, and the health care information HHS protects is a prime target for cybercriminals. Our plan sets the direction for cybersecurity in health care, both from a policy and operational lens, and commits HHS to pursuing new priorities to both strengthen and support the sector at this critical time. The FY 2025 budget prioritizes investments to address cybersecurity threats and invests $141 million in cybersecurity initiatives in the Office of the Chief Information Officer to address cybersecurity mandates and allow deployment of cybersecurity initiatives and tools that will keep

the Department at the forefront in battling ever-evolving cyber threats. The investment in cybersecurity includes $11 million for the Department's Health Insurance Portability and Accountability Act modernization to increase compliance, enhance the privacy and security of health information, and to improve breach prevention and response efforts. The budget also includes an increase of $12 million above FY 2024 for ASPR as the agency designated to coordinate cybersecurity incident prevention and response in the health care and public health sector. The budget also establishes a Medicare incentive program to encourage hospitals to adopt essential and enhanced cybersecurity practices.

The budget also invests in civil rights enforcement to ensure we do our part to protect the American people's fundamental rights of nondiscrimination and health information privacy. The budget provides the HHS Office for Civil Rights a $17 million increase, which includes a robust investment in enforcement staff to address and resolve major case increases that have led to a significant backlog.

HHS also invests in program integrity and promoting competition to support our commitment to good stewardship of taxpayer dollars. Our responsibility is to ensure that every dollar entrusted to us directly enhances the lives of the American people. The budget invests a total of $4 billion over 10 years in new mandatory Health Care Fraud and Abuse Control funding to provide oversight of nursing homes, managed care, and community-based settings. This mandatory investment will yield a net savings of $5 billion over 10 years. Additionally, the budget provides increased funding to the discretionary Health Care Fraud and Abuse Control program and the HHS Office of Inspector General to support its oversight.

Improving the Customer Experience for the American Public

Lastly, I wanted to talk about how we are making government and government programs easier for American people to access and use. HHS is improving customer experience throughout the Department, mostly using current administrative funds. In FY 2025, the budget includes an $11 million investment for the Department to improve data services for benefits delivery, as well as $3 million to support the Streamlining Medicare-Only Enrollment project, among other efforts. These investments are bolstered by the HHS-wide customer experience initiative launched in FY 2024, one of the largest such initiatives in the federal government to date. Our goal is to provide a customer experience that ensures the public can access and utilize the impactful resources within HHS. As part of the initiative, every agency within HHS will pursue substantial projects to improve services to the American people. This expands on the many customer experience initiatives HHS has already pursued. For example, HHS continues to partner with other departments and agencies through the Life Experiences initiative to streamline enrollment and eligibility across benefits programs such as Medicaid and the U.S. Department of Agriculture's Supplemental Nutrition Assistance Program, increase access to decision-making support for older adults, reduce burdensome and repetitive manual income verifications, and support states in innovating and improving federal-state benefits access and delivery.

Conclusion

I am honored to lead the Department of Health and Human Services, working alongside dedicated civil servants to enhance the health and well-being of the American people. Investments in this budget will allow us to continue fulfilling our mission, and we know you are all critical partners in achieving this goal. We are grateful for your support of the Department, and we are excited to work with you on funding for FY 2025.

I want to thank the Committee for inviting me to discuss the President's FY 2025 Budget for HHS. I look forward to working with you to fulfill that vision. Thank you for your partnership in advancing our shared goal to improve the health, safety, and well-being of our nation.

Chairwoman FOXX. Thank you, Mr. Secretary. Under Committee Rule 9, we will now question the witness under the 5-minute rule. I ask members to keep your questions succinct, so the witness has time to answer. I recognize myself for 5 minutes of questioning.

Mr. Secretary, this Committee's efforts helped lead to the passage of the historic No Surprises Act, however the law's independent dispute resolution process has been mired in litigation, delays and faulty implementation. Data shows that 77 percent of disputes are ruled in favor of providers, and the Brookings Institute now anticipates that the IDR process will raise costs and premiums, contrary to the law's goals.

What is HHS doing to improve the operations of the IDR process under the No Surprises Act? Are you concerned that the law's current implementation will raise healthcare costs for employers and employees?

Secretary BECERRA. Madam Chair, thank you for the question. You are right, because there was a mad rush to try to make this independent dispute resolution process work, I think we saw that the gates got overcrowded, and as a result we saw that there were delays.

The arbitrators were wondering if they were going to get paid. There were a limited number of arbitrators. We think most of that has now sort of settled. We are now beginning to see that the cases that are coming through are eligible to be processed through this dispute resolution process. Initially in that first year we saw scores of these cases that were ineligible, and of course it took time.

Since an arbitrator only gets paid for a case that is actually adjudicated and completed, arbitrators were getting very unhappy because they were having to adjudicate claims that did not go anywhere.

Chairwoman FOXX. We are very concerned about the increased costs, so what are you going to do about that?

Secretary BECERRA. By having been able to essentially scrub the system so that it now is much more efficient, so that the claims that come in will have an opportunity to go before an arbitrator. We are beginning to see them run a little faster. Because the courts have given us a little more guidance on how they wish to see us interpret the law, it should go faster as well.

Chairwoman FOXX. Thank you. I am concerned about our regulatory overreach by HHS over self-insured health plans. The recent notice of benefit and payment parameters final rule, and the Section 1557 nondiscrimination in health programs and activities final rule saddles self-insured health plans with new Obamacare regulations.

Under current law, self-funded plans are not subject to Section 1557 are regulated by the Department of Labor. Will you confirm that it is HHS policy that self-insured health plans are not subject to HHS regulation, and will you commit to abandoning any unlawful HHS efforts to regulate self-insured health plans.

Secretary BECERRA. Madam Chair, let me make sure I give you accurate information, because we have seen an evolution there. I

do not want to give you an answer that is not complete, so if it is okay, let me followup with you to give you the precise answer.

Chairwoman FOXX. Okay. We would like that answer right away. No delays please.

Secretary BECERRA. I commit to giving you that.

Chairwoman FOXX. I would like to ask about parental rights in the Head Start program. The Head Start statute goes out of its way to describe parent and family engagement in Head Start services. In the Department's recent Head Start Workforce proposed rule there is even language that claims to ensure, "Programs are consulting and engaging with current parents and families to be involved in the methods the program uses."

However, the proposed rule strikes from current regulation the requirement that parent consent—parental consent be obtained for mental health consultation. What is the Office of Head Start trying to hide? Does HHS intend to complete mental health consultations on children without parental consent?

Secretary BECERRA. Madam Chair, there is nothing that's being hidden. What we are trying to make sure we do is provide the services that are important for any child in the Head Start program. We want to make sure that whether it is ensuring the physical safety a child, we are also addressing any mental health concerns. We can also followup with you if you have particular concerns with some of the language, but I can guarantee that what is going on in this rule on Head Start proposed rule is the best interests of the child.

Chairwoman FOXX. Well, we will see, but we think that needs to be clarified, and that you are not giving mental health consultations on children without parental consent. With that, I yield, and I recognize Mr. Courtney for 5 minutes.

Mr. COURTNEY. Thank you, Madam Chairwoman, and again, Mr. Secretary, it is good to see you in the people's house, your real home, in Washington. Again, I would just like to begin my questions by noting the fact that your department's Medicare Board of Trustees just issued its 2024 solvency report about a week ago, which was really nothing short of astonishing.

In 2023 the Trustees projected that Medicare would run into solvency issues in 2031. Again, a week ago they pushed that out by 5 years to 2036. Again, that is partly because we have such a strong job market, and stock market, the revenue that is coming into the program is much stronger than anyone expected.

Also, the report noted that the Inflation Reduction Act is expected to lower Part B drug spending by about 9 percent starting in 2028. Again, you mentioned the price negotiation, which is again, very much going to help patients, but this report suggests that this actually is going to address the question of Medicare solvency for not just seniors, but working age Americans and young people. Is that correct?

Secretary BECERRA. That is correct. The Inflation Reduction Act is working, just as you all thought it might.

Mr. COURTNEY. In your testimony you noted that the 2025 budget included legislative proposals, which again, would use that drug negotiation authority to even further strengthen the Medicare trust

fund. Again, I think the term was that it would basically, you know, make it solvent for the long-term future.

Secretary BECERRA. For our lifetimes. Beyond our lifetimes.

Mr. COURTNEY. Can you talk about that a little bit because I really think that is something that for people who really question the solvency of these programs, is really a profound statement.

Secretary BECERRA. Yes. It is not rocket science. You just have to be willing to invest your dollars and your savings that you incur from having better programs in healthcare back into the healthcare system. As a result of what President Biden is proposing with the legislation you all passed, to help us negotiate down the prices of prescription drugs, you pump that money back into the system and guess what?

Now you guaranteed the strength of the Medicare system beyond our lifetimes.

Mr. COURTNEY. Mr. Scott, along with his colleagues on the Energy and Commerce Committee and the Ways and Means Committee introduced a measure The Lowering Drugs Costs for American Families Act, which again would take the benefits of that price negotiation, and actually make it available to the rest of the country in terms of employer-based plans, or individual market plans. Again, that was in the bill when we passed the measure in the House, and unfortunately did not make it through the Senate. Again, can you sort of talk about again, the department's perspective on this because really this is about lowering drug costs for everyone.

Secretary BECERRA. Congressman, as you recall from the President's State of the Union Address, he is right where you are, and where Congressman Scott is. He would like to see the benefits we see for Medicare recipients, and lower drug costs, expanded to include every American. There is no reason why only Americans who are in the Medicare program should get $35.00 or less insulin. Why should not every American get it? He is very supportive of this effort to expand access to more affordable prescription drugs to all Americans.

Mr. COURTNEY. One other sort of ripple effect of again, the department's work in terms of prescription drugs is that some of the drug manufacturers have almost kind of been shamed into announcing that they want to actually lower the price of insulin and inhalers, you know, for Americans.

Again, I mean I think it is creating a virtuous sort of, you know, environment where again, it is encouraging and realizing that for people who sell into this market, you know, they really—it is not sustainable to overcharge people based on their age. Again, can you talk about, you know, again that—again really non-mandatory, but still beneficial impact of the Inflation Reduction Act.

Secretary BECERRA. Once again, when you make it so that the drug companies have to actually negotiate on prices versus just dictate to the American people what the American people must pay, you inject a little competition and guess what? You get to lower prices. I keep telling folks that competition is as American as apple pie.

What we are doing in the prescription drug space is saying companies, let us negotiate, get the best price because we have a right

to be competitive for the seniors on Medicare, and for every American to get good prices, so we are not paying two or three times the price for medication here in the U.S. above what others pay around the world.

Mr. COURTNEY. As someone who suffers from seasonal allergies, I was really excited about the inhaler development, so again, thank you for your great work, and again, lowering costs for Americans. I yield back.

Mr. Walberg [presiding]. The gentleman yields back. I now recognize the gentleman from Pennsylvania, Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. Mr. Secretary, it is good to see you. As you may know I spent nearly three decades in healthcare, as a therapist, rehabilitation services manager, and licensed nursing administrator prior to being elected to Congress. I served patients from rural communities throughout central Pennsylvania during that time and learned that the barriers that these communities face in accessing quality, affordable healthcare.

While I appreciated your stated goals of expanding coverage and access, the care that you detailed in your testimony, your Agency's recently finalized rule establishing minimum staffing requirements for nursing homes seems to fly in the face of these goals. Mr. Secretary, do you believe that nursing homes across the country today have enough staff to meet their current needs?

Secretary BECERRA. Congressman first, thank you for the work that you did in this space because it is obviously essential for so many families. There is obviously something going on within the nursing home industry where while they represent about less than one-third of 1 percent of all Americans living in nursing homes, when COVID hit we saw 20 percent of people dying living in nursing homes.

That disparity shows that there is something going on.

Mr. THOMPSON. Well, Mr. Secretary, I will say that was because of one of the huge contributing factors to that was bad policy by Governors like my former Governor who required that the readmission of nursing home residents diagnosed with COVID back into these populations, it was—many of these people died as a result of bad public policy that was put forward.

I mean, but getting back to my original question, do you believe that nursing homes across the country today have enough staff to meet the current needs? Yes or no?

Secretary BECERRA. I believe that too many of these long-term care facilities are not providing the staffing. In fact, the comments we received to our rule made it clear when people are talking about having five CNAs, certified nurse assistants available for 55 residents, clearly that is not enough.

When people are talking about a resident had a stroke and was on the floor for more than 15 minutes because it was breakfast time, not enough staff knew, and it was not until they were collecting the food trays that they discovered there was this person on the floor who had suffered from a stroke, clearly there are not sufficient numbers of qualified people.

Mr. THOMPSON. Obviously, I keep close contact obviously, having worked with older adults, and specifically everything in the past including that. I think perhaps the only former licensed nurse admin-

istrator between the House and the Senate. I may be wrong about that, but I think that may be accurate.

It is certainly not what I have heard from nearly every provider in my District. I would encourage you to engage with these providers more closely to learn about current conditions on the round. It is important for Federal agencies to engage with local providers and stakeholders, and I would encourage you to do more of that, certainly in the future.

According to your Department's own estimates under the proposed staffing minimums, nursing homes around the country would need to hire nearly 13,000 registered nurses and 76,000 nursing assistants. That is actually where I started my career, working as a nursing assistant, as I worked my way through my undergraduate degree.

Can you certify here today that not one senior across the country will lose access to care as a result of this proposal?

Secretary BECERRA. Congressman, what I can certify is that one single American, your loved one, my loved one is going to go into a nursing home, we are going to try to make sure that they are provided with safe, quality care because there will be the staff necessary to provide that care.

Mr. THOMPSON. Well yes, but in terms of access, having available facilities are still open is an incredibly important part of that. Do you believe that nursing homes in rural areas that already face staffing shortages will be forced to close their doors, or drastically reduce the number of seniors that they serve if this minimum staffing mandate takes effect?

Secretary BECERRA. The rule takes into consideration rural health facilities and nursing homes facilities, as well as smaller nursing home facilities. We provide them with a longer transition time to adopt these new rules. We also provide them with a hardship exemption. They can show that it would be tough for them to meet the standards, they have more time.

We have listened to a lot of the facilities, and especially those in rural communities, and those that are small.

Mr. THOMPSON. in terms of listening, how do you expect nursing homes to pay for the costs of implementing this rule, which your agency estimates will cost between 1.5 billion to 6.8 billion to fully implement?

Secretary BECERRA. Congressman, the way I ask the question is what kind of operation do you have now if you are saying you do not have the people you need to provide quality care to the people who are your residents? What we are simply saying is you should have a minimum level. We are not telling them they have to hire more than that, we are just saying have a minimum level, so you do not have the situation as occurred in Ohio where an individual who was in a nursing home was suffering from a wound.

Because they did not get wound care, and diaper changes and feeding, ultimately that wound became a bedsore. That bedsore then got to the bone and ultimately led to death.

Mr. THOMPSON. Having worked many years in nursing homes, both as a delivering that care, and as an administrator, I certainly understand that, but also understand that when you are dictating and mandating from Washington without bringing the people to

the table that provide the care, what you are doing is actually creating a decrease in access to care at a time when our population is aging.

Thankfully most people age with dignity and do not go on to a nursing home.

Mr. WALBERG. The gentleman's time has expired. I now recognize the gentlelady from Oregon, Ms. Bonamici.

Ms. BONAMICI. Thank you, Mr. Chair. Welcome back to the committee, Mr. Secretary. Nice to see you. Thank you for visiting Oregon, we had last year a wonderful conversation about behavioral health, and the need to grow the workforce. What I want to focus on first this morning is the roundtable conversation we had about how to address the challenges around substance use among our Nation's youth.

We heard from John and Jennifer Epstein from Beaverton, Oregon, who tragically lost their son Cal, when he took what was a fake pill that turned out to be fatal. The Epstein's turned their grief into action, and they worked with the Beaverton School District, and they created a curriculum called Fake and Fatal, to spread awareness of the danger.

A compelling story. I know you heard them tell that story. The program is already saving lives. The Beaverton School District has not lost a student to fentanyl poisoning since they implemented the program in 2021. With that lesson as our guide, my committee colleague who was just here, Mr. Kiley and I have introduced the Fentanyl Awareness for Children and Teens in Schools or FACTS Act.

It establishes a pilot program at HHS encouraging the development of partnerships between local or State educational agencies, local and State public health agencies, and nonprofit organizations to provide that necessary education, awareness, and prevention regarding the misuse of synthetic opioids.

I am grateful that the chairwoman who is also no longer here, cares about this issue and mentioned it in her opening. I do want to clarify, however, that even though she said that fentanyl was only mentioned once in the budget, in fact in the justification documents, for example, for CDC it is mentioned 21 times, and for SAMHSA 22 times. Mr. Secretary, I know you care about this issue, so will you tell us what the department is doing to address the issue of synthetic opioid overdose in youth, and how would implementation of policies like the bipartisan FACTS Act support your ongoing efforts?

Secretary BECERRA. Congresswoman, thank you. Thanks for the work that you are doing, and I appreciated the chance to visit with the Epsteins and other families who have gone through these difficult times. Maybe some folks did not see the mention of fentanyl in the President's budget, but the President mentions fentanyl nearly 50 billion times, because that is the amount of money he is putting in his budget to address fentanyl.

Most of that is going in to control at the border, and to make sure that fentanyl does not cross the border, and is not trafficked in this country. Several billions of those dollars that the President puts in his budget for fentanyl are for the Department of Health

and Human Services to work with folks like those we met in Oregon who are trying to prevent people from overdosing.

This is a priority for the President, for this administration, and we look forward to working with you on your legislation, and other efforts to try to keep Americans alive.

Ms. BONAMICI. I appreciate that, Mr. Secretary, and I do urge the Committee to bring up this bipartisan bill that Representative Kiley and I, and I believe Representative Chavez-DeRemer as well, has co-sponsored. It is really important. This is going to save lives. Now I want to turn to the importance of the care economy, and how Federal policies can help American families.

I will start with just a couple easy yes or no questions. Is making childcare more affordable a pro-family policy, Mr. Secretary?

Secretary BECERRA. Yes. I am always careful when someone says it is a yes or no, but that is a pretty clear yes or no, and that is a yes.

Ms. BONAMICI. For Fiscal Year 2024, House Republicans actually proposed a cut in Head Start funding that would reduce the availability of affordable childcare for more than 51,000 children. Would that kind of cut be considered pro-family?

Secretary BECERRA. It would make it very difficult for us to operate.

Ms. BONAMICI. Thank you. Also, Mr. Secretary, does President Biden's Fiscal Year 2025 budget increase funding for affordable childcare and high-quality early childhood education?

Secretary BECERRA. Dramatically.

Ms. BONAMICI. That makes a difference, and I thank you for your leadership. I recently led more than 160 House Democrats in calling for House leadership to increase the Child Care and Development Block Grant funding to more than 12 billion dollars. My question, Mr. Secretary, is how will investing in affordable, accessible childcare benefit not only children and families, but also businesses and the economy?

Secretary BECERRA. Congresswoman, perhaps the greatest benefit is that families will have the freedom to work where they want and earn the income they need if they know they have decent, quality childcare for their kids. It will also help the people who are actually providing the childcare because right now many of these folks are leaving the childcare industry because they can make more money flipping burgers at a fast food joint.

We need to treat them as professionals. They are taking care of the future of this country, and we should pay them adequately, so they are able to stay and make that a profession.

Ms. BONAMICI. Mr. Secretary, do you agree that Federal investment is necessary because there is no market solution to this? We cannot just raise the tuition so we can pay the providers more because it is already too expensive. Can you emphasize the importance of a Federal investment here, and what it does to the economy?

Secretary BECERRA. It is a Federal State partnership. We provide some of the resources, but we need the states to also chime in and do their part.

Ms. BONAMICI. Thank you very much, and I look forward to working with you, and hopefully my colleagues on both sides of the

aisle about expanding access to affordable, accessible childcare, and I yield back the balance of my time.

Mr. WALBERG. I thank the gentlelady. Her time has expired. I now recognize myself. Secretary Becerra, welcome back. As you may or may not recall last time that you were before this Committee I asked you about HHS's vetting procedures in light of reports that unaccompanied children were being placed with sponsors who were exploiting these children.

At that time, you stated that you believed sponsors were properly vetted by HHS. In February, the HHS Office of Inspector General issued a report examining whether the Office of Refugee Resettlement took steps that were required to ensure the safe release of unaccompanied children through sponsor screening and followup calls.

One of the findings from the report stated that the case files of 16 percent of unaccompanied children, who were released to sponsors did not contain any documentation that a required safety check on the sponsor was conducted. Mr. Secretary, ORR received referrals for nearly 119,000 at least according to our records, of unaccompanied children in the Fiscal Year 1923.

That could mean over 19,000 children were released to sponsors without proper safety checks. Yes or no, do you still stand by your statement to me last year that HHS properly vetted sponsors?

Secretary BECERRA. I stand by my response. Congressman, we need to clarify. You have mixed different numbers because the report that you reference OIG is from 2021, and now you mentioned 2023 numbers, and what you have to remember is in 2021, in the Spring of 2021, we were barely coming in.

We were taking over a program that had essentially been dismantled by the previous administration, so it was difficult to have spots for these children, and it was difficult to have an operation to be able to send them to sponsors, as we are required by law. Things are very different from that point in 2021 today.

Mr. WALBERG. Then let us talk about that. My notebook is over there, or I would debate you a little further. Let us not quibble on that. What changes have been made as a result of this audit, and second, what changes have been made in regards to release of unaccompanied children to individuals who have previously sponsored children?

Secretary BECERRA. We have continued over those 3 years to improve the services that are provided to children. I would refer you to our foundational rule, which just became final this year, which takes a lot of those best practices. Today, for example, we have enough space for the children that are coming to us from the Department of Homeland Security.

We are no longer having to use convention centers to house these kids because we did not have the infrastructure in place. We established the infrastructure, which is the most important thing because now they are getting the healthcare they need, they are getting the services they need as we prepare to send them to a vetted sponsor.

Second, we are trying to followup with your help in getting the resources. We are able to do not just the referral to a sponsor, but hopefully, if you give us the resources, we will be able to do fol-

lowup. We do not have authority to do followup. We are not required to, but we believe it is a good idea to do it.

If you give us the resources, we will continue to do more followup with these kids.

Mr. WALBERG. If a child who was under the care of HHS unaccompanied children program is found to be a victim of human labor trafficking, is the sponsorship immediately terminated, and does the Federal Government reclaim custody of the child?

Secretary BECERRA. You have touched on the issue, the difficulty. Once we find the sponsor and transfer the child to the sponsor, we no longer have jurisdiction authority over that child. When you ask, will the sponsorship be terminated? We do not have the authorities to just terminate, because we do not have sight on what happens to the child once the child is in the sponsor's hands.

You are welcome, and I have offered this before, Congress is welcome to give us more authority so we can follow them.

Mr. WALBERG. Immediate action is taken. Immediate action is taken though once you find out there is a problem there?

Secretary BECERRA. Yes, yes. If we are alerted, we will contact the appropriate authorities, but we do not have jurisdiction to try to stop that activity. Remember, if you are talking about a child being exploited in labor, they are already outside of our custody because kids that are in our custody stay in our custody, they do not go out and work.

Mr. WALBERG. Are there circumstances under which the child would be returned to an immediate relative of the original sponsor?

Secretary BECERRA. I am sorry?

Mr. WALBERG. Are there circumstances under which the child will be returned to an immediate relative of the original sponsor?

Secretary BECERRA. That is our priority to make sure that we can place the child closest to whom they know. A parent, if there is a parent available, maybe a relative, we seek to have them if they pass the vetting.

Mr. WALBERG. Is there a vetting process for them as well?

Secretary BECERRA. Yes, there is. No one gets to sponsor a child without going through a vetting process, even if they are the parents.

Mr. WALBERG. We hope that that continues if that is the change that has been made.

Secretary BECERRA. Yes.

Mr. WALBERG. My time is expired. I yield back. I now recognize the gentleman from California, Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman. Mr. Secretary, welcome. Thank you for being here today. I am thrilled to see that the Department of Health and Human Services recently finalized and released its regulations under Section 1557 of the Affordable Care Act, and many thanks to you and your team for your diligent work.

Mr. Secretary, can you describe what the final rule for Section 1557 does, and why your department felt it was important to finalize it?

Secretary BECERRA. Congressman, thank you. Under Section 1557, along with the Civil Rights statutes, we have all an obligation to ensure that no American is discriminated against, whether it is based on race, religion, ethnic origin. At HHS, to make sure

that healthcare services are provided without discrimination, we take action under our Office for Civil Rights, principally under Section 1557.

We have made sure it is clear under Section 1557 that every American deserves to have protection for access to the care that they need, and we will make sure that regardless of your status as a transgender individual, or an LGBTQ American, that you will have access to the care that you need.

Mr. TAKANO. You mentioned LGBTQ and transgender, but this addresses issues related to people, you know, women.

Secretary BECERRA. Everyone.

Mr. TAKANO. Discrimination. Everyone.

Secretary BECERRA. Everyone.

Mr. TAKANO. As you know, LGBTQ Americans face severe health disparities because discrimination in healthcare facilities is rampant. There are over three times more—they are three times more likely to avoid, postpone, or skip medical care. According to a 2022 survey, 15 percent of LGB individuals, 32 percent of transgender and non-binary individuals, and over half of intersex individuals reported experiencing some form of refusal of care by a doctor, or other healthcare provider within the last year.

LGBTQ people of color reported an even higher rates of refusal. How would this rule impact LGBTQ patients?

Secretary BECERRA. Yes. I should note, Congressman, it is even worse for young people who are LGBTQ. If it is bad for adult LGBTQ Americans, it is even worse when you talk about our adolescents, and suicide rates are higher, the outcomes are worse, and we need to reach those individuals in our country.

What Section 1557 does is it shows them that there will be a protection for them. We obviously need them to report. Someone has to let us know that there are violations occurring, so we can go in and stand up and enforce any actions that discriminate against these individuals. We made a good start in making sure the rule is much clearer about protecting all Americans.

Mr. TAKANO. Well, thank you. My Republican colleagues have been less concerned with the benefits of increased access to healthcare, and more concerned about what this rule would supposedly force providers and insurance carriers to do. I would like to ask a few clarifying questions.

You might answer with just a yes or no if you feel adequate. Mr. Secretary, does this rule require doctors to perform any procedures, or provide treatments that are outside the scope of their practice?

Secretary BECERRA. No. Of course not.

Mr. TAKANO. Does this rule require—does this rule just require that providers provide the same care as services to transgender individuals that it would to other non-transgender individuals?

Secretary BECERRA. We do not dictate what services they provide. A medical professional determines what services an individual needs, and we do not get in the way of that. We just want to make sure that if an individual needs that care, they receive it.

Mr. TAKANO. Well, thank you. Is the Federal rule for Section 1557 consistent with numerous court cases, including the Supreme Court decision in Bostock, and most recently a decision on the Fourth Circuit Court of Appeal that discrimination against individ-

uals on the basis of their gender identity and sexual orientation is sex discrimination?

Secretary BECERRA. Yes of course. We took into account those various decisions in rendering the rule.

Mr. TAKANO. Thank you. Does this rule establish a new standard of care for any condition?

Secretary BECERRA. It simply protects people's access to the care that they need.

Mr. TAKANO. Well, thank you. Mr. Secretary, we know that gender affirming care is medically necessary care that has been endorsed by every major medical association. I ask unanimous consent to enter into the record the position statements of 30 professional medical associations in the care of transgender people.

Among them are the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, and the World Medical Association.

Mr. WALBERG. Without objection.

[The Information of Mr. Takano follows:]

WHITMAN-WALKER Institute

Professional Organizations' Position Statements on Care for Transgender People

This document is a compilation of position statements from major U.S. medical professional associations affirming support for age-appropriate, individualized care for transgender youth.
Emphasis added

Updated May 2024

American Academy of Child and Adolescent Psychiatry (AACAP)

AACAP Statement Opposing Actions in Texas Threatening the Health, Mental Health and Well-Being of Transgender and Gender Diverse Youth and Their Families
March 1, 2022

"***Attempts to criminalize gender-affirming care deprive youth and families of treatment and endanger the physician-patient-caregiver relationship, which is the foundation of pediatric healthcare.*** The allocation of scarce child protective services to these efforts further endangers youth who actually require those important services. Gender-affirming care is not child abuse.

Variations in gender expression are not pathological; rather, they represent normal dimensions of human development. All youth and families benefit from access to professional support and information about gender development. ***Gender-affirming care is informed by long-standing standards of care and by evidence-based clinical studies supporting improved mental health and health outcomes for youth.*** For transgender and gender-diverse youth, family and social supports have improved mental health outcomes and functioning, and for some, medical treatment may be necessary. AACAP has strongly advocated for gender-affirming evidence-based care and vehemently opposes efforts to block access to care."

AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth
November 8, 2019

"***State-based legislation regarding the treatment of transgender youth that directly oppose the evidence-based care recognized by professional societies across multiple disciplines is a serious concern***. Many reputable professional organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Pediatrics, and the Endocrine Society, which represent tens of thousands of professionals across the United States, recognize natural variations in gender identity and expression and have published clinical guidance that promotes nondiscriminatory, supportive interventions for gender diverse youth based on the current evidence base. These interventions may include, and are not limited to, social gender transition, hormone blocking agents, hormone treatment, and affirmative psychotherapeutic modalities."

"***The American Academy of Child and Adolescent Psychiatry (AACAP) supports the use of current evidence-based clinical care with minors. AACAP strongly opposes any efforts – legal, legislative, and otherwise – to block access to these recognized interventions***. Blocking access to timely care has been shown to increase youths' risk for suicidal ideation and other negative mental health outcomes."

American Academy of Dermatology

American Academy of Dermatology Association statement on legislative interference in health care for transgender patients
June 1, 2021

"***The American Academy of Dermatology Association strongly opposes recent efforts by state legislatures to restrict physicians' ability to provide care to transgender youths.*** Legislation such as the bill enacted this spring in Arkansas as well as those proposed in several other states are a dangerous intrusion by government into medical decision-making."

"The AADA recognizes the dignity and identity of transgender individuals and advocates for dermatologists' ability to provide therapy and procedures that help the mental and physical well-being of these and all patients. Evidence has shown that transgender individuals who are forced to forgo gender-affirming care face an increased risk of mental health disorders including substance abuse disorders, and have higher rates of suicide."

"***Transgender and gender-diverse individuals can benefit greatly from medical and surgical gender-affirming treatments. These treatments are often medically necessary for the health and well-being of these patients and are not to be considered as cosmetic or elective.***"

"***Decisions about care should remain within the confines of the physician-patient relationship, guided by strong medical evidence and the best interests of the individual patient***."

American Academy of Family Physicians (AAFP)

Family Physicians Stand Against Policies That Criminalize Care, Threaten Patient-Physician Relationship
April 6, 2022

"***The American Academy of Family Physicians stands firmly against any policies that unnecessarily regulate the evidence-based practice of medicine, criminalize physicians and medical care, threaten the patient-physician relationship, and inhibit the delivery of safe, timely, and comprehensive care, including reproductive health services and information and gender-affirming care***.

"Patients must be able to depend on their physicians to help them make critical decisions about their personal health. Laws and mandates that restrict or create undue burdens in accessing these services endanger patients and put those of us who provide medical care—or even offer evidence-based information—at great risk."

"***The AAFP will continue to advocate for everyone's right to health care and to protect family physicians. This echoes our longstanding policies opposing any governmental interference in the confidential relationship between patient and physician, including those related to criminalizing medical care***. To that end, the AAFP strongly urges state and federal legislators and courts to strike down any laws that jeopardize care to protect physicians and their patients."

"Physicians must be able to practice medicine that is informed by their years of medical education, training, experience, and the available evidence, freely and without threat of punishment, harassment, or retribution. Our patients, not policymakers, must make their own medical decisions."

Frontline Physicians Oppose Legislation That Interferes in or Criminalizes Patient Care
April 2, 2021
Joint statement from the American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American College of Obstetricians and Gynecologists

"***Our organizations, which represent nearly 600,000 physicians and medical students, oppose any laws and regulations that discriminate against transgender and gender-diverse individuals or interfere in the confidential relationship between a patient and their physician***. That confidentiality is critical to allow patients to trust physicians to properly counsel, diagnose and treat. ***Our organizations are strongly opposed to any legislation or regulation that would interfere with the provision of evidence-based patient care for any patient, affirming our commitment to patient safety. We recognize health as a basic human right for every person, regardless of gender identity or sexual orientation***."

The American Academy of HIV Medicine (AAHIVM)

The American Academy of HIV Medicine Statement on Transgender Care and Gender-Diverse Care
September 21, 2023

"Transgender care, gender-diverse care, and gender-affirming care is life-saving health care. ***As an organization whose members are comprised of health care providers and clinicians, the Academy unequivocally supports transgender care, gender-diverse care, and gender-affirming care as well as the professionals who provide it. We uphold the sanctity of the patient-provider relationship and the individual decisions regarding the provision of health care that the patient and their provider make together***."

"***Additionally, providing health care for the whole person, including gender-affirming care, is an integral part of status-neutral care delivery and the federal Ending the HIV Epidemic initiative. We will not achieve the goal of ending the HIV epidemic without providing comprehensive medical care for transgender and gender-diverse (TGD) individuals***. The Academy's mission is to ensure health care professionals have the resources needed to provide prevention, treatment, and care for those with or at risk for HIV and related conditions to achieve optimal health. In upholding our mission, we support gender-affirming care for TGD individuals, because barriers to comprehensive gender-affirming care exacerbate existing health inequities and prevent TGD individuals from accessing HIV prevention and treatment services that may be appropriate for them."

American Academy of Pediatrics (AAP)

American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth
March 16, 2021

"The American Academy of Pediatrics has long been on the record in support of affirmative care for transgender children through our clinical policy. Today, we are going on the record to oppose public policies that would allow for the opposite…The American Academy of Pediatrics recommends that youth who identify as transgender have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space. We also recommend that playing on sports teams helps youth develop self-esteem, correlates positively with overall mental health, and appears to have a protective effect against suicide. These bills not only ignore these recommendations, they undermine them."

Statement from the American Academy of Pediatrics and the Oklahoma Chapter of the American Academy of Pediatrics on Gender-Affirming Care
September 28, 2022

"***Our organizations strongly oppose any legislation or regulation that would discriminate against gender-diverse individuals, including children and adolescents, or limit access to comprehensive evidence-based care which includes the provision of gender-affirming care…Our organizations also oppose any action that would interfere with the physician-patient relationship and with parental involvement in making medical decisions for their own children.*** We stand with our physician members and the patients they care for in Oklahoma and across the country today and every day."

American Association for Marriage and Family Therapy (AAMFT)

Statement on Anti-Transgender Legislation
April 9, 2021

"AAMFT has been clear and vocal in its position that as an association, discrimination will not be tolerated on any basis. We reiterate our global commitment to inclusivity, diversity, and a fundamental belief in the power of relationships upon which our profession is built. ***We recognize the adverse effects of this legislation on the livelihood of the transgender and gender diverse community, including depression, increased suicide and attempted suicide, and fewer safe, inclusive spaces in which to thrive.****"*

"Legislative proposals like [Arkansas'] HB 1570 may also leave mental health providers overwhelmed with clients experiencing gender dysphoria, without any medical providers to refer clients to for further treatment. ***AAMFT opposes legislation that discriminates against the LGBTQ+ population, such as HB 1570 and legislation that seeks to limit MFTs' ability to provide gender affirmative care.***"

American College Health Association (ACHA)

Organizational Position: Access to Health Care Services for Transgender Patients
February 8, 2023

"***Health care services should be made universal to all and should not discriminate in any way***, whether this be on the basis of age; race; ethnicity; sex; sexual orientation; gender; gender identity; marital status; physical size or ability; religious, spiritual or cultural identity; neuro diversity; socioeconomic status; or veteran status. This is consistent with ACHA's long-held values of cultural inclusion, respect, equality, and equity."

"Therefore, ***ACHA opposes any policy, at any level, that restricts, limits, or discourages access to gender-related services for transgender and nonbinary youth and/or adults in our communities. This includes government requirements for data sharing that target gender-affirming care and diagnoses related to gender identity or gender dysphoria***. The sharing of this confidential, personal medical data, even when de-identified, erodes trust in healthcare services and interferes with the patient-provider relationship to the detriment of the person's physical and mental health. The health and well-being needs of all college students, including those who identify as transgender and nonbinary, must always be the highest priority of health care providers and campus health centers."

American College of Nurse Midwives (ACNM)

Statement: ACNM Opposes Texas Opinion on Gender-Affirming Care
March 10, 2022

"***The American College of Nurse-Midwives (ACNM) strongly opposes recent actions taken in Texas by Governor Gregg Abbott and Attorney General Ken Paxton that seek to unnecessarily harm the health and well-being of transgender and gender non-binary youth in the state***. In the last couple weeks, officials in Texas issued an opinion equating the provision of gender-affirming health care services to child abuse."

"'ACNM's Philosophy of Care states that all people have a right to health care that is equitable, ethical, and accessible and that upholds human dignity and diversity among groups,' stated ACNM President Cathy Collins-Fulea, DNP, CNM, FACNM. 'This applies to people of every gender identity and sexual orientation. ***ACNM opposes any legislative or regulatory measures that seeks to erode shared-decision making between midwives and individuals and the provision of evidence-based care.*** Every person, regardless of age, sex, race, color, creed, religion, ethnicity, sexual orientation, gender identity, national origin, citizenship, disability, or marital status has the right to safe, supportive, and affirming health care."

"***Many transgender and non-binary people across the United States are underserved by our health care system and struggle to find safe spaces and providers to care for them. Gender-affirming care not only includes clinical interventions that are necessary for health and can be lifesaving, but it also includes health care that is unrelated to one's gender identity***. The legal opinion issued in Texas exacerbates the issue of lack of access to safe and evidence-based gender-affirming care and places countless individuals and families at risk of harm from inadequate and discriminatory healthcare."

The American College of Obstetricians and Gynecologists (ACOG)

Issue Brief: Health Care and Support for Transgender and Gender Diverse Adolescents

2023

"***State policies to deny transgender and gender diverse adolescents care to realize their gender identities undermine evidence-based care, compromise the patient-clinician relationship, and would have grave consequences for the health and lives of young people***."

"***Policies that dictate medical practice, restrict patient-clinician communications, and criminalize or penalize clinicians for practicing according to their professional judgement and training represent dangerous and ill-advised interference in quality, ethical patient care***."

"Policies driven by discrimination and misinformation create a harmful environment for transgender youth and compromise quality patient care…***ACOG joins major medical associations in supporting access to evidence-based gender affirming care for transgender youth, free from political interference***…ACOG calls for policies that affirm and uplift the civil, human, and reproductive rights of the LGBTQIA and gender diverse communities."

American College of Physicians (ACP)

ACP Advocates Against Restrictions on Gender-Affirming Care
May 19, 2023

"***ACP opposes efforts to restrict access to such evidence-based care and to prohibit public payers, such as state Medicaid programs, from covering this care***."

"'***ACP is strongly opposed to unnecessary government interference in the patient-physician relationship that prevents physicians from providing their patients with evidence-based, medical services***,' Dr. Ryan D. Mire, ACP past president, said in a statement on the Mississippi law. He added: 'Physicians should not face civil or licensure penalties for providing medical care that is in accordance with the recommendations of ACP and other medical organizations. Instead of policies that block access to health care and harm the patient-physician relationship, we need to seek ways to better support these families, improve access to care for these services and reduce social stigma.'"

American Counseling Association (ACA)

ACA Opposes TX Definition of Child Abuse to Include Gender-Affirming Care
March 2, 2022,

"***All major medical and mental health associations recognize sexual orientation and gender identity as a part of human growth and development. These targeted legislative efforts are dangerous to the health and well-being of non-binary and transgender youth, as they are at risk for a significant increase in suicidal behavior, anxiety and depression, homelessness, substance abuse, etc***. Children need to be able to trust their parents, families, and counselors and not live in fear of having those persons prosecuted for helping them."

American Medical Association (AMA)

AMA strengthens its policy on protecting access to gender-affirming care
June 12, 2023

"The American Medical Association (AMA) House of Delegates today passed the Endocrine Society's resolution to protect access to evidence-based gender-affirming care for transgender and gender-diverse individuals…In the resolution, ***the AMA committed to opposing any criminal and legal penalties against patients seeking gender-affirming care, family members or guardians who support them in seeking medical care, and health care facilities and clinicians who provide gender-affirming care.*** The AMA will work at the federal and state level with legislators and regulators to oppose such policies and collaborate with other organizations to educate the Federation of State Medical Boards about the importance of gender-affirming care.

AMA reinforces opposition to restrictions on transgender medical care
June 15, 2021

"***The American Medical Association (AMA) today strengthened its established position opposing the governmental intrusion into the practice of medicine that is detrimental to the health of transgender and gender-diverse children and adults.***"

"***The AMA opposes the dangerous intrusion of government into the practice of medicine and the criminalization of health care decision-making***," said AMA Board Member Michael Suk, MD, JD, MPH, MBA. "Gender-affirming care is medically-necessary, evidence-based care that improves the physical and mental health of transgender and gender-diverse people."

"The AMA is a strong supporter of human rights and freedoms and will continue to strongly oppose discrimination based on an individual's sex, sexual orientation, or gender identity. ***AMA will continue to work to ensure transgender and gender-diverse minors have the opportunity to explore their gender identity under the safe and supportive care of a physician."***

American Medical Student Association (AMSA)

Calling Out Scientific Information and Protecting Transgender Youth
June 29, 2022

"In response to these inhumane state-sponsored attacks on transgender youth, a group of medical and law faculty members from the Yale School of Medicine, Yale Law School, and University of Texas Southwestern joined to examine the claims made in the recent AG Opinion and Alabama legislation. In their report, *'Biased Science: The Texas and Alabama Measures Criminalizing Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims,'* this team of medical and legal experts expose the multitude of errors in these two recent high profile anti-transgender policies."

"As medical students and future physicians, we, the Yale Chapter of AMSA, join with AMSA National to commend these medical and law leaders who have assembled this scientifically well-informed report. A large body of literature shows that transgender youth endure higher risks of

bullying, depression, and suicidality, not to mention greater barriers to accessing health care. ***Out of consideration for the additional harms that these systemic acts of hate and scientific misinformation impose on transgender youth and their families, as well as on our ability as future physicians to properly care for them, AMSA endorses the report published by faculty members of the Yale Law School faculty, Yale School of Medicine, University of Texas Southwestern, and condemns the AG Opinion, Alabama Law, and similar attempts to limit and attack gender-affirming care.***"

American Nurses Association (ANA)

American Nurses Association Opposes Restrictions on Transgender Healthcare and Criminalizing Gender-Affirming Care
October 26, 2022

"***The American Nurses Association strongly opposes any legislation or policy action that places restrictions on transgender health care and that criminalizes gender-affirming care.*** Due to recent state legislative efforts, transgender and gender-diverse youth and their parents or guardians who choose to access gender-affirming care may come under legal assault in many states. Health care professionals, including nurses and advanced practice registered nurses (APRNs) who provide gender-affirming care, may also be subject to judicial process or other legal action. ***These restrictive laws interfere with the trust and confidentiality between patients, parents or guardians, and clinicians in the delivery of evidence-based care. The legislative intent and medical claims behind these laws are not grounded in reputable science and conflict with the nurse's obligation to promote, advocate, and protect the rights, health, and safety of patients***."

American Psychiatric Association

Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth, Approved by the Board of Trustees July 2020

"***The American Psychiatric Association:***

1. ***Supports access to affirming and supportive treatment for trans and gender diverse youth and their families, including appropriate mental health services, and when indicated puberty suppression and medical transition support.***
2. Opposes all legislative and other governmental attempts to limit access to these services for trans and gender diverse youth, or to sanction or criminalize the actions of physicians and other clinicians who provide them."

Frontline Physicians Oppose Legislation That Interferes in or Criminalizes Patient Care
April 2, 2021
Joint statement from the American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American College of Obstetricians and Gynecologists

"***Our organizations, which represent nearly 600,000 physicians and medical students, oppose any laws and regulations that discriminate against transgender and gender-diverse individuals or interfere in the confidential relationship between a patient and their physician***. That

confidentiality is critical to allow patients to trust physicians to properly counsel, diagnose and treat. ***Our organizations are strongly opposed to any legislation or regulation that would interfere with the provision of evidence-based patient care for any patient, affirming our commitment to patient safety. We recognize health as a basic human right for every person, regardless of gender identity or sexual orientation***."

American Psychoanalytic Association (APsA)

Position Statement Opposing Anti-Trans Legislation
May 30, 2023

"***The American Psychoanalytic Association (APsA) notes a troubling increase in misinformation and legislation adversely affecting trans and gender expansive (TGE) people***…Today, a third of trans and gender expansive youth in the United States are at risk of losing or have already lost access to the ability to medically transition, long established as an essential component of gender-affirming care by the American Psychological Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Medical Association, the American Academy of Pediatrics, the Endocrine Society, the World Health Organization, and the World Professional Association for Transgender Health…***These restrictive legislative efforts have sought legitimacy in a profusion of misinformation and disinformation—that is, false information disseminated intentionally to cause serious social harm…As an analytic community, APsA wishes to clearly and publicly disagree with those promulgating falsehoods about gender-affirming care… the American Psychoanalytic Association strongly opposes recent, overreaching government intrusion into clinical care that adversely affects trans and gender expansive people, their families and their health care providers."***

American Psychological Association (APA)

Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science
February 2024

"...***this Policy Statement affirms APA's support for unobstructed access to healthcare and evidence-based clinical care for transgender, gender-diverse, and nonbinary children, adolescents, and adults***, and for increased public accessibility to timely and accurate information founded in clinical and psychological science."

"Be it resolved that ***the APA opposes state bans on gender-affirming care, which are contrary to the principles of evidence-based healthcare, human rights, and social justice***, and which should be reconsidered in favor of policies that prioritize the well-being and autonomy of transgender, gender-diverse, and nonbinary individuals."

"Be it further resolved that ***the APA urges support for policies facilitating access to comprehensive, gender-affirming healthcare for children, adolescents, and adults, recognizing the positive impact on mental health outcomes***."

"Be it further resolved ***the APA affirms the essential role and legal rights of parents and caregivers in taking action to ensure the well-being of children and adolescents*** while honoring their expressed gender identity, ***including involvement in the process of healthcare decision-making, as well as the role of parents, caregivers, and providers in supporting developmentally appropriate youth self-advocacy***."

Statement opposing legislation targeting transgender and gender diverse people
July 2023

"***There is no scientific or health justification for legislation which restricts access to gender-affirming care***. In fact, the medical and mental health professions support gender-affirming care, recognizing the scientific fact that gender identities are diverse and rigid notions of sex and gender are barriers to good healthcare for all patients."

"***APA Division 44 affirms the legitimacy of gender affirming care and stands in strong opposition to attempts by local, state, and federal governmental bodies to misinform the public, interfere in the patient-provider relationship, and infringe upon the rights of TGD people and their families to seek and receive appropriate care and accommodations which evidence indicates is supportive of their health***."

Position Statement: Support Access to Gender-Affirming Care for Transgender and Gender-Diverse Youth
July 2023

"***Pediatric gender-affirming healthcare saves lives***. TGD youth are at heightened risk of anxiety, depression, and suicidality compared to their cisgender peers. They also face discrimination, stigma, and physical harm due to their gender identity. ***Gender-affirming healthcare is critical to alleviating gender dysphoria and related distress, including suicidality. Legislation blocking healthcare professionals from providing gender-affirming care will harm TGD youth by perpetuating discriminatory environments and reinforcing barriers to accessing needed mental health and medical services.*** This will inevitably lead to more severe dysphoria and psychological morbidities (e.g., anxiety, depression, suicidality and self-harm), and contribute to higher rates of discrimination, harassment, and physical violence."

"***Restricting access to gender-affirming healthcare is discrimination.*** Gender-affirming medical interventions are not novel and have well-established used with cisgender youth for precocious puberty and conditions that result in underproduction of hormones. This provides support that these are safe interventions regardless of gender identity. Discriminatory practices, such as banning access to care or invoking "conscientious objection" to providing these important medical interventions, further perpetuate discriminatory attitudes towards TGD youth. Fear of discrimination in combination with systemic barriers to health care access, such as difficulty finding a provider trained in gender-affirming care or poor insurance coverage creates unnecessary risks for poor physical and mental health."

American School Counselor Association

The School Counselor and Transgender and Nonbinary Youth

Revised 2022

"School counselors work to safeguard the well-being of transgender and nonbinary youth. ***School counselors recognize all students have the right to be treated equally and fairly, with dignity and respect as unique individuals, free from discrimination, harassment and bullying based on their gender identity and gender expression… School counselors recognize the responsibility for determining a student's gender identity rests with the student rather than outside confirmation from medical practitioners, mental health professionals or documentation of legal changes…School counselors promote affirmation, respect and equal opportunity for all individuals regardless of gender identity or gender expression.*** School counselors encourage a safe and affirming school environment and promote awareness of and education on issues related to transgender and nonbinary students."

American Society of Plastic Surgeons

State Focus on Gender Affirmation Intensifies
February 25, 2021

"***ASPS firmly believes that plastic surgery services can help gender dysphoria patients align their bodies with whom they know themselves to be and improve their overall mental health and well-being***. In 2021, the Society has actively opposed legislation seeking to criminalize actions by physicians and guardians when minors receive gender affirmation surgery in Missouri, Montana and Alabama and is readying engagement in other states where the issue has emerged. ***ASPS will continue its efforts to advocate across state legislatures for full access to medically necessary transition care***."

Association of American Medical Colleges (AAMC)

AAMC Statement on Gender-affirming Health Care for Transgender Youth
April 9, 2021

"The AAMC is committed to ensuring access to high-quality care that treats all people, including transgender individuals, equally and with respect, and providing training to physicians and other health care professionals that is consistent with those values.

In medical decision making, the doctor-patient relationship must be paramount, and the needs of the patient must be given precedence. ***Efforts to restrict the provision of gender-affirming health care for transgender individuals will reduce health care access for transgender Americans, promote discrimination, and widen already significant health inequities.***

In addition to harming some of the most vulnerable patients, efforts to restrict care undermine the doctor-patient relationship and the principle that doctors are best equipped to work with patients and their families to arrive at shared decision-making.

The AAMC is committed to improving the health of all people everywhere, and we will continue to oppose any effort to restrict the health care community's ability to provide necessary care to any patient in need."

Endocrine Society and Pediatric Endocrine Society

Endocrine Society condemns efforts to block access to medical care for transgender youth
April 14, 2021

"***The Endocrine Society opposes legislative efforts that do not conform to medical evidence and clinical practice to prevent transgender and gender diverse adolescents from accessing gender-affirming medical care…These policies criminalize physicians' efforts to provide needed medical care and disregard widely accepted medical evidence and clinical practice guidelines.*** 'The treatment of transgender and gender diverse youth should be governed by the best available medical evidence, not politics,' said Joshua D. Safer, M.D., F.A.C.P., F.A.C.E., co-author of the Society's Clinical Practice Guideline and position statement on transgender medicine. "When caring for transgender and gender diverse youth, physicians and mental health professionals must be able to freely practice and choose the best available treatment options in consultation with the patients and their parents, as they would when treating any other condition."

Endocrine Society alarmed at criminalization of transgender medicine
February 23, 2022

"The Endocrine Society condemns the directive by Texas Governor Greg Abbott ordering the Department of Family and Protective Services (DFPS) to investigate any reported instances of Texas children receiving gender-affirming care as "child abuse." This policy rejects evidence-based transgender medical care and will restrict access to care for teenagers experiencing gender incongruence or dysphoria."

"***Health care providers should not be punished for providing evidenced-based care that is supported by major international medical groups— including the Endocrine Society, American Medical Association, the American Psychological Association, and the American Academy of Pediatrics—and Clinical Practice Guidelines.***"

"***Medical evidence, not politics, should inform treatment decisions.*** We call on policymakers to rescind this directive and allow physicians to provide evidence-based care, including to prescribe medications to delay puberty."

Transgender Health: An Endocrine Society Position Statement
December 16, 2020
Endorsed and created in partnership with the Pediatric Endocrine Society

"***Medical intervention for transgender youth and adults (including puberty suppression, hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care.*** Federal and private insurers should cover such interventions as prescribed by a physician as well as the appropriate medical screenings that are recommended for all body tissues that a person may have."

Discriminatory policies threaten care for transgender, gender diverse individuals
December 16, 2020

"The Endocrine Society and the Pediatric Endocrine Society oppose legislative efforts to block transgender and gender diverse individuals from accessing gender-affirming medical and surgical care…***The course of gender-affirming treatment should be determined by patients and their health care providers, not by policymakers***."

GLMA: Health Professionals Advancing LGBTQ+ Equality

Position Statement: Transgender Healthcare
September 1, 2021

"***GLMA: Health Professionals Advancing LGBTQ+ Equality considers therapeutic treatments, including hormone therapy, mental health therapy, vocal therapy, hair removal, and gender- affirming surgeries, as medically necessary for the purpose of gender-affirmation or the treatment of gender dysphoria or gender incongruence***. These gender-affirming medical and surgical treatments should be covered by all public and private insurance plans."

Helfer Society

Position Statement of the Ray E. Helfer Society On Gender Affirming Care Being Considered Child Abuse and Neglect
February 2022

"***The Ray E. Helfer Society is an international, multi-specialty society of physicians having substantial research and clinical experience with all medical facets of child abuse and neglect.*** The physicians of the Ray E. Helfer Society have a great deal of experience working with governmental organizations investigating and protecting children suspected of suffering harm from child abuse and neglect. Along with many other organizations devoted to providing quality medical and mental health care for children, and in keeping with the joint statement of the American Academy of Pediatrics (AAP) the Texas Pediatric Society (TPS), and the Texas chapter of the American Academy of Pediatrics, ***the Ray E. Helfer Society opposes equating evidence based, gender affirming care for transgender youth with child abuse, and the criminalization of such care. The provision of medical and mental health care, consistent with the standard of care, is in no way consistent with our definitions of child abuse.*** The medical and mental health evaluation and management of these youth would be in no way enhanced, and likely harmed, by the involvement of a state child protection agency. ***We advocate for appropriate, scientifically sound medical care for transgender youth and resolutely oppose subjecting their families to threats of involvement in the child protection system or their medical providers to civil or criminal penalties merely for providing optimal treatment to these vulnerable youth.***"

National Association of Nurse Practitioners in Women's Health (NPWH)

Position Statement: Healthcare for Transgender and Gender Diverse Individuals
Originally published October 2017, Reaffirmed June 2022

"***NPWH continues to support initiatives to address the healthcare needs of transgender and gender diverse (TGD) individuals and the implementation of policies and strategies to reduce***

barriers to inclusive, quality healthcare for these populations. As an organization, NPWH opposes all forms of discrimination against individuals based on sexual orientation, gender expression, or gender identity and urges nurse practitioners (NPs) to speak out against discrimination, violence, and maltreatment of TGD individuals."

"NPWH supports the role of women's health nurse practitioners (WHNPs) in providing gender-affirming hormone therapy and pre- and post-gender-affirming surgical care for individuals…***NPWH guidelines for practice and education includes recommended content on counseling and management of gender-affirming treatments to be included in educational curricula***."

National Association of Social Workers (NASW)

Gender-Affirming Health Care Saves Lives
March 28, 2023

"***The National Association of Social Workers (NASW) asserts that discrimination and prejudice directed against any individuals on the basis of gender identity or expression are damaging to the social, emotional, psychological, physical and economic well-being of transgender and gender diverse (TGD) people and society as a whole.***"

"The unprecedented increase in legislation focused on TGD youth seeking affirming health care, the professionals who provide their medical care, and the families and social supports that offer resources to them is an unfortunate indicator of the lack of understanding and misinformation that currently exists."

"NASW participates in coalitions with other professional associations and organizations to advocate for the civil rights of all people of diverse gender expression and identity. We recognize TGD people often experience multiple intersections of oppression based on racism, poverty, heterosexism, cissexism, ageism, ableism, and mental and behavioral health status. ***Our code of ethics requires that we challenge social injustice and respect the inherent dignity and worth of every person***."

"Providing holistic care while honoring intersectionality is a foundational element of informed social work practice. ***To achieve health equity for all, we believe that trauma-informed care, gender-affirming care, and mental and behavioral health care should all be recognized as evidence-based and informed health care in our nation***."

NASW Condemns Efforts to Redefine Child Abuse to Include Gender-Affirming Care
February 25, 2022

"***NASW stands against all efforts to limit the fundamental civil liberties of transgender youth, and their access to essential health services. We must remain vigilant in guarding ourselves against this climate of fear and disinformation by remaining anchored to our professional and enduring commitment to respecting dignity and worth of the all people and to challenging the injustices that befall vulnerable and oppressed people***."

"NASW stands in solidarity with transgender and gender expansive youth and their support systems, and will continue to advocate with our coalition partners, with our NASW-TX Chapter, and with all of our state and local chapters to uplift transgender rights as human rights."

National Commission on Correctional Health Care

Position Statement: Transgender and Gender Diverse Health Care in Correctional Settings
Originally adopted October 18, 2009, Reaffirmed November 1, 2020

"Correctional leaders and health care and custody staff have a responsibility to ensure the physical and mental health and well-being of people in their custody; therefore, health staff should evaluate and treat transgender patients in a manner that respects their unique transgender, medical, mental health, and psychosocial needs. ***The National Commission on Correctional Health Care recommends… All incarcerated people, including those who are transgender, should receive comprehensive health care that is clinically and developmentally appropriate (for adolescents in particular), culturally sensitive, and offered through a nonjudgmental, gender-affirming approach***."

The Society for Adolescent Health and Medicine (SAHM)

SAHM Supports Protecting Access to Gender-Affirming Clinical Care for Transgender and Nonbinary AYA
August 2023

"***The Society for Adolescent Health and Medicine (SAHM) embraces our professional responsibility to ensure that all adolescents and young adults, including transgender and nonbinary youth, have access to health, equity, and well-being***. This responsibility includes protecting access to gender-affirming clinical care for transgender and nonbinary adolescents and young adults."

"***SAHM supports protecting access to gender-affirming clinical care for transgender and nonbinary adolescents and young adults***…SAHM calls on community members, health professionals, institutional leaders, and policymakers to do all within their power to support and protect transgender and non-binary adolescents and young adults, their families, and the clinicians who serve them. ***Recommendations to protect access to gender-affirming clinical care for transgender and nonbinary adolescents and young adults are the following:***

1. ***Oppose restrictive laws and policies, coercive tactics, and targeted harassment campaigns that obstruct the provision of health care.***
2. Educate stakeholders and policymakers on the evidence supporting gender-affirming care and the centrality of adolescents and young adults and their families in making informed health decisions.
3. Affirm health system-level commitments to provide health care for transgender and nonbinary adolescents and young adults by providing accurate information on gender-affirming care, using multiple platforms to battle misinformation, opposing the targeted harassment and intimidation of clinicians who provide gender-affirming care, and ensuring the safety of clinicians and clinical programs.

4. ***Call on policymakers to enact and implement protections to safeguard the personal security and professional careers of clinicians who provide gender-affirming care.***
5. Engage and mobilize community members to support legal protections for access to medically necessary gender-affirming care, hold elected officials accountable for policies that are contrary to evidence-based care, and expose lawmakers' coercive tactics forced upon clinicians, health systems, and insurers.

Promoting Health Equality and Nondiscrimination for Transgender and Gender-Diverse Youth
June 2020

"Adolescent and young adult health-care providers often care for transgender and gender-diverse (TGD) youth—youth whose gender identity is incongruent with the gender assigned to them at birth. This patient population faces health challenges distinct from their cisgender peers (i.e., youth whose gender identity aligns with their assigned gender at birth), which include the health impacts from gender dysphoria and from societal stigma and discrimination. SAHM encourages adolescent and young adult health-care providers to receive training in providing culturally effective, evidence-based care for TGD youth; calls for more research on gender-affirming health care; and advocates for policies that protect the rights of TGD youth and minimize barriers to attaining healthcare. ***Consistent with other medical organizations, the Society for Adolescent Health and Medicine promotes the call for gender affirmation as a mainstay of treatment and is opposed to the notion that diversity in gender is pathological***."

United States Professional Association for Transgender Health (USPATH)

USPATH and WPATH Confirm Gender-Affirming Health Care is Not Experimental: Condemns Legislation Asserting Otherwise
March 22, 2023

"The United States Professional Association for Transgender Health (USPATH) and the World Professional Association for Transgender Health (WPATH) denounces the emergency regulation halting gender-affirming healthcare for transgender and gender diverse (TGD) children and adolescents issued by Missouri Attorney General Andrew Bailey as lacking scientific grounding."

"The emergency regulation issued by Missouri Attorney General Andrew Bailey is based upon manipulated statistics, flawed reports, and incomplete data, and prevents the provision of medically necessary care. ***Medical decisions must remain between providers and patients and their families. Consistent with earlier statements, WPATH and USPATH condemn any legislative actions to restrict or prohibit access to gender-affirming health care***."

USPATH Position Statement on Legislative and Executive Actions Regarding the Medical Care of Transgender Youth
April 22, 2022

"***The US Professional Association for Transgender Health (USPATH) believes that decision making regarding the use of hormone therapy or puberty blocking medicine in transgender adolescents should involve physicians, psychologists, and other health personnel, parents or guardians, adolescents, and other community stakeholders identified on a case-by-case basis***."

"***USPATH opposes recent efforts in several states to restrict parental rights and direct the practice of medicine through legislative or executive action.*** These efforts lack scientific merit, and in some cases misinterpret or distort available data, or otherwise lend credence to individual opinions in the literature that are at odds with the overwhelming majority of experts and publications in this field."

World Medical Association (WMA)

Statement on Transgender People
October 2015

"***The WMA emphasises that everyone has the right to determine one's own gender and recognises the diversity of possibilities in this respect***. The WMA calls for physicians to uphold each individual's right to self-identification with regards to gender."

"***The WMA urges that every effort be made to make individualised, multi-professional, interdisciplinary and affordable transgender healthcare (including speech therapy, hormonal treatment, surgical interventions and mental healthcare) available to all people who experience gender incongruence in order to reduce or to prevent pronounced gender dysphoria***."

World Professional Association for Transgender Health (WPATH)

Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the US
March 8, 2023

"***Both the World Professional Association for Transgender Health (WPATH) and the US affiliate, the United States Professional Association for Transgender Health (USPATH), vehemently oppose the broad and sweeping legislation being introduced and ratified in states across the country to ban access to gender-affirming health care to transgender and gender diverse (TGD) people. WPATH's long-standing Standards of Care for Transgender and Gender Diverse People, now in its eighth version (SOC8), explain in detail the science- and evidence-based benefits of gender affirming care for TGD people***. Any legislation that restricts or prohibits access to this care is against best practice medical standards and is condemned by WPATH and USPATH."

"All major medical associations including WPATH have supported the provision of gender-affirming care for TGD people as medically necessary care. ***Global contributors of SOC8 participated in rigorous debate and methodology using the Delphi process to ratify science and evidence-based guidelines for care. Legislation that seeks to inhibit or restrict access to care are in direct contradiction to decades of research and numerous studies touting the overwhelming mental and physical health benefits of gender-affirming care for TGD people***."

Mr. TAKANO. Recently we have seen unprecedented attacks on access to gender affirming care, particularly from minors with doctors and hospitals that treat youth facing threats of violences, and some families making the difficult choice to relocate to a different State. Mr. Secretary, I think my colleagues would agree that Americans have a right to access necessary medical care. Do you feel

that parents have the right to seek evidence-based care for their children?

Secretary BECERRA. We should all have the right to seek evidence-based care.

Mr. TAKANO. Well, Mr. Secretary, I would just like to offer another—to respond to Chairwoman Foxx's concern about the lack of research surrounding gender affirming care. I woud like to submit for the record a 19-page bibliography of research demonstrating that individualized and age appropriate medical care for transgender people improves mental health, and overall well-being.

These are peer reviewed research studies that have been published in journals such as the New England Journal of Medicine, the Journal of Adolescent Health and Pediatrics.

Mr. GROTHMAN [presiding]. So ordered.

[The Information of Mr. Takano follows:]

WHITMAN-WALKER Institute

Care for Transgender Youth and Adults: Evidence Compilation Updated May 2024

A strong and well-established body of evidence, developed over decades, demonstrates that individualized and age-appropriate medical care for transgender people, including transgender youth, improves mental health and overall well-being. The positive effects of this care include decreases in depression, anxiety, and suicidal ideation, as well as improvements in quality of life and body satisfaction. These peer-reviewed research studies and systematic reviews have been published in well-respected journals such as the *New England Journal of Medicine*, *Journal of Adolescent Health*, *Pediatrics*, and *The Lancet*.

TOP RESEARCH STUDIES

1) Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, & Olson-Kennedy J. Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine.* 2023 Jan 19;388(3):240-250.

   Summary: Gender-affirming hormone therapy (GAH) for transgender adolescents (8% had also had previous puberty-delay medications) improved appearance congruence (the feeling that their body matches their gender), positive affect, and life satisfaction. It also decreased depression and anxiety symptoms. These improvements were sustained over a period of 2 years and are consistent with those of other longitudinal studies involving transgender youth receiving GAH.

2) Nolan BJ, Zwickl S, Locke P, Zajac JD, & Cheung AS. Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open.* 2023;6(9):e2331919.

   Summary: Transgender and gender diverse adults seeking testosterone therapy were randomly divided into two groups: those who started treatment right away and those who waited three months before initiation. Transgender individuals who had immediate access to hormone therapy saw significant decreases in gender dysphoria, depression, and suicidality compared to individuals who had to wait three months for treatment. Furthermore, among individuals experiencing suicidality at the start of the study, 52% of those with immediate treatment access reported their suicidality resolved, compared to only 5% of individuals who waited three months for treatment.

3) Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, & Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open.* 2022;5(2):e220978.

   Summary: Transgender and non-binary youth who were followed for one year had lower odds of depression and suicidality after receiving puberty delay medications and/or hormone therapy. Specifically, the study observed 60% lower odds of depression (adjusted odds ratio [aOR], 0.40; 95% CI, 0.17-0.95) and 73% lower odds of suicidality (aOR, 0.27; 95% CI, 0.11-0.65) among youths who had initiated puberty delay medications or hormone therapy compared with youths who had not.

4) Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, & Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine.* 2015;12(11):2206-2214.

   Summary: At baseline, adolescents with gender dysphoria (GD) showed poor functioning. GD adolescents' global functioning improved significantly after 6 months of psychological support ($p < 0.001$). GD adolescents also receiving puberty suppression had significantly better psychosocial

functioning after 12 months of puberty delay medications, compared with when they had received only psychological support ($p = 0.001$).

5) Russell ST, Pollitt AM, Li G, & Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *Journal of Adolescent Health*. 2018;63(4):503-505.

   Summary: Transgender youth who had a chosen name that they could use freely in different environments—such as home, school, work, and with friends—reported fewer symptoms of depression, less suicidal ideation, and less suicidal behavior. Specifically, an increase by one context in which a chosen name could be used predicted a 5.37-unit decrease in depressive symptoms, a 29% decrease in suicidal ideation, and a 56% decrease in suicidal behavior. Depressive symptoms, suicidal ideation, and suicidal behavior were at the lowest levels when chosen names could be used in all four contexts.

6) van der Miesen AIR, Steensma TD, de Vries ALC, Bos H, & Popma A. Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*. 2020 Jun;66(6):699-704.

   Summary: Before medical treatment, transgender adolescents showed more internalizing problems and reported increased self-harm/suicidality and poorer peer relations compared with their age-equivalent peers. Transgender adolescents receiving puberty delay medications had fewer emotional and behavioral problems than the group that had just been referred to care and had similar or fewer problems than their same-age cisgender peers. Overall, transgender adolescents show poorer psychological well-being before treatment but show similar or better psychological functioning compared with cisgender peers from the general population after the start of specialized transgender care involving puberty suppression.

FULL RESEARCH COMPILATION

MENTAL HEALTH

Numerous research studies show that transgender young people are at risk for poorer mental health outcomes and that access to medically necessary care can improve mental health.

Achille C, Taggart T, Eaton NR, et al. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International Journal of Pediatric Endocrinology*.

- Transgender adolescents and young adults who received treatment for gender dysphoria reported improved mental health and quality of life.

Allen LR, Watson LB, Egan AM, & Moser CN. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*.

- Transgender youth who received hormone therapy saw a significant increase in overall well-being and a decrease in suicidality.

Arnoldussen M, van der Miesen AIR, Elzinga WS, et al. (2022). Self-Perception of Transgender Adolescents After Gender-Affirming Treatment: A Follow-Up Study into Young Adulthood. *LGBT Health*.

- In this longitudinal study of transgender adolescents who completed assessments on average six years after starting treatment, there were significant improvements in physical appearance and feelings of self-worth.

Boskey ER, Jolly D, Kant JD, & Ganor O (2023). Prospective Evaluation of Psychosocial Changes After Chest Reconstruction in Transmasculine and Non-Binary Youth. *Journal of Adolescent Health.*

- Transgender individuals aged 15-35 who had chest surgery experienced improved gender and appearance congruence (the feeling that their body matches their gender) and reduced chest dysphoria.

Chelliah P, Lau M, Kuper LE. (2024). Changes in Gender Dysphoria, Interpersonal Minority Stress, and Mental Health Among Transgender Youth After One Year of Hormone Therapy. *Journal of Adolescent Health.*

- After one year of receiving hormone therapy, transgender adolescents reported significant decreases in depression, anxiety, and body dissatisfaction, along with significant improvements in quality of life.

Chen D, Berona J, Chan Y-M, Ehrensaft D, et al. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine.*

- Treatment for transgender adolescents that included puberty delay medications improved appearance congruence (the feeling that their body matches their gender), positive affect, and life satisfaction, as well as decreasing depression and anxiety symptoms.

De Castro C, Solerdelcoll M, Teresa Plana M, Halperin I, et al. (2022). High persistence in Spanish transgender minors: 18 years of experience of the Gender Identity Unit of Catalonia. *Revista de Psiquiatría y Salud Mental.*

- Among more than 100 minors seen at a gender identity clinic in Spain between 1999 to 2016, 97.6% persisted in their transgender identity after a median follow-up time of 2.6 years.

deVries ALC, Steensma TD, Doreleijers TAH, & Cohen-Kettenis PT. (2010). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *Journal of Sexual Medicine.*

- Puberty delay medications for young transgender people (aged 12-16) were associated with a decrease in behavioral and emotional problems and depressive symptoms, and general functioning improved significantly.

deVries ALC, McGuire JK, Steensma TD, et al. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.*

- Treatment starting in adolescence resulted in alleviated gender dysphoria and improved psychological functioning.

Fontanari AMV, Vilanova F, Schneider MA, et al. (2020). Gender Affirmation Is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement. *LGBT Health.*

- Treatment for transgender young people (aged 16-25) was linked to less anxiety and depression.

Grannis C, Leibowitz SF, Ghan S, et al. (2021). Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. *Psychoneuroendocrinology.*

- Testosterone treatment for transgender adolescent boys was associated with a significant decrease in anxiety and depression, as well as greater body satisfaction.

Green AE, DeChants JP, Price MN, & Davis CK. (2022). Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health.*

- Transgender youth who received hormone therapy had lower odds of depression and suicidal thoughts compared to youth who wanted this care but did not receive it.
- For youth under 18, hormone therapy was associated with 40% lower odds of attempting suicide.

Heylens G, Verroken C, De Cock S, T'Sjoen G, & De Cuypere G. (2014). Effects of Different Steps in Gender Reassignment Therapy on Psychopathology: A Prospective Study of Persons with a Gender Identity Disorder. *Journal of Sexual Medicine*.

- Patients followed for more than three years saw significant decreases in psychological distress (including anxiety and depression) after receiving hormone therapy.
- Patients indicated they had a better mood and increased happiness after receiving treatment.

Hisle-Gorman E, Schvey NA, Adirim TAA, et al. (2021). Mental Healthcare Utilization of Transgender Youth Before and After Affirming Treatment. *Journal of Sexual Medicine*.

- This study of nearly 4,000 transgender adolescents found that, compared to their cisgender siblings, trans and gender diverse adolescents used more mental healthcare services, namely for anxiety, suicidal ideation, and mood, personality, and psychotic disorders.
- This indicates that ongoing mental health support, in addition to necessary medical treatments, are key to supporting the well-being of transgender young people.

Kaltiala R, Heino E, Tyolajarvi M, & Suomalainen L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*.

- Suicidality among adolescents with gender dysphoria who received hormone therapy decreased from 35% to 4% ($p<0.0001$).

Kuper LE, Stewart S, Preston S, Lau M, & Lopez X. (2020). Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics*.

- Transgender adolescents experienced significant improvements in body dissatisfaction after receiving hormone therapy. Symptoms of depression and anxiety also decreased after receiving this care.

Lavender R, Shaw S, Maninger JK, et al. (2023). Impact of Hormone Treatment on Psychosocial Functioning in Gender-Diverse Young People. *LGBT Health*.

- Transgender adolescents who received puberty delay medications followed by hormone therapy experienced significant reductions of gender dysphoria and improvements in social skills (e.g., engaging and interacting with others). They also reported reductions in self-harm and suicidality.
- Caregivers of transgender adolescents observed a significant decrease in depressive and anxious behaviors one year after the adolescent began hormone therapy treatment.

Lee MK, Yih Y, Willis DR, Fogel JM, Fortenberry JD. (2024). The Impact of Gender-Affirming Medical Care During Adolescence on Adult Health Outcomes Among Transgender and Gender Diverse Individuals in the United States: The Role of State-Level Policy Stigma. *LGBT Health*.

- An analysis of survey data from more than 1,000 transgender people found that accessing medical care during adolescence significantly reduced severe psychological distress in adulthood.

Lelutiu-Weinberger C, English D, & Sandanapitchai S. (2020). The Roles of Gender Affirmation and Discrimination in the Resilience of Transgender Individuals in the US. *Behavioral Medicine*.

- Transgender adults who were affirmed in their gender identity—including access to appropriate medical care—had lower odds of suicidal ideation and psychological distress.

Lopez de Lara D, Rodriguez OP, Flores IC, & Masa JLP. (2020). Psychosocial assessment in transgender adolescents. *Anales de Pediatria*.

- Transgender adolescents who received hormone treatment saw significant improvement in emotional symptoms, including less anxiety, depression, and emotional distress.

McGregor K, McKenna JL, Williams CR, Barrera EP, & Boskey ER. (2024). Association of Pubertal Blockade at Tanner 2/3 With Psychosocial Benefits in Transgender and Gender Diverse Youth at Hormone Readiness Assessment. *Journal of Adolescent Health*.

- Studied more than 400 transgender adolescents (aged 13-17) seeking gender-affirming hormone therapy. Transgender youth who had been prescribed puberty-delaying medications before hormone assessment reported significantly lower problems with anxiety, depression, and stress.
- Transgender youth who received puberty-delaying medications had lower odds of having suicidal thoughts. Only 12.5% of transgender youth who received puberty-delaying medications reported suicidal thoughts, compared to 27.2% of transgender youth who did not receive these medications.

Nolan BJ, Zwickl S, Locke P, Zajac JD, Cheung AS. Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open*.

- In this randomized controlled trial of transgender and gender diverse adults seeking testosterone therapy, those who had immediate access to hormone therapy saw significant decreases in gender dysphoria, depression, and suicidality compared to individuals who had to wait three months for treatment.

Olsavsky AL, Grannis C, Bricker J, et al. (2023). Associations Among Gender-Affirming Hormonal Interventions, Social Support, and Transgender Adolescents' Mental Health. *Journal of Adolescent Health*.

- Among transgender and nonbinary adolescents, hormone therapy was associated with fewer anxiety bosymptoms; family support was associated with fewer depressive symptoms and nonsuicidal self-injury; and friend support was associated with fewer anxiety symptoms and less suicidality.

Trivedi C, Rizvi A, Mansuri Z, et al. (2024). Mental health outcomes and suicidality in hospitalized transgender adolescents: A propensity score-matched Cross-sectional analysis of the National inpatient sample 2016-2018. *Journal of Psychiatric Research*.

- Transgender adolescents (identified from hospitalization data) had nearly two times the odds of experiencing suicidal ideation compared to non-transgender adolescents. A greater percentage of transgender adolescents also experienced mood and anxiety disorders.

Tordoff DM, Wanta JW, Collin A, et al. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open*.

- Transgender and nonbinary youth who were followed for one year had lower odds of depression and suicidality after receiving treatment that included puberty delay medications or hormone therapy.

Turban JL, King D, Carswell JM, & Keuroghlian AS. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*.

- In survey data from more than 20,000 transgender adults, those who received puberty delay medications had significantly lower odds of lifetime suicidal ideation when compared to transgender adults who wanted this treatment but were unable to obtain it.

Turban JL, King D, Kobe J, Reisner SL, & Keuroghlian AS. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PloS One*.

- Analyzing data from more than 20,000 transgender adults, the study found that access to hormone therapy during adolescence was associated with lower odds of suicidal ideation in the past year compared to accessing hormone therapy during adulthood.

Van der Miesen AIR, Steensma TD, de Vries ALC, Bos H, & Popma A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*.

- Transgender adolescents who received puberty delay medications had fewer emotional and behavioral problems than their transgender peers who didn't receive appropriate medical treatment.

Williams CR, McGregor K, Feld A, & Boskey ER. (2024). Understanding Their Experiences: Psychosocial Functioning of Nonbinary and Binary Youth at the Time of Hormone Readiness Assessment. *LGBT Health*.

- Comparing binary and nonbinary transgender youth seeking hormone therapy, researchers found that nonbinary youth had substantially higher odds of reporting depressive symptoms and self-harm.

SOCIAL SUPPORT

Numerous studies show that social support (e.g., allowing a young person to use their chosen name and pronouns) improves a range of health outcomes for transgender young people.

Belmont N, Cronin TJ, Pepping CA. (2023). Affirmation-support, parental conflict, and mental health outcomes of transgender and gender diverse youth. *International Journal of Transgender Health*.

- In a study with transgender youth ages 11-17, affirming support from parents predicted fewer depressive symptoms. This included having parents that affirmed their gender identity socially, legally, and medically.
- Parents also cited laws as frequently delaying or controlling desired medical affirmation for their child.

Campbell T, Mann S, van der Meulen Rodgers Y, & Tran N. (2023). Family Matters: Gender Affirmation and the Mental Health of Transgender Youth. *Social Science Research Network*.

- Unsupportive families are associated with a higher risk of suicide attempts and running away from home among transgender young people, whereas supportive family environments mitigate, and in some cases virtually eliminate, these risks.

Costa R, Dunsford M, Skagerberg E, et al. (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*.

- Adolescents with gender dysphoria showed significant improvements in psychosocial functioning after receiving psychological support from their families, doctors, and/or therapists.
- Adolescents experienced even further improvements in psychosocial functioning after receiving puberty delay medications.

Durwood L, McLaughlin KA, Olson KR. Mental Health and Self-Worth in Socially Transitioned Transgender Youth. *Journal of the American Academy of Child and Adolescent Psychiatry*.

- Transgender youth who were socially supported by their parents reported high feelings of self-worth and had no significant differences in depression or anxiety when compared with their siblings or with youth of the same age and gender.
- Supportive parents of transgender youth reported higher rates of anxiety among their transgender child when compared to their siblings or the age- and gender-matched controls.

Fontanari AMV, Vilanova F, Schneider MA, et al. (2020). Gender Affirmation Is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement. *LGBT Health*.

- Transgender young people (aged 16-25) whose parents used their chosen name had fewer depression symptoms and less anxiety.
- Transgender young people who could not express their true gender had more anxiety and symptoms of depression.

Gupta P, Barrera E, Boskey ER, Kremen J, & Roberts SA (2023). Exploring the Impact of Legislation Aiming to Ban Gender-Affirming Care on Pediatric Endocrine Providers: A Mixed-Methods Analysis. *Journal of the Endocrine Society*.

- A survey of more than 100 pediatric endocrinologists providing care to transgender people found that nearly 60% were concerned about the risk of legal action/medical liability related to their practice.
- More than 25% of providers in states with a medical care ban expressed concerns for their personal safety in the work and/or home settings because of the gender-affirming care they provide.

Kuper LE, Adams N, & Mustanski BS. (2018). Exploring Cross-Sectional Predictors of Suicide Ideation, Attempt, and Risk in a Large Online Sample of Transgender and Gender Nonconforming Youth and Young Adults. *LGBT Health*.

- Friend and family support was associated with decreased suicide attempts and suicidal ideation among transgender youth and young adults (aged 14-30).

Olson KR, Durwood L, DeMeules M, & McLaughlin KA. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*.

- Transgender children who were socially supported—including being able to express their gender identity in public and use their chosen pronouns—had mental health outcomes similar to their peers.

Olson KR, Durwood L, Horton R, et al. (2022). Gender identity 5 years after transition. *Pediatrics*.

- 97.5% of transgender youth who were socially supported at early ages (median age: 8.1 years) continued to identify as transgender after 5 years.

Pariseau EM, Chevalier L, Long KA, et al. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. *Clinical Practice in Pediatric Psychology*.

- Low acceptance of transgender youths' gender identity from their primary caregivers was associated with increased depressive and anxiety symptoms.
- Lower sibling acceptance of gender identity predicted increased suicidal ideation among transgender youth.

Russell ST, Pollitt AM, Li G, & Grossman AH. (2018). Chosen Name Use is Linked to Reduced Depressive Symptoms, Suicidal Ideation and Behavior among Transgender Youth. *Journal of Adolescent Health*.

- Transgender youth who had a chosen name that they could use freely in different environments—such as home, school, work, and with friends—reported fewer symptoms of depression, less suicidal ideation, and less suicidal behavior.

Simons L, Schrager SM, Clark LF, Belzer M, Olson J (2013). Parental support and mental health among transgender adolescents. *Journal of Adolescent Health*.

- In a study of 66 transgender youth and young adults (aged 12-24), parental support was significantly associated with higher life satisfaction and fewer depressive symptoms.

STUDIES REBUTTING DISINFORMATION

This section highlights research that rebuts common myths and disinformation about gender identity and transgender medical care for youth, such as myths of social contagion, impact on bone density, and persistence of gender dysphoria.

Arnoldussen M, Hooijman EC, Kreukels BP, de Vries AL (2022). Association between pre-treatment IQ and educational achievement after gender-affirming treatment including puberty suppression in transgender adolescents. *Clinical Child Psychology and Psychiatry*.

- A study of transgender adolescents found that gender-affirming medical care did not influence the relationship between their cognitive ability and educational achievement. For example, transgender adolescents who had higher IQ before starting care had greater odds of obtaining higher education similar to the general population.
- The study also found that the mean total IQ, verbal IQ, and performance IQ of transgender young adults who had received gender-affirming medical care was similar to the general population.

Bauer GR, Lawson ML, Metzger DL, Trans Youth CAN! Research Team. (2022). Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"? *Journal of Pediatrics*.

- A study of more than 150 transgender adolescents looked at whether those with more recent knowledge of their gender experienced different outcomes compared to adolescents who had known about their gender for longer. They found that more recent gender knowledge was not associated with symptoms of depression, psychological distress, neurodevelopmental disorders, self-harm, or symptoms of gender dysphoria.
- The study concluded that there is no empirical support for the concept of "rapid onset gender dysphoria."

Carmichael P, Butler G, Masic U, et al. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12- to 15-year-old young people with persistent gender dysphoria in the UK. *PloS One*.

- A study that followed 12–15-year-olds with persistent and severe gender dysphoria who received puberty delay medications found no change in baseline in spine bone mineral density nor hip bone mineral density.
- No changes in psychological function were identified. Overall patient experiences of treatment on puberty delay medications were positive.

Cavve BS, Bickendorf X, Ball J, et al. (2024). Reidentification With Birth-Registered Sex in a Western Australian Pediatric Gender Clinic Cohort. *JAMA Pediatrics*.

- Among more than 550 patients who received gender care services at a Children's Hospital between 2014 and 2020, only 29 patients (5.3%) re-identified with their sex assigned at birth. Of these patients, the majority (93.1%) re-identified with their sex assigned at birth before medical treatment was initiated, including while waiting for initiatl assessment or early on in the assessment process.
- Additionally, only two patients reidentified with their sex assigned at birth following initiation of puberty blockers or hormone therapy. This constituted 1% of patients who received any kind of medical treatment during the study period.
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Fischbach AL, Hindenach A, van der Miesen AIR, et al. (2024). Autistic and non-autistic transgender youth are similar in gender development and sexuality phenotypes. *British Journal of Developmental Psychology*.

- A study of autistic and non-autistic transgender youth (aged 13-21) found there were no differences in symptoms of gender dysphoria, gender experiences, or sexual attraction. For example, both autistic and non-autistic transgender youth expressed similar interest in gender-affirming medical interventions and experienced similar symptoms of gender dysphoria.

Gupta P, Patterson BC, Chu L et al. (2023). Adherence to Gender Affirming Hormone Therapy in Transgender Adolescents and Adults: A Retrospective Cohort Study. *Journal of Clinical Endocrinology and Metabolism*.

- Analyzed data from transgender youth (aged 12+) who initiated gender-affirming hormone therapy from 2000-2019. Of the 385 youth in the study, around than one-third started hormone therapy before their 18th birthday.

- Only six participants (1.6%) ultimately discontinued gender-affirming hormone therapy, and at least two patients later resumed receiving care. Reasons for discontinuing hormone therapy included financial barriers, bullying by peers, and experiencing a change in their gender identity.
- Only two patients permanently discontinued receiving hormone therapy, but they reported not regretting initiating care because they found it was an important part of understanding their gender identity.

Boogers LS, Wiepjes CM, Klink DT, et al. (2022). Transgender Girls Grow Tall: Adult Height Is Unaffected by GnRH Analogue and Estradiol Treatment. *The Journal of Clinical Endocrinology & Metabolism*.

- In this study of more than 150 transgender girls it was found that puberty blockers and gender-affirming hormones (e.g., estrogen) had little effect on adult height. While growth and bone maturation decelerated while taking puberty blockers, they accelerated again after starting hormone therapy.

McNamara M, Lepore C, Alstott A, et al. (2022). Scientific Misinformation and Gender Affirming Care: Tools for Providers on the Front Lines. *Journal of Adolescent Health*.

- Rebuts common misconceptions frequently asserted in medical care ban legislation. For example, mental health services alone are often inadequate to address the root cause of gender dysphoria and current guidelines describe a rigorous informed consent process for medical decision-making for transgender youth.

Nos AL, Klein DA, Adirim TA, et al. (2022). Association of Gonadotropin-Releasing Hormone Analogue Use With Subsequent Use of Gender-Affirming Hormones Among Transgender Adolescents. *JAMA Network Open*.

- Transgender adolescents who were prescribed puberty blockers were less likely to start gender-affirming hormones compared to transgender adolescents who did not use puberty blockers. This suggests that clinicians can prescribe puberty blockers to transgender youth without an increased likelihood of subsequent gender-affirming hormone use.

Roy MK, Bothwell S, Kelsey MM, et al. (2024). Bone Density in Transgender Youth on Gender-Affirming Hormone Therapy. *Journal of the Endocrine Society*.

- In this study of transgender adolescents, those taking hormone replacement therapy (e.g., testosterone or estradiol) had normal bone mineral density. Transgender adolescents taking puberty delay medications also had bone mineral density within the normal range.

Schagen SEE, Wouters FM, Cohen-Kettenis PT, et al. (2020). Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones. *The Journal of Clinical Endocrinology & Metabolism*.

- Transgender adolescents taking puberty blockers experienced stabilization or a slight decrease in their bone mineral density, followed by a significant increase in bone mineral density during gender-affirming hormone treatment.

Staphorsius AS, Kreukels BP, Cohen-Kettenis PT, et al. (2015). Puberty suppression and executive functioning: An fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*.

- Adolescents with gender dysphoria taking puberty delay medications showed no difference in executive brain function compared to adolescents with gender dysphoria who did not take puberty delay medications.

Turban JL, Dolotina B, Freitag TM, King D, Keuroghlian AS (2023). Age of Realization and Disclosure of Gender Identity Among Transgender Adults. *Journal of Adolescent Health*.

- Analyzed data from nearly 27,500 transgender adults who completed the 2015 US Transgender Survey and found that 40.8% reported they realized their gender identity later in life (i.e., 11 years or older).
- Among participants who realized their gender identity in childhood (10 years or younger), the median age at which they first told someone about their gender identity was 22 years old.

van der Loos MATC, Hannema SA, Klink DT, et al. (2022). Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in the Netherlands. *The Lancet Child & Adolescent Health*.

- In a study that followed more than 700 transgender young people in the Netherlands, 98% of those who started medical treatment in adolescence (specifically, puberty delay medications followed by hormone therapy) continued this treatment into adulthood.

van der Loos MATC, Vlot MC, Klink DT, Hannema SE, den Heijer M, Wiepjes CM. (2023). Bone Mineral Density in Transgender Adolescents Treated with Puberty Suppression and Subsequent Gender-Affirming Hormones. *JAMA Pediatrics*.

- In a study of 75 transgender people who received puberty delay medications and hormone therapy, it was found that after 15 years of hormone use, bone density levels returned to pre-treatment (baseline) levels.

Wiepjes, CM, Nota NM, de Blok, CJM, et al. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. *The Journal of Sexual Medicine*.

- In this study of nearly 6,800 people who presented for gender-affirming treatment between 1972-2015 in the Netherlands, only 0.6% of transwomen and 0.3% of transmen who had gender-affirming surgery expressed regret. Some of the reasons for regret included identifying as nonbinary or a lack of social acceptance.
- Among adolescents in the study, 41% started taking puberty blockers and 1.9% of them ended up not starting hormone therapy, indicating a high persistence of gender dysphoria in transgender youth.

QUALITATIVE STUDIES

The studies in this section conducted interviews with transgender adolescents and parents to capture their experiences with providers and the health care system. This section also includes studies that interviewed health care providers and captured their experiences since the rise of anti-trans legislation.

Eisenberg ME, McMorris BJ, Rider GN, et al. (2020). "It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States. *Health and Social Care in the Community*.

- Transgender adolescents raised the importance of providers asking about their gender and pronouns to show caring and respect.

Goetz TG & Arcomano AC (2023). "Coming Home to My Body": A Qualitative Exploration of Gender-Affirming Care-Seeking and Mental Health. *Journal of Gay and Lesbian Mental Health*.

- Transgender adults described their desire for, and importance of, accessing care to alleviate their gender dysphoria and be recognized by society as the gender they know themselves to be. Accessing this care improved their mental health, and for many helped them recover from previous eating disorders.
- Several barriers prevent transgender adults from accessing the care they wanted, including (1) high financial costs for care and inadequate insurance coverage; (2) logistical barriers (i.e., lack of local

providers, inability to take time off work); (3) personal fears about suboptimal outcomes; and (4) fears of societal discrimination, such as family rejection and job loss.

Gridley SJ, Crouch JM, Evans Y, et al. (2016). Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth. *Journal of Adolescent Health*.

- Transgender youth and caregivers described barriers in accessing medically necessary care, including (1) few accessible pediatric providers are trained in transgender care; (2) lack of consistently applied protocols; (3) inconsistent use of chosen name/pronoun; (4) uncoordinated care and gatekeeping; (5) limited/delayed access to pubertal blockers and hormone therapy; and (6) insurance exclusions.

Guss CE, Woolverton GA, Borus J, et al. (2019). Transgender Adolescents' Experiences in Primary Care: A Qualitative Study. *Journal of Adolescent Health*.

- Transgender adolescents and young adults described affirming care as having providers who correctly used their chosen name, respected them, took them seriously, and treated them "like a normal person."

Horton C. (2024). Experiences of Puberty and Puberty Blockers: Insights From Trans Children, Trans Adolescents, and Their Parents. *Journal of Adolescent Research*.

- In interviews with transgender children, adolescents, and their parents, many children experienced anxiety or fear about the thought of puberty and the changes that would bring. As adolescence approached, stress, fear, and anxiety tended to worsen.
- Many parents emphasized that knowledge of puberty-delaying medications was important for reducing their child's anxiety. Both parents and adolescents described the long assessment process to access these medications as frustrating and unnecessarily upsetting, particularly for their children.

Horton C. (2022). "I never wanted her to feel shame": Parent reflections on supporting a transgender child. *Journal of LGBT Youth*.

- Parents of transgender children described noticeable improvements in their child's happiness once their child was socially supported, and they talked about how affirmation of their child's gender identity was critical in protecting their child's well-being.
- The majority of parents emphasized the risks inherent in not supporting trans children, and they higlighted that there is no harm in showing someone "unconditional acceptance."

Hughes LD, Gamarel KE, Restar AJ, et al. (2023). Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care. *Journal of Adolescent Health*.

- In a survey of more than 100 medical and mental healthcare providers across the U.S., 70% shared that they, their practice, or their institution had received threats for delivering care to transgender patients.
- Providers described the impact of this targeted harassment on their physiological well-being and on their ability to deliver care to their patients.

Kidd KM, Sequeira GM, Katz-Wise SL, et al. (2023). "Difficult to Find, Stressful to Navigate": Parents' Experiences Accessing Affirming Care for Gender-Diverse Youth. *LGBT Health*.

- Surveyed 277 parents of gender diverse youth, nearly all of whom described the positive impact of transgender medical care on their child's mental health.
- On experiences accessing care, some had to travel far distances to a clinic and experienced long wait times (e.g., 8 months). Many parents expressed relief in finding a gender-affirming care provider. *"We felt like we were drowning, and the immediate support and medical care helped us catch our breath." – Mother of a transgender son from Ohio*

- Parents said that some providers threatened to report them to child protective services. Others had positive experiences with healthcare providers who created a safe and respectful space and worked closely with both the parents and the child.

Kidd KM, Slekar A, Sequeira GM, et al. (2024). Pediatric gender care in primary care settings in West Virginia: Provider knowledge, attitudes, and educational experiences. *Journal of Adolescent Health*.

- In interviews of rural pediatric primary care providers in West Virginia, 82% had cared for a transgender or gender diverse youth in the past year and documented the importance of social support.

Roden RC, Billman M, Francesco A, et al. (2023). Treatment Goals of Adolescents and Young Adults for Gender Dysphoria. *Pediatrics*.

- In a study of 176 transgender adolescents and young adults, the majority expressed interest in starting hormone therapy. A smaller percentage expressed interest in eventual surgery, and most of the participants with surgery did not want genital surgery.

Vrouenraets LJJ, de Vries MC, Hein IM, et al. (2021). Perceptions on the function of puberty suppression of transgender adolescents who continued or discontinued treatment, their parents, and clinicians. *International Journal of Transgender Health*.

- Clinicians described how almost all transgender adolescents suffer from (the anticipation of) the development of secondary sex characteristics that come with puberty. Most clinicians are aware that delaying or avoiding development of those changes through puberty delay medications would help reduce this suffering.
- Parents, clinicians, and adolescents stated that puberty delay medications give them time to think about whether they want to pursue next steps in medical care without worrying about irreversible changes.

REVIEWS

The studies in this section reviewed large numbers of research studies to draw overall conclusions about the established body of literature that demonstrates the benefits of this care for transgender people.

Bustos VP, Bustos SS, Mascaro A, et al. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and Reconstructive Surgery: Global Open*.

- A systematic review of 27 studies, pooling 7,928 transgender patients who underwent any type of surgery to treat gender dysphoria, found that the pooled prevalence of regret after these surgeries was 1%.

Connolly MD, Zervos MJ, Barone CJ, et al. (2016). The Mental Health of Transgender Youth: Advances in Understanding. *Journal of Adolescent Health*.

- A review of 15 articles published since 2011 found that transgender youth have higher rates of depression, suicidality and self-harm, and eating disorders when compared with their peers.
- Appropriate care and social support in childhood was associated with improved psychological functioning for gender-variant children and adolescents.

Goodrich E, Walcott Q, Dallman J, Crow H, & Templeton K. (2023). Bone Health in the Transgender Population. *JBJS Reviews*.

- A review of the scientific literature found that transgender youth who receive puberty delay medications experience either no change or a slight decrease in bone mineral density, and bone mineral density returns to baseline after starting hormone therapy.

King WM & Gamarel KE. (2021). A Scoping Review Examining Social and Legal Gender Affirmation and Health Among Transgender Populations. *Transgender Health*.

- A review of 24 studies on social affirmation (e.g., family support) and legal affirmation (e.g., name or gender marker change) found positive relationships with several health outcomes. This included findings that social and legal affirmation was associated with fewer reports of depression, anxiety, PTD, and psychological distress.

Mahfouda S, Moore JK, Siafarikas A, et al. (2017). Puberty suppression in transgender children and adolescents. *Lancet Diabetes & Endocrinology*.

- A review of the literature on the impact of puberty delay medications on transgender youth notes that psychiatric disorders have been shown to decrease in intensity after receipt of medical interventions. Studies have found significant reductions in depression and improvements in overall functioning.
- Notably, after receiving treatment for gender dysphoria, transgender youth become similar to their same-age non-transgender peers in quality of life, life satisfaction, and happiness.

Maung HH. (2024). Gender Affirming Hormone Treatment for Trans Adolescents: A Four Principles Analysis. *Bioethical Inquiry*.

- This analysis of the four principles of biomedical ethics and the body of research on gender-affirming care concludes that the provision of gender-affirming hormone therapy for transgender adolescents is ethically required and that restricting this care is ethically wrong. The analysis describes the literature as it pertains to 1) beneficence – the obligation to bring benefit to the person; 2) nonmaleficence – the obligation to avoid harm to the person; 3) autonomy – the obligation to respect the person's right to self-determination; and 4) justice – the obligation to provide just treatment for the person.

National Academies of Sciences, Engineering, and Medicine. 2023. Supporting the Health and Well-Being of Transgender and Gender Diverse Youth: Proceedings of a Workshop in Brief. Washington, DC: National Academies Press.

- In a workshop featuring physicians, transgender youth, and their parents, it was noted the evidence-based guidelines for care set forth by organizations such as the American Academy of Pediatrics, The Endocrine Society, the American Society for Reproductive Medicine, and the World Professional Association for Transgender Health indicate that medical care alleviates gender dysphoria in a way that mental health care alone cannot address.

Ramos GGF, Mengai ACS, Daltro CAT, et al. (2021). Systematic Review: Puberty suppression with GnRH analogues in adolescents with gender incongruity. *Journal of Endocrinological Investigation*.

- A review of 11 studies found that the use of puberty delay medications improved mental health in transgender adolescents.

Swan J, Phillips T, Sanders T, et al. (2022). Mental health and quality of life outcomes of gender-affirming surgery: A systematic literature review. *Journal of Gay & Lesbian Mental Health*.

- A review of 53 studies found reduced rates of suicide attempts, anxiety, and depression among transgender adults after surgery to treat gender dysphoria.
- Findings also indicate higher levels of life satisfaction, happiness, and quality of life after surgery to treat gender dysphoria.

Thornton SM, Edalatpour A, & Gast KM (2024). A systematic review of patient regret after surgery- A common phenomenon in many specialties but rare within gender-affirmation surgery. *American Journal of Surgery*.

- A review of 55 research articles on post-operative regret from plastic surgery operations found that regret ranged from 0 to 47.1%, with patients reporting the most decisional regret after breast reconstruction. The authors compare these regret percentages to other types of surgeries. For gender-affirming surgeries, for example, regret rates are approximately 1%. This is much lower than regret for other types of elective surgery, such as gastric binding (19.5%) and tubal sterilization (28%), as well as regret for non-surgical life decisions, such as getting a tattoo (16.2%) and having a child (7-8%).

OTHER HEALTH OUTCOMES

This section contains research that looked at the impact of care on other health outcomes and utilization of health services, including for transgender adults.

Andrzejewski J, Dunville R, Johns MM, et al. (2018). Medical Gender Affirmation and HIV and Sexually Transmitted Disease Prevention in Transgender Youth: Results from the Survey of Today's Adolescent Relationships and Transitions, 2018. *LGBT Health.*

- Transgender youth who could access treatment that included puberty delay medications or hormone therapy were more likely to have gotten tested for sexually transmitted diseases (STDs) and have heard about PrEP.
- Uptake and awareness of sexual health services is particularly important for transgender youth who are at disproportionately high risk for HIV and STDs.

Bruce L, Khouri AN, Bolze A, et al. (2023). Long-Term Regret and Satisfaction with Decision Following Gender-Affirming Mastectomy. *JAMA.*

- In this cross-sectional study of 139 transgender survey respondents who underwent mastectomy in the past 30 years, the median satisfaction score was 5 on a 5-point scale, with higher scores indicating higher satisfaction. The median decisional regret score was 0 on a 100-point scale, with lower scores indicating lower levels of regret.
- Additional commentary in JAMA: Low Rate of Regret After Gender-Affirming Mastectomy Highlights a Double Standard

Christiano JG, Punekar I, Patel A, et al. (2024). Qualitative Assessment of the Experiences of Transgender Individuals Assigned Female at Birth Undergoing Gender-Affirming Mastectomy for the Treatment of Gender Dysphoria. *Transgender Health.*

- This study interviewed adult transgender men who had undergone gender-affirming top surgery. Participants reported that after surgery, they experienced fewer symptoms of gender dysphoria, less anxiety, and less fear about their physical safety.

Falck F & Bränström R. (2023). The significance of structural stigma towards transgender people in health care encounters across Europe: Health care access, gender identity disclosure, and discrimination in health care as a function of national legislation and public attitudes. *BMC Public Health.*

- This study analyzed survey data from more than 6,500 transgender individuals across the 27 European Union (EU) member states. In countries with more discriminatory laws against transgender people (e.g., requiring medical or surgical interventions to change one's legal gender), transgender people were about 25% less likely to seek necessary medical care compared to countries with more inclusive laws and policies.

Feir D & Mann S. (2024). Temporal Trends in Mental Health in the United States by Gender Identity, 2014-2021. *American Journal of Public Health.*

- Analysis of BRFSS data from 2014 to 2021 found widening disparities in mental health between transgender and cisgender individuals. In 2014, frequent mental health distress was reported by an average of 11.4% for cisgender individuals and 18.9% for transgender individuals. In 2021, averages had increased to 14.6% of cisgender adults reporting frequent mental health distress compared with 32.9% of transgender adults.

Goldenberg T, Jadwin-Cakmak L, Popoff E, et al. (2019). Stigma, gender affirmation, and primary healthcare use among black transgender youth. *Journal of Adolescent Health*.

- Black transgender youth (ages 16-24) who were not affirmed in the doctor's office delayed or chose not to seek out health care. Affirmation included the use of the person's pronouns in the doctor's office and the ability of their doctor to provide resources that affirmed their gender identity.

Hung YC, Park BC, Assi PE, et al. (2023). Multidimensional Assessment of Patient-Reported Outcomes After Gender-Affirming Surgeries Using a Validated Instrument. *Annals of Plastic Surgery*.

- A study of more than 200 transgender and gender diverse patients who had surgery to treat gender dysphoria (average age 31.8 years) found that surgery sustainably improved patients' self-reported health, including gender dysphoria.

Jedrzejewski BY, Marsiglio MC, Guerriero J, et al. (2023). Regret after Gender-Affirming Surgery: A Multidisciplinary Approach to a Multifaceted Patient Experience. *Plastic Reconstructive Surgery*.

- In a review of nearly 2,000 individuals who had surgery to treat gender dysphoria between 2016-2021, only 0.3% requested the surgery be reversed or transitioned back to their sex assigned at birth. This rate of regret is consistent with other evidence-based findings.

Kilmer LH, Chou J, Campbell CA, DeGeorge BR, Stranix JT (2024). Gender-Affirming Surgery Improves Mental Health Outcomes and Decreases Anti-Depressant Use in Patients with Gender Dysphoria. *Plastic and Reconstructive Surgery*.

- In a study of more than 3,000 adults with gender dysphoria who obtained gender-affirming surgery, there were significant decreases in depression, anxiety, suicidal ideation and suicide attempts within 10 years after surgery as compared to pre-surgery.

Lelutiu-Weinberger C, English D, & Sandanapitchai S. (2020). The Roles of Gender Affirmation and Discrimination in the Resilience of Transgender Individuals in the US. *Behavioral Medicine*.

- Transgender adults who were affirmed in their gender identity—including access to medical care—were more likely to have sought out healthcare in the past year and reported better overall health.

Narayan SK, Hontscharuk R, Danker S, et al. (2021) Guiding the conversation-types of regret after gender-affirming surgery and their associated etiologies. *Annals of Translational Medicine*.

- In a survey of surgeons who had collectively treated approximately 18,000-27,000 transgender patients over their careers, they reported only 62 patients expressed regret for their surgery, which is a regret rate of 0.2-0.3%.

- The reasons why patients regretted surgery included being misdiagnosed or changing their gender identity (42%), being rejected or alienated from their family and social circles (15%), and difficulty in their romantic relationships (11%).

Olson-Kennedy J, Warus J, Okonta V, Belzer M, & Clark LF. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*.

- Among transgender adolescents and young adults, those who had not undergone chest surgery reported significantly higher levels of chest dysphoria. Additionally, self-reported regret was near zero.

Price MA, Hollinsaid NL, McKetta S, et al. (2023). Structural transphobia is associated with psychological distress and suicidality in a large national sample of transgender adults. *Social psychiatry and psychiatric epidemiology*.

- Using data from more than 27,000 transgender adults, the researchers found that those in US states with more structural transphobia (i.e., anti-trans laws/policies and transphobic attitudes) reported more severe psychological distress and were more likely to have experienced suicidal ideation in the past year.

ANTI-TRANSGENDER POLICIES AND POLITICS

The research in this section details the negative impacts of anti-transgender policies (e.g., conversion therapy), politics, and rhetoric on the well-being of transgender youth.

Borah L, Zebib L, Sanders HM, Lane M, Stroumsa D, Chung KC (2023). State Restrictions and Geographic Access to Gender-Affirming Care for Transgender Youth. *JAMA*

- Analyzed drive times to the nearest gender-affirming care clinic under optimal conditions (i.e., no traffic) compared to state bans on care. Only 1.4% of trans youth lived more than a 1-day drive from a clinic before state bans took effect, compared to 25.3% of trans youth once state restrictions were enacted.

Campbell T & van der Meulen Rodgers Y. (2023). Conversion therapy, suicidality, and running away: An analysis of transgender youth in the U.S. *Journal of Health Economics*.

- Analyzed data from the 2015 U.S. Transgender Survey and found that exposure to conversion therapy substantially increased the likelihood a transgender adolescent would attempt suicide (55% increase in risk) and run away (more than double the risk).
- These effects were largest when exposure to conversion therapy happened between 11-14 years of age.

Dhanani LY & Totton RR (2023). Have You Heard the News? The Effects of Exposure to News About Recent Transgender Legislation on Transgender Youth and Young Adults. *Sexuality Research and Social Policy*.

- This study examined the implications of consuming news related to proposed bans on medically necessary care for transgender people. Consuming more news related to anti-transgender legislation was associated with more persistent or unwanted thoughts and poorer physical health symptoms among transgender youth and adolescents.

Hughes LD, Kidd KM, Gamarel KE, et al. (2021). "These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents. *Journal of Adolescent Health*.

- In a survey of more than 100 physicians, nurse practitioners, and physician's assistants across the country, it was widely agreed that anti-transgender laws would have an adverse effect on the mental health of transgender youth and would worsen discrimination and societal exclusion.
- Providers described anti-transgender laws as unnecessary political influence in medical care and noted that this legislation goes against science and evidence-based practice.

Hughto JMW, Meyers DJ, Mimiaga MJ, et al. (2021). Uncertainty and Confusion Regarding Transgender Non-discrimination Policies: Implications for the Mental Health of Transgender Adults. *Sexuality and Social Policy*.

- Transgender adults who were concerned about the enactment of state-level, anti-transgender policies had greater odds of depression, anxiety, and PTSD.

Kidd KM, Sequeira GM, Paglisotti T, et al. (2021). "This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents. *Journal of Adolescent Health*.

- More than 250 parents of transgender and gender diverse youth expressed fear that the proposed anti-transgender laws would worsen their child's mental health, including increased depression, anxiety, and suicidal ideation.
- Parents emphasized that bans on medically necessary care are government overreach into private medical decisions.

Kraschel KL, Chen A, Turban JL, Cohen IG (2022). Legislation restricting gender-affirming care for transgender youth: Politics eclipse healthcare. *Cell Reports Medicine*.

- This article discusses how laws preventing access to care for transgender youth are based on false claims about standards of care and inaccurate, biased, and misleading representations of the health outcomes of this care for transgender people. The article reviews current standards of care and the substantial body of research literature that shows this care is linked to improvements in depression, anxiety, and suicidality. Lastly, there is discussion of how these bans may be illegal under the US Constitution, state constitutions, the Affordable Care Act, and the Americans with Disabilities Act.

McNamara M, Sequeira GM, Hughes L, Goepferd AK, & Kidd K (2023). Bans on Gender-Affirming Healthcare: The Adolescent Medicine Provider's Dilemma. *Journal of Adolescent Health*.

- Approximately 45% of board-certified adolescent medicine providers practice in the jurisdiction of a proposed or enacted ban on treatment for gender dysphoria. This piece speaks to the need for supported public engagement, linkage of clinical services across state borders, institutional backing, and medical society advocacy to protect access to this care.

Paceley MS, Dikitsas ZA, Greenwood E, et al. (2021). The Perceived Health Implications of Policies and Rhetoric Targeting Transgender and Gender Diverse Youth: A Community-Based Qualitative Study. *Transgender Health*.

- Transmasculine and nonbinary youth described how anti-trans policies had negative impacts on their mental health, including depression, suicidality, and fear. They also expressed the structural impacts of these policies, including impacts on their personal safety and fear of losing access to health care.

White BP, Abuelezam NN, Fontenot HB, & Jurgens CY. (2022). Exploring Relationships Between State-Level LGBTQ Inclusivity and BRFSS Indicators of Mental Health and Risk Behaviors: A Secondary Analysis. *Journal of the American Psychiatric Nurses Association*.

- Using HRC's State Equality Index measure, researchers found that LGBTQ youth in states with low LGBTQ inclusivity had higher odds of reporting their health as fair or poor and as experiencing poor mental health days.

RETRANSITION

This section highlights research on individuals who decided to discontinue their gender transition (often referred to as retransition or detransition).

Cavve BS, Bickendorf X, Ball J, et al. (2024). Reidentification With Birth-Registered Sex in a Western Australian Pediatric Gender Clinic Cohort. *JAMA Pediatrics*.

- In a study of nearly 550 youth who were referred to a pediatric gender clinic between 2014-2020, only two patients reidentified with their sex assigned at birth (i.e., no longer identified as transgender) after starting puberty delay medications. This represented 1.2% of all patients in the study who had ever initiated puberty suppression.

MacKinnon KR, Gould WR, Enxuga G, et al. (2023). Exploring the gender care experiences and perspectives of individuals who discontinued their transition or detransitioned in Canada. *PlosOne*

- In this study of 28 individuals who detransitioned, the majority of participants felt that medical interventions for transitioning were the right choice for them at the time and reported positive feelings about their gender transition. A majority also expressed support in autonomy to make healthcare decisions and an individualized approach to care.
- Of note, 60% of individuals in the study shifted from a binary transgender identity at the time of initiating their transition to a nonbinary identity as they continue to explore their gender.

Pullen Sansfaçon A, Gravel É, Gelly M, et. Al. (2024). A retrospective analysis of the gender trajectories of youth who have discontinued a transition. *International Journal of Transgender Health.*

- This was a study of 20 young people (aged 16-25) who discontinued their transition (socially, medically, and/or legally). Of these participants, 12 had undergone hormone therapy and only one participant decided to discontinue using this treatment.
- Participants discussed shifts in their views on gender, with many deciding to adopt other labels to describe their gender, such as agender, nonbinary, fluid, or not defining themselves with any one label.
- During transition, most participants mentioned feeling better in their bodies and/or experiencing less gender dysphoria.

EXPERIENCES OF TRANSGENDER YOUTH

Herrmann L, Bindt C, Hohmann S, Becker-Hebly I (2023). Social media use and experiences among transgender and gender diverse adolescents. International Journal of Transgender Health.

- Compared to adolescents in the general population, transgender adolescents spent similar amounts of time online and slightly less time on social media. Most of the time they spent online was for listening to music, watching movies/series, and communicating with friends.
- For transgender adolescents, their experience of gender was most influenced by puberty and distress around their body.

Tsai MV, Kuper LE, Lau M. (2024). Transgender Youth Readiness for Health Care Transition: A Survey of Youth, Parents, and Providers. *Transgender Health.*

- In a study of transgender youth, their parents, and their healthcare providers, all three had similar ratings of the young person's knowledge of gender-affirming care across a range of skills, including knowing and explaining their medical needs, knowing the name and dosage of their treatment, and knowing the long-term plan for hormone therapy.

CLINICAL GUIDELINES

The evidence-based clinical guidelines and standards of care that guide support and medical care for transgender people are detailed below.

Coleman E, Radix AE, Bouman WP, et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health.*

Hembree WC, Cohen-Kettenis PT, Gooren L, et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism.*

Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, et al. (2018). Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents (American Academy of Pediatrics Policy Statement). *Pediatrics*.

UCSF Gender Affirming Health Program, Department of Family and Community Medicine, University of California San Francisco. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People: 2nd edition*. Deutsch MB, ed. June 2016.

Mr. TAKANO. Thank you, Mr. Secretary, for being here, and I yield back.

Mr. GROTHMAN. Okay. I guess I will call on myself for 5 minutes. I would like to talk a little bit about the Office of Refugee Resettlement. How many minors without parents—do you know how many have been allowed in this country in the last 3 years?

Secretary BECERRA. Congressman, I do not have the precise number, but it has been over 100,000 over the last few years each year.

Mr. GROTHMAN. How many each year?

Secretary BECERRA. Over 100,000.

Mr. GROTHMAN. Every year. Every year in this county we let 100,000 kids in without either parent, right?

Secretary BECERRA. We process these children, and they come to our custody because they are unaccompanied children.

Mr. GROTHMAN. Okay. Do you know how many you are keeping track of right now, or how long you keep track of a 14-year-old who shows up at the border? How long do we keep track of them?

Secretary BECERRA. To clarify the way this works, if a child crosses the border, and does not have an adult supervisor, the DHS, Department of Homeland Security has 72 hours within which they must transfer that child into HHS's care because they are not equipped to handle children.

We then will process the children. Get all the information on the child. We then hold custody of that child, as we work to find a sponsor who we vet because by law we are supposed to place that child in the most appropriate setting for children, and it is not in large congregate care, so we go through that process.

Mr. GROTHMAN. Percentage wise, how many are going to another relative?

Secretary BECERRA. How many are going to a relative?

Mr. GROTHMAN. Yes.

Secretary BECERRA. The vast majority.

Mr. GROTHMAN. Okay. Do we need DNA testing to make sure it is really a relative?

Secretary BECERRA. DNA testing is one of the tools that we use to try to identify the individuals who are seeking——

Mr. GROTHMAN. How frequently percentage wise do we do a DNA test of——

Secretary BECERRA. It depends, because often times we get some very credible information on the identify of both the child and the sponsor. If we need to do the confirmation, we will go to something like DNA.

Mr. GROTHMAN. Do we know to this day where those kids are? Whether they moved on somewhere else? Even if it is a relative, say an uncle or whatever, do we do followup to see if they are in an appropriate place?

Secretary BECERRA. Yes, and as I tried to mention before, we have the records of the sponsors, and so we could reach out to the sponsors to find out about these children afterwards.

Mr. GROTHMAN. I think the New York Times once published something. I do not quite believe their numbers.

Secretary BECERRA. They are not correct.

Mr. GROTHMAN. A large number, I will believe that tens of thousands of children in this country, and we do not know where they are or who is taking care of them. Is that true?

Secretary BECERRA. People talk about them being lost. That is all inaccurate. Remember that they are placed with a sponsor. We no longer have jurisdiction to followup with them. We try because we think it is important, best interests of the children. We make an

effort to try to contact both the child and the sponsor three different times.

Mr. GROTHMAN. Okay. Go ahead.

Secretary BECERRA. Yes, three different times. The number that you are citing from the New York Times is based on the fact that some of those children and sponsors do not respond to us. We do not have the authority to make them respond. They are not lost.

Mr. GROTHMAN. That of interest though. I guess—I am for keeping families together, okay, and I am going to give you two more questions.

Secretary BECERRA. Yes.

Mr. GROTHMAN. Do you feel that if somebody comes here without a parent, a 14 year old, a 15 year old, why do we not at least try to turn them back to their country of origin? Is there any reason why we do not do that if a 14-year-old kid shows up? My parents are not here, well, we are going to look for a foster parent. Why do we not send them back home where maybe their parents can take care of them.

Secretary BECERRA. Congressman, that may be the end result. The difficulty is——

Mr. GROTHMAN. Well, it may be, but why is it not the norm?

Secretary BECERRA. Well, I cannot say it is not the norm. What I can tell you is it takes so long to process the case of that child in Immigration Court that it could be four or 5 years before we finally decide what the status of the child will be. Whether the child stays, or whether the child goes back.

It is the fact that the process takes so long that leaves this child in limbo.

Mr. GROTHMAN. Oh, okay. I am going to go ahead with one more question.

Secretary BECERRA. Yes.

Mr. GROTHMAN. Even if in our country, if there is a divorce or something, our court system tries to keep both parents in contact with the child.

Secretary BECERRA. Yes.

Mr. GROTHMAN. It bothers me that when a parent shows up with one child in this country, we can allow them in this country, rather than saying hey, wait a minute, you are here from whatever country, you are from Brazil. Why do you—why do we not wait, and you see if you can come here with both parents. We are not going to take a parent and a child and leave the other parent in some other country.

When we would not allow that maybe even for a parent to move to a different State. Why do we not, at least in that case, try to keep the families intact?

Secretary BECERRA. You have struck on the problem we have with the broken immigration system. We cannot do that because everyone is entitled to a due process hearing, and because it takes forever to hold the hearing, we cannot get to the point of adjudicating to what you just said. That is the difficulty when you have a broken system that does not let you process all these individuals, not just the kids, but the adults as well, it takes forever to finally get justice, whatever that justice might be.

It may be going back to the home country.

Mr. GROTHMAN. Dr. Adams.

Ms. ADAMS. Thank you, Mr. Chairman. Thank you, Secretary Becerra, for testifying before the Committee today, and certainly I enjoyed having you in my District. I look forward to your next visit. Let me ask you in terms of the Office of Civil Rights.

The Office of Civil Rights has opened a Federal civil rights investigation into a Los Angeles Hospital for its treatment of black women in labor and delivery, which follows several lawsuits filed by Charles Johnson, following the death of his wife, Kira Johnson, who my bill in the Momnibus package is named for.

It addresses the role that racial bias and racial disparities in maternal health outcomes have. Can you speak briefly to the OCR's work as it relates to racial discrimination in maternal health settings.

Secretary BECERRA. Absolutely Congresswoman, and thanks for your efforts in this area because I know that maternal health and trying to get justice when it comes to access for maternal health is something very important to you. I cannot comment specifically about the case of Ms. Johnson because it right now is under investigation.

What I can tell you is that the Office for Civil Rights investigates cases of discrimination, whether race, religion, national origin under Section 1557, which you mentioned, but also under Title 6 of our Civil Rights laws. We are prepared to conduct investigations if information comes to our attention.

Ms. ADAMS. Okay. Thank you. The CDC estimates that approximately 700 women die each year in the U.S. from pregnancy related complications, and we know that disparities exist among black American, Indian and Alaskan Native women who are about three times as likely to die from pregnancy related causes compared to white women.

Given that more than 80 percent of pregnancy related deaths are preventable, can you please elaborate a bit on how the budget invests in improving maternal health outcomes across the country?

Secretary BECERRA. Absolutely Congresswoman. The President's budget, if you look at it closely, invests close to 400 million dollars to try to address this issue of maternal mortality and morbidity. As you know, we have engaged in numerous efforts over these last 3 years to try to attack this problem.

You are likely aware of the fact that under the Medicaid program today, we have instituted, with your help, instituted a program where instead of offering only 60 days of postpartum care to a woman in Medicaid, for herself and for her child, today a State is able to offer 365 days of postpartum care to that woman and her child.

That now has been taken up by 45 of our 50 states who have the program. The interesting thing about that is there are still five states that have not seen it fit to offer to their women and children in their State, access to healthcare services when they could.

Ms. ADAMS. Yes, we need to work on that. According to KFF, that study, it compared white women to women of color have higher pregnancy related mortality rates, and more likely to live in states with abortion bans and restrictions, have higher

uninsurance rates, and face greater financial barriers to seeking out of State abortions.

These findings suggest that Dobbs widened the existing stark racial disparities in mental health while also putting black women, especially at risk for further criminalization. What steps has HHS taken to combat widening racial disparities in maternal health being exacerbated at the State level by abortion bans?

Secretary BECERRA. Yes Congresswoman, I think we should note that in these states that now restrict access to the care that a woman needs for reproductive services, the growing number of women who are going to be impacted most are women of color because typically they are the ones that have the lowest income.

They are the ones that have least opportunity to access the care they need in another State because they do not have the resources or the capability to leave the State they may have commitments, and so forth. It becomes very difficult in these states for women period, but for women of color it is desperation.

What are we doing, I mentioned some of the work that we are doing to make sure that all women have access to the care that they need, even in these states that are restricting access to reproductive healthcare services, the Medicaid program that offers care for a woman and her baby postpartum care for 365 days is available.

The close to 400 million dollars that will be there for maternal mortality and morbidity work is going to be available to all of those states. We are doing what we can. We just instituted a rule that will protect the privacy of that woman's healthcare needs, and the privacy of her physician and provider so that they can feel comfortable engaging in conversations about the reproductive health services a women needs.

Ms. ADAMS. Thank you, Mr. Secretary, and again thank you for all of your incredible work. We appreciate it, and you are welcome to come back to my district any time. Mr. Chairman I yield back, my time is up.

Chairwoman FOXX. The gentlelady's time has expired. Mr. Allen, you are recognized for 5 minutes.

Mr. ALLEN. Thank you, Madam Chairman, and thank you Mr. Secretary for being with us today. Now that the Federal Government owns and is running healthcare, we are encountering disastrous problems throughout the country. We are losing providers because of the oppressive policies of HHS and CMS.

Patients are compromised by complicated rules requiring prior approvals and limits on care, and rehabilitation. It is not free market, and it is not free patient, it is all governed by this branch of the government. We are spending four trillion in this country on healthcare. 1.6 trillion in taxpayer dollars on healthcare in this country.

When Medicare began law, three people were paying for each one Medicare recipient. Today, one American is paying for every three Medicare recipients. We have had some difficult policy made in the last 80 years in healthcare. It is a runaway train. I have asked you this question every time you have come to this, and I have served on the Healthy Future Task Force, and I could not get an answer there either.

I keep asking, you know, where are all the dollars going? Who is getting them? Is it the Federal agencies? The providers, you know, their incomes are decreasing as I understand it. Practices, hospitals are consolidating because of this problem, it is creating a problem everywhere.

I have asked you that question. Have you all figured it out over there? Can you give me a breakdown of where every Federal and paid dollar goes for healthcare?

Secretary BECERRA. Well, here is the interesting thing Congressman, I could tell you where the Federal dollars go because we keep an accounting of it. I cannot tell you where the private sector dollar goes. You mentioned prior authorization. That has nothing to do with the Federal Government. Prior authorization is something that the insurance companies came up with to try to keep providers from being able to offer the services that they believe are necessary.

We do not—we cannot get in that space because that is done by a private entity, that private business. I would tell you that the answer to your question where are those dollars going, it is the middlemen. We have heard about all the money that is going into the PBMs. PBMs are the ones that are essentially the go between, between pharmaceutical companies and the pharmacies, and the dispensing.

In between the pharmaceutical companies and the pharmacies, a whole bunch of money is in that system.

Mr. ALLEN. Not to cut you off, but I have got limited time here, but realize the insurance companies are basically in bed with the Federal Government. I mean the Federal Government——

Secretary BECERRA. I have never seen them next to my pillow. I will tell you that.

Mr. ALLEN. Yes, Democrats passed a partisan bloated Inflation Reduction Act, and the drug price setting provisions in this bill make developing treatments even more difficult by not allowing the cost of the development to be recouped, especially for small molecule products. Due to these differing timelines, there is concern in the medical community that the law does not provide enough time for small molecule manufacturers to recoup research and development costs.

Could you tell me yes or no, will HHS address the different timelines between small and large molecule drugs to ensure it does not increase the cost of drugs for patients, and does not disincentivize the innovation of drugs in the future?

Secretary BECERRA. If you are speaking about the negotiation program that we are engaged in with drug companies, we cannot seek to negotiate the prices of some of those drugs that you just mentioned until they have been on the market for many, many years.

Mr. ALLEN. Yes, you are.

Secretary BECERRA. We have taken that into account.

Mr. ALLEN. Yes, okay.

Secretary BECERRA. Innovation we take into account what they charge, or what they say they invest in research and development in any price negotiation.

Mr. ALLEN. All right. Yes, is what I needed to hear. Back in February, the National Association of Attorneys General sent a letter to congressional leaders on behalf of a bipartisan group of 39 Attorneys Generals, including Georgia's AG Chris Carr, urging action on pharmacy benefit manager practices.

This letter outlines several PBM practices, such as spread pricing, tying their own compensation to the list price of medicine, they are increasing costs to millions of patients, employers, and community pharmacies, not only in my State, but across the country. Since you have mentioned on record that HHS is currently enforcing the drug price transparency rule, I am assuming that you also agree something needs to be done to protect patients and stakeholders from such practices?

Secretary BECERRA. As I mentioned, PBMs, we would all like to do more with.

Mr. ALLEN. That would be a yes?

Secretary BECERRA. We would all like to see you do more when it comes to PBMs.

Mr. ALLEN. Okay. I have a few more questions. I will submit those for the record. I am out of time, and I yield back, thank you.

Chairwoman FOXX. Thank you, Mr. Allen. Ms. Jayapal, you are recognized for 5 minutes.

Ms. JAYAPAL. Thank you, Madam Chair. Secretary Becerra, it is good to see you. Congratulations on the important work that President Biden and your department have done to lower prescription drug prices, to improve transparency for patients, and to bring the number of Americans without health insurance down to historic lows.

This is very, very important work, and of course you know that despite these historic lows, there are still 25 million people who are uninsured in America. On top of that many Americans are still under insured, meaning that even if you have insurance of some kind, you simply cannot afford healthcare.

The premium tax credits that we included in the Inflation Reduction Act serve as a very important patch for our broken for-profit healthcare system to immediately lower costs for Americans, but as you know my belief is that we are only going to have full accessibility when we transition to a single payer Medicare for all, improved Medicare for all model.

Medical providers are steering patients toward bank loans and credit cards that saddle them with interest on top of their medical debt. It is really unimaginable that in the richest country in the world, 23 million Americans owe 220 billion dollars in medical debt, the majority of whom owe over $10,000.00 in debt, which just continues to accumulate interest, and meanwhile we have private insurance companies that are doing everything they can to continue to raise premiums, and lower care, and part of that is an increasingly public effort to privatize Medicare.

As you know, I am the proud lead sponsor of improved Medicare for All because I believe it is time to make sure that our healthcare system prioritizes people over profits. A recent Congressional Budget Office study estimates that transitioning to a Medicare for All system would actually save 650 billion dollars per year in costs, and so I am going to continue to work on that.

In the meantime, I want to discuss what can be done right now to improve healthcare for all Americans and prevent wasteful subsidies to corporate insurers that offer what I call Medicare Disadvantage plans. It is estimated that the Federal Government will overpay Medicare Disadvantage companies approximately 83 billion dollars in 2024 alone.

83 billion dollars. That is at least four times as much money as we would need to expand traditional Medicare to cover dental, hearing, and vision benefits. A report from the Committee for Responsible Budget showed that over the next decade these overpayments will increase the national debt by at least 2 percent of GDP and advance Medicare trust fund insolvency by 3 years.

I want to thank you, particularly, for your very strong 2025 Medicare Disadvantage rate notice that your department put out in April, as it takes key steps to curb these drastic overpayments. How can Congress continue to partner with your department to go further in curbing overpayments?

Secretary BECERRA. Congresswoman, thanks for all the work you have done on this, and I would say that probably the most important thing you can do to help us with this is transparency. We need to get behind the curtain of these insurance companies to find out how they are operating because, as you mentioned, they are getting paid more than the traditional Fee-for-Service Medicare.

We want to see how they are spending the money because in some cases they are saying they do not have enough, and they are going to have to start cutting services, and it is not Medicare that would be cutting, it would be the insurance companies.

Ms. JAYAPAL. Not only are the plans exorbitantly costly, but without that kind of meaningful oversight that you are talking about with bad actors, these plans actually have negative health impacts on Americans. An analysis from the National Bureau of Economic Research found that if CMS canceled contracts with the worst performing 5 percent of MA plans, it would save 10,000 plus lives per year.

Can you tell me what resources your department needs to strengthen enforcement mechanisms and how strong oversight of these plans can actually promote health equity and healthcare for people across the country?

Secretary BECERRA. I probably need 5 minutes to give you the full answer because as you know, the Centers for Medicare and Medicare Services has been underfunded for more than a decade when it comes to its budget, even though it has been asked to do the lion's share of work at HHS when it comes to Medicare and Medicaid. If we had an agency that was fully resourced, we could certainly be more aggressive in trying to do the work to get behind that curtain that I mentioned, so we could see exactly how taxpayer dollars are being spent by all these recipients of these dollars, insurance companies and so forth.

Ms. JAYAPAL. I really appreciate your work on this, and I have to tell you that my, and I have said this to you separately outside of the hearing, I am hearing from constituents every day who are getting pulled into these Medicare Disadvantage plans, promised a whole bunch of stuff that they do not get, and ultimately then end

up trying to get off of them, which is extremely difficult in many cases, and get back on traditional Medicare.

I think we need to continue to improve traditional Medicare, and make sure that we provide healthcare for all Americans, thank you for your work.

Chairwoman FOXX. Thank you. Mr. Banks, you are recognized for 5 minutes.

Mr. BANKS. Mr. Secretary, the number of children who have come across our southern border on your watch and Joe Biden's watch is estimated at 481,535. Last year alone it was 137,000, and if you compare that to the last year of President Trump's term, on his watch in the last year of his term it was less than 25,000, so a pretty significant and dramatic increase of unaccompanied children coming across the southern border.

The New York Times says that your Department has lost contact with 85,000 minors, and that statistic is over a year old, so undoubtedly it has risen in the past year. Congressional Research Services says that 75 to 80 percent of unaccompanied children are now traveling with smugglers, and those smugglers have reportedly sold migrants into situations of forced labor or prostitution, forms of human trafficking, in order to recover their cost.

The Coalition Against Trafficking and Women says that 60 percent of unaccompanied children caught by cartels and are exploited through child pornography and drug trafficking. The New York Times has reported that almost one in three migrant women, including a large population of young girls, are reported to be sexually assaulted, over one in three of them, coming across our southern border.

Mr. Secretary, is it the policy of this administration to return children, unaccompanied children, coming across the southern border back to their families where they came from, or is it to send them into the United States away from their families instead?

Secretary BECERRA. Congressman, let me address that question as it pertains to the Department of Health and Human Services because we do not engage in immigration activities. We accept the children that the Department of Homeland Security has encountered.

Mr. BANKS. Is it the policy of the Biden administration return children back to their families, or to send them into the United States to sponsors, or to someone else never to be seen from again? What is the policy?

Secretary BECERRA. The administration policy, and I will try to speak generally because again it goes beyond my jurisdiction, but generally the policy is to abide by what the law says we must do. When someone requests an asylum hearing, by law they are entitled to an asylum hearing.

Mr. BANKS. Let me ask this a different way. If a 15-year-old girl came across the border from say Guatemala, would we send her back to her family in Guatemala, or would we keep her in the United States?

Secretary BECERRA. If she requested an asylum hearing, we would by law be required to offer her a hearing.

Mr. BANKS. How many children have we returned back to their families in the country they came from on your watch?

Secretary BECERRA. That would not be something I have information on because I have——

Mr. BANKS. Thousands, hundreds? Can you estimate?

Secretary BECERRA. I am not going to speculate, but that is something that you can ask the Department of Homeland Security.

Mr. BANKS. You and I both know the answer to that is zero. Zero children that you have returned back to their country. Let me ask you this, hypothetically you and I have something in common. We both have girls. If my daughter or your daughter was smuggled to Guatemala, would we expect Guatemala to return our daughters back to us, our families in the United States of America, or would we expect them to keep them in Guatemala?

Secretary BECERRA. Again, you Are asking me to speculate. I will tell you I would do anything I have to do to get my daughters back.

Mr. BANKS. Yes. Why is the Biden administration not doing that?

Secretary BECERRA. We have to respect what the law says, and the law says you have to provide someone with an adjudication of their claim for asylum.

Mr. BANKS. The law says that because Joe Biden has made that the law. One of his first acts as President was to——

Secretary BECERRA. That is inaccurate.

Mr. BANKS. Unaccompanied minors under Title 42. He did that. You did that. You are responsible for that law, and you have never—by the way, have you ever come to this Committee and asked us to change that law? Do you support changing that law to allow us to send those children back to their families in the country they came from?

Secretary BECERRA. The President has asked you all to change the law. There was a bipartisan bill to change the law.

Mr. BANKS. I think—I have only got a limited time left. I think the reason that you are doing this, Mr. Secretary, and your boss Joe Biden is because Democrats are getting rich off of it. The Global Refuge CEO and NGO that you funnel a lot of money to, her salary is $520,000.00, and it doubled over 3 years.

The former CEO of an NGO called Southwest Key Programs made three and half million dollars. The new CEO makes a million. The CEO of Endeavors, who was an Obama administration aid, made $600,000.00 in 2022. A former Biden transition official, who helped you vet political appointees, helped endeavor and secure a 520 billion dollar no bid contract.

These groups are making hundreds of millions of dollars and now you are asking us to give you 9.3 billion dollars to funnel to more of these NGO's so that your Democrat friends and donors can get even more rich. I think that Is shameful, it Is sickening, and I am going to do everything I can to fight against it. Madam Chair, I yield back.

Chairwoman FOXX. The gentleman's time is expired. Ms. Wild, you are recognized for 5 minutes.

Ms. WILD. Thank you, Madam Chair. Secretary Becerra, good to see you again. When you were in my District not too long ago, we briefly discussed mental health issues and I want to return to that. In recognition of May as Mental Health Awareness Month I would like to discuss what the department is doing to address the very

real mental health crisis that continues to affect so many Americans.

At the very top of that list my concern has to do with kids and online safety, and their health, or the harmful impact. According to CDC data, children between the ages of eight to 12 spend an average of more than 5 hours a day on their screens, while teenagers log over 8 hours every day on their devices.

I am not entirely sure whether that includes school, you know, interactive time online or not, but either way that is a lot of hours. I am a really proud supporter of the bipartisan Kids Online Safety Act, which would require social media platforms to protect minors from specific online harms, like promoting eating disorders, substance abuse, suicide, sexual exploitation.

I know the Surgeon General has indicated that he will prioritize the mental health of children. As tech companies, quite frankly, massively profit through traffic generated by young users. First, can I assume that you would agree with the Surgeon General's assessment that children are vulnerable and at risk?

Secretary BECERRA. No doubt our children are vulnerable.

Ms. WILD. Can you describe for us what your department has done along the lines of protecting kids from the harms of social media, particularly with regard to mental health issues?

Secretary BECERRA. Congresswoman, we have tried to provide support where we can. Most of the areas where we have jurisdiction relate to providing services, treatment, and so for example, standing up the nationwide 988 suicide and crisis lifeline, so that kids who are experiencing real challenges, mental health challenges for example, know where they can go.

We have provided behavioral services in the schools, and we are doing more and more of actually providing, through Medicaid, behavioral health services in the schools so we can approach a child while they are in school. We are doing more of that, but what we do not have is we do not have the authorities or jurisdiction to try to regulate the social media industry.

Ms. WILD. The content, and I understand that, that is why I was trying to ask my question in such a way that it was focused on, and I understand you pretty much have to deal with their health situation, without being able to address the root cause because that is not under your jurisdiction.

You mentioned suicide, and one of the things I am terribly concerned about is that in Pennsylvania suicide is the third leading cause of death for children and young adults aged 10 to 25, which is to me just unfathomable. We created the 988 suicide and crisis lifeline, which I was a proud supporter of, very happy about that.

How does your budget for 2025 support the continued improvement of these kinds of services?

Secretary BECERRA. This President has invested more money in behavioral health than any previous President, and his budget continues that increase in services and support. We believe it is important when nine in 10 Americans are telling you that America is experiencing a mental health crisis, you have go to do something, it is really impacting our children.

You mentioned the issue of social media. We know we have to be there. We are trying to work with our states. The more resources you give us, the more we can help our states.

Ms. WILD. Yes. Well, I hear you on that, and one of the things I will say, you mentioned behavioral health in schools. Every school superintendent I talk to, and I have talked to many in my District, their No. 1 flag for me is that they need more trained and educated therapists, counselors, that kind of thing, many of our schools, elementary schools, you know one counselor is shared among five or six schools, which of course does not allow them to get to know the children at all.

I am glad that your budget is focused on that, and that the President is focused on that, and I want to make sure that the states know exactly what they need to do to access the help they need. In the last 20 seconds here, is there anything in particular you would highlight for the states?

Secretary BECERRA. I believe the number is now somewhere around 15 states that have taken up the challenge that we put before them to increase Medicaid services in the schools for behavioral health. Not every State is doing this. They have to submit a waiver authority so they can do this.

Rather than have to find that your child in your class is having troubles, and send them off to the principal and say they need to be referred to some physician, you have the behavioral health specialist right there in the school, and you can do it immediately.

Ms. WILD. Thank you very much for your focus on mental health. With that, I yield back, Madam Chairwoman.

Chairwoman FOXX. Thank you. Mr. Owens, you are recognized for 5 minutes.

Mr. OWENS. Thank you. Mr. Secretary, I had not planned on going in this direction, but I cannot help it at this point. We just had one of our colleagues talk about some of the evil that is happening at our border. There is no longer a rapid DNA test as of June 2023 because of the Biden administration, which means we can no longer tie children coming across the border with the people bringing them across the border.

There are reports that 85,000 children are being lost. So far, the best you can give us is that they are not lost, just that people are not answering the phone. We are now hearing about children that are used and reused going back and forth to the border because of the cartel. We are talking about slavery, rape, abuse of children, stealing of children. You say that if this is your child you would do everything you could to stop it. What about other people's children?

How can you remain part of an administration that allows this evil to happen? We talk about it. We are going to take lunch in a little bit, we move on, and nobody thinks about it other than the folks that have been impacted. These parents, their children have been stolen. They cannot just give it up the way it seems like the Biden administration is doing.

Let me just say this because it appears that there is a big hit on private market. Let me tell you what happened in the private market. A private company did the same thing, they would be shut down after losing the first ten kids. Then those who would be re-

sponsible for it, we will find them in orange suits, paying a price for decades because of losing 85,000 children.

I think it is disgusting to be honest with you. We are not in the 1800's, the slave trading. We are not in the 1930's where we allowed the Nazi's to do the same thing with the Jews. We are seeing this real time. We are sitting here talking about the lives of children, adults, and yet there seems to be no concern about resolving it.

Let me do this. I need to say that. I have heard your answers, so I know right now that is not on the top of your agenda. There has been a plethora of rules coming through our administration, this administration. A new rule called the Non-Discrimination in Health Programs and Activities is an example of one of the rules that HHA members have now put together.

I am curious, who on your team is responsible for putting together and deciding on these rules? Do you have a team? A group of people that do this, that say this is what we are going to do now for this particular industry?

Secretary BECERRA. We have a very large team because we have a number of agencies. We have CMS, we have NIH, we have FDA——

Mr. OWENS. Okay, but within those agencies there has to be somebody. You have a small team, there has to be somebody making these rules.

Secretary BECERRA. That is correct.

Mr. OWENS. All right. Who are they? Is it possible to get the names of these bureaucrats that are changing, literally, the industries that we see across the board?

Secretary BECERRA. I am not sure. Congressman, that all goes through a public comment period. Everybody sees what we are doing.

Mr. OWENS. I am sorry?

Secretary BECERRA. There is no rule that becomes final that has not gone through a public comment where you and everyone else——

Mr. OWENS. When you go through that process, somebody comes up with the rules. We are talking about——

Secretary BECERRA. Before that rule becomes final you get to see it, everyone gets to see it.

Mr. OWENS. No, no, no, I am not talking about what goes through the process. Who makes up these rules? Who is sitting at the table? You have physicians sitting at the table, but it comes down to that is going to be impacting physicians?

Secretary BECERRA. Yes.

Mr. OWENS. Okay. This rule we have here, the Non-Discrimination of Health Program, I want to understand, by the way, physicians do have religious liberties, right? They still have that opportunity to be able to act based on their religious conscience.

Secretary BECERRA. Everyone does.

Mr. OWENS. Okay. The Non-Discrimination and Health Program, would that require doctors to provide gender affirming care regardless of their religious beliefs?

Secretary BECERRA. No one is forced to do anything that goes beyond their civil liberties.

Mr. OWENS. Even though that is a rule, they are not forced to do this in their situation in their industries?

Secretary BECERRA. The rule does not force any physician to do something that is against their religious beliefs.

Mr. OWENS. Okay. Well, I was told differently, but we will make sure to followup on that one.

Secretary BECERRA. Yes.

Mr. OWENS. If in case—so I guess in this case here that the rules really are not rules. It is just a suggestion?

Secretary BECERRA. No. These are rules.

Mr. OWENS. All right. It is a rule. Are you saying then that they can decide not to just do whatever the rule might say then?

Secretary BECERRA. If it goes against their religious beliefs, under the law they have protections for their religious beliefs, therefore they would not be forced to do something that goes against their religious beliefs.

Mr. OWENS. Okay. All right. Well, I am glad to hear that. I was told differently. Let me just wrap up here, and I just have a few seconds. We are going to make sure we—I think the American people hold this administration accountable for what is happening at the border. 85,000 lives of innocent children is not acceptable in this country, no longer, and the fact that you are in a position in the administration, you should have some sway to make sure that those that are part of this process are making changes.

Secretary BECERRA. Congressman, if I could just, in 5 seconds just respond.

Mr. OWENS. Yes.

Secretary BECERRA. If 85,000 children were lost, you, me, everyone in this room would have taken action. That number is inaccurate. That is not a statistic, that is real.

Mr. OWENS. What is the real number? How many have been lost?

Secretary BECERRA. That is the thing, they are not lost. They are there.

Mr. OWENS. They are just not answering the phone. In other words, the response is they are not answering the phone.

Secretary BECERRA. Congress did not give anyone——

Mr. OWENS. Let me say this. When you leave it, you give it to a sponsor, they do not answer their phone, you do not know where those kids are, they are lost. Let us just keep—if you do not know where they are, you do not have the address, you cannot go and pick them up. You cannot do any welfare, okay and with that, I want to yield back my time, thank you.

Chairwoman FOXX. Yes. We invite the Secretary to send us proof that you know where those kids are. Ms. McBath, you are recognized.

Mrs. MCBATH. Thank you so much Madam Chair. Good afternoon, or good afternoon, Secretary Becerra. It is very good to see you. Thank you so much for coming before us today. For more than a year my bill to cap the cost of insulin at $35.00 a month has been lowering prescription drug costs for our seniors.

This life saving medication is more affordable for millions thanks to our work here in Congress, and your work in the Biden-Harris administration, so thank you once again for that Mr. Secretary, but I believe we can do a lot more, as we all do in this room.

The fact of the matter is that insulin is still too expense for working families in America, especially for those who have young children. Parents are still waiting in the line at the pharmacy after work, or during their lunch break, and being forced to pay 20 or 30 times more than what citizens of other developed nations are paying for this lifesaving drug.

Just, you know, actually it is just a few dollars for the manufacturers to produce it, but of course, you know, our constituents are paying far more money for this life saving drug. I am just proud to be the lead here on this Committee, on our efforts to lower the price of insulin for every American in the United States. Mr. Secretary, can you briefly discuss your budget request that ensures that every American has access to insulin at a price point that they and their families can truly afford?

Secretary BECERRA. Congresswoman first, thank you for the work that you did to make it possible for so many Americans to benefit from $35.00 or less insulin. We in this budget, we proposed that that $35.00 amount be available to every American, not just to those in the Medicare program. Medicare, 66 million Americans, it is great for the 66 million, but there are 332 million or so Americans in this country, everyone should have access to reasonably priced insulin and other prescription medication.

Mrs. MCBATH. Well, thank you. I would also like to discuss our efforts to protect survivors of domestic and family violence. The House did pass my bill. I am really grateful for that. The bipartisan Family Violence Prevention and Services Improvement Act, as we call it, FVPSA, they passed that last Congress to reauthorize and improve family and domestic violence prevention and support programs.

As the only source of Federal funding that is actually dedicated to supporting domestic violence programs and the shelters around the country, this program is really a lifeline, truly a lifeline for organizations and for families that they are doing their best to escape this cycle of violence that they find themselves in.

Could you please use what time that you actually have left, and you have quite a bit of time, so please expound as much as you can, to talk about the importance of reauthorizing the Family Violence and Prevention Services Act.

Secretary BECERRA. Congresswoman, there is no doubt that we are seeing families, children suffer as a result of domestic violence because we treat it as a criminal activity. We lose out because we should also treat it as a healthcare crisis where we need to improve the health of the families that are impacted most by this domestic violence.

We are trying to do what we can. In the money that was made available through the bipartisan bill to address gun violence, there were some moneys that we invested to address domestic violence because many times that domestic violence is actuated through the use of weapons.

What we are trying to do is more immediately reach families before the violence occurs, and that means giving people alternatives. There may be a case, for example that the individual, a spouse for example, may not have any other options but to leave. Sometimes they have nowhere to go.

If we can increase the options for a safe place for that person to go, we can probably save a life and probably help ensure that the family can start to recover. We are going to do everything we can in this issue of domestic violence because we consider that type of violence we see in this country as a healthcare crisis that must be addressed immediately, especially because of the mental health concerns that we see for so many of these family members.

Mrs. MCBATH. Well, I just want to thank you so much for all the work that you and the administration do. Is there anything else that we specifically here on the hill can do to help expedite that very kind of support that you need because we know that exponentially a lot of the domestic violence cases are growing.

Gun violence cases are growing across the country. I think all the empirical data continues to show that, you know, we are in a public health crisis as you stated. Is there anything specific that you need from us to help do what you need to do to protect Americans?

Secretary BECERRA. Treat this as a healthcare crisis so that way we are able to receive some of the resources to try to address this as a healthcare crisis. Second, you mentioned it, data. We need to have good data to see what we can do, where we need to do it, and we need to collect the data, and then be able to assess it.

Mrs. MCBATH. I thank you so much. I appreciate you. I yield back the balance of my time.

Chairwoman FOXX. Thank you, Ms. McBath. Mr. Good, you are recognized for 5 minutes.

Mr. GOOD. Thank you, Madam Chair, and welcome back Director Becerra. I appreciate you being here, Secretary. Do you think abortion is a good thing?

Secretary BECERRA. I think—my wife is an OB/GYN. I will tell you——

Mr. GOOD. Do you think abortion is a good thing?

Secretary BECERRA. Congressman, if it is a service that is needed in terms of providing good health——

Mr. GOOD. Do you think abortion is a good thing?

Secretary BECERRA. I think abortion is a service that is essential for many women.

Mr. GOOD. Do you think abortion is a good thing? That would be a yes or no answer?

Secretary BECERRA. I think I have answered your question, but——

Mr. GOOD. You have not answered it. Do you think abortion is a good thing.

Secretary BECERRA. I think for many women it is a——

Mr. GOOD. Do you think abortion is a good thing?

Secretary BECERRA. I think for many women——

Mr. GOOD. Okay. Do you think abortion is something that should be reduced, or something that should be expanded?

Secretary BECERRA. I think women should have access to the healthcare services they need.

Mr. GOOD. Do you think abortion is something that should be reduced, or something that should be expanded?

Secretary BECERRA. I think women should have access to the healthcare that they need.

Mr. GOOD. Do you think that abortion should be reduced or expanded? Do you think it is something that is a good thing that should be expanded? We ought to have more of it, and celebrate that as success, or do you think it ought to be reduced, it is a bad thing. We ought to do everything we can to reduce abortion. One or two of the directions.

Secretary BECERRA. Women having access to healthcare is a good thing——

Mr. GOOD. Which one do you believe, should be reduced or expanded.

Secretary BECERRA. If the question is do I think having access to healthcare is a good thing, having access to healthcare is a good thing.

Mr. GOOD. I did not ask you about healthcare. I asked you about abortion.

Secretary BECERRA. Abortion is healthcare.

Mr. GOOD. Killing a child, terminating a child in the womb is healthcare?

Secretary BECERRA. Access to the healthcare a woman needs is important.

Mr. GOOD. That would make sense, that that is how you would view it with your policies on it. On May 6th, HHS issued a final rule titled Non-Discrimination in Health Programs and Activities, that uses Affordable Care Act to advance the radical left, that would be you, agenda to redefine sex by including sexual orientation and gender identify as classes protected from discrimination.

Further, the rule also says discrimination on the basis of pregnancy termination can be a form of sex discrimination. Let me read that again. The rule says discrimination on the basis of pregnancy termination can be a form of sex discrimination. Can you explain what this means? How is pregnancy termination now a class of people that needs to be protected?

Secretary BECERRA. Women need access to care. If they need reproductive care and they are denied it, they are now having their rights abridged.

Mr. GOOD. If we do not provide coverage for the termination of a pregnancy, the killing of a child in the womb, which by the way, I might add, the No. 1 killer in America is what? You are Health and Human Services, what is the No. 1 killer in America?

Secretary BECERRA. Why not tell me since you are going to tell me anyway.

Mr. GOOD. Go ahead. What is the No. 1 killer in America?

Secretary BECERRA. I will let you tell me. You do not seem to want me to have the answer to the question, so I will let you answer.

Mr. GOOD. Heart disease, yes they are numbers two and three, No. 1 killer in America is abortion. The No. 1 killer in America is abortion. Your rule says that if a woman's health insurance plan is not giving her the unfettered right to end her child's life, then she can claim she has been discriminated against. That is correct?

Secretary BECERRA. The way you described it, no.

Mr. GOOD. Okay. Why do you not clarify it then?

Secretary BECERRA. A woman should have access to the care that she needs.

Mr. GOOD. Let me ask that a different way. It would not be discrimination to not cover the ability for a woman to kill her child in the womb. For that not to be covered is not discrimination. You are not saying that?

Secretary BECERRA. I would not characterize it the way you have, so I can try to answer the question, but I would not answer the question that you have posed, because it is posed inaccurately.

Mr. GOOD. Do you believe that someone who opposes abortion should be accused of discriminating against a woman because they choose not to end the life of a child? Is that discrimination? If you oppose abortion, you oppose the termination of life in the womb, the killing of a child in the womb, that that's discrimination?

Secretary BECERRA. If a person is being denied the healthcare that they need, then that requires action to be taken.

Mr. GOOD. It is bad enough that this regulation applies to Obamacare, but of course you did not stop there. The rule also states that the HHS Office of Civil Rights will extend non-discrimination enforcement to third-party administrators contracting with group health plans that are self-funded.

This is reaching into a whole new category of private insurance. Now, under your regime, every employer sponsored health plan would be required to provide gender affirming procedures. That is an interesting term that you and your colleagues like to use, and abortions, and it could even force medical professionals to violate their expertise if they believe these things, these procedures are wrong or harmful, which they are, or their beliefs on the best care in a plan for individuals, particularly children.

Worse yet, your budget proposes a 17 million dollar increase for the Office of Civil Rights, so you can weaponize the Department against doctors who do not want to provide abortions to women. The question is why do you, and the rest of Biden administration, why are you so determined to violate American's religious beliefs through abortion and so-called gender reassignment mandates?

They are mandates, but why are you so determined to violate American's religious beliefs through that?

Secretary BECERRA. We are not. We actually protect and are willing to enforce the religious beliefs and conscious protections that are afforded to all Americans.

Mr. GOOD. Well, we do not see that in this rule. There is no need for the rule, non-discrimination and all this, not give you or HHS the authority to mandate this nationwide abortion and gender reassignment surgeries, and I yield back Madam Chairwoman.

Chairwoman FOXX. Ms. Manning, you are recognized for 5 minutes.

Mrs. MANNING. Thank you, Madam Chair. I do not know about you, but I need a breath after that appalling attack on women's healthcare, so let us take a breath and move on. I would like to start by responding to some comments made at the top of the hearing regarding the proposed budget.

The investment in our young people, in their health and education is critically important for the future of our country. If we do not ensure that all of our children get a top quality education, including preschool, and the healthcare they need, we will fail to create future scientists, physicians, nurses, teachers, tech innovators,

artists, and business leaders from diverse walks of life who will ensure the future of this great country.

I want to thank you for presenting us with a budget that invests in our future, our children, including universal preschool, which will help all kids get the start they need to achieve. I would like to move to another area, and that is an area of crisis in this country, and that is mental health.

In your testimony you State that HHS is transforming the way we deliver behavioral healthcare. I am delighted to see that because I met yesterday with a constituent from one of my major hospital systems, Cone Health, and he raised the urgent need for more options for treating people, especially young people, with mental health problems.

Earlier this week I met with a group of our police officers, and they gave me the same message. We need more options for effectively treating people with mental health problems. Secretary Becerra, you are no doubt aware that the mental health crisis is overwhelming our emergency rooms across this country, which are often forced to keep patients until a bed in a long-term facility opens up.

Can you talk about what HHS is doing to relieve the stress on our emergency rooms, and find more effective options for treating people with mental health problems?

Secretary BECERRA. Congresswoman, thank you for the question. One of the things that we are trying to do is work with states who are the ones who have oversight over the hospitals and mental health services, to make it possible for them to expand their mental health services, so you do not take up an emergency room bed for someone who really is in need of behavioral health services and is not there for some physical emergency need.

What we are doing, for example, with many states is offering them a chance to modify the way they use Medicaid dollars, so that they can expand access to Medicaid dollars in the behavioral health space. Some states have taken us up on this opportunity, so that they are showing that they can take a person, whether in an emergency room, or someone who is homeless, take them off the street, provide them with mental health services, housing, stabilize them, and therefore keep them out of that emergency room in the future.

That saves everyone money, including the Medicaid program, and so we are willing to engage with a State that wants to come up with innovative ways to use Medicaid dollars because if at the end of the day we are saving Medicaid money by having that person treated more directly by the State, it is a good thing for everyone.

Mrs. MANNING. Great. I hope you will make sure that CMS has a proper code, so that they can get reimbursed for those creative, innovative purposes, because that is a problem. Also, we are seeing mental health crises in our schools, and I have visited schools across my District that are desperate to have more school psychologists, nurses, social workers, to help our young people deal with the mental health crisis.

I have introduced a bipartisan bill to integrate mental health wellness programs and necessary resources into our school wellness

programs. Can you tell us how your budget would help address the mental health issues our students are experiencing?

Secretary BECERRA. Here again, while the President tries to invest a substantial amount of money as I mentioned, more money for behavioral health than any we have seen in our generation, but more precisely, working, for example through Medicaid again, trying to get the Medicaid program directly into the schools to provide behavior health services to children, so they do not have to wait until they leave the classroom, leave the school, and then go to a doctor to get the mental health services they need.

They can get it right there on campus, so that we could start to treat these issues quickly for children, and we can do that without costing a school or the school district dollars that they would otherwise spend for learning because they're able to draw down Medicaid dollars.

Mrs. MANNING. Thank you. I was going to talk about my Right to Contraception Act, which will help defeat the attack on women's right just to even have birth control, but I am out of time, so I want to thank you for your testimony. I yield back.

Chairwoman FOXX. Thank you, Ms. Manning. Ms. Miller, you are recognized for 5 minutes.

Ms. MILLER. Secretary Becerra, in your final rule titled Non-Discrimination in Health Plans and Activities, you mandate that private health plans provide sex change operations on children, and abortions for minors, or risk losing their Federal funding. This rule certainly would violate the religious conscience of thousands of doctors and medical providers.

What would your Department do if a doctor refused to provide the treatments mandated by this rule?

Secretary BECERRA. Congresswoman, first, that was not accurate what you said, and a provider, if they for religious reasons object, they are not forced to provide any particular service.

Ms. MILLER. Well, your rule says that gender identity and sexuality is protected under the title Sex Discrimination, so it says that a doctor cannot refuse service to a patient for that care, and I actually do not believe you. Your Department has a history of violating the closely held religious beliefs of people, and doctors do need to know.

Would you tell me today can you commit here today that your Department will not withhold Federal funding from hospitals or doctors who refuse to provide the gender affirming care that you are, you know, mandating if it violates their religious beliefs?

Secretary BECERRA. Now, Congresswoman, I recognize you are going somewhere completely different. First, you started talking about how a doctor should have the right to not offer particular care. Then you stretch it out to provide for the system wide services, very different.

Ms. MILLER. Yes. You have put out this guidance, and doctors do need to know.

Secretary BECERRA. Yes.

Ms. MILLER. What are you going to do if they refuse to provide this care?

Secretary BECERRA. A doctor, if that doctor has religious objections, that doctor under these rules is not required to offer care.

Ms. MILLER. Okay. You are committing here today that you will not withhold Federal funding.

Secretary BECERRA. Doctors do not get Federal funding, ma'am.

Ms. MILLER. The hospitals do.

Secretary BECERRA. Okay. We are not talking about the hospitals. Do not confuse the two.

Ms. MILLER. Okay.

Secretary BECERRA. A doctor is not a hospital.

Ms. MILLER. Doctors are working in these hospitals. Are you going to say today, are you committing that you will not withhold Federal funding from those healthcare facilities?

Secretary BECERRA. If a healthcare facility is violating the law, and not providing the service they are required to, they are not entitled to the resources.

Ms. MILLER. We believe that you would withdraw Federal funding. Mr. Secretary, the United Kingdom recently banned private health providers from performing gender affirming care on minors. Their decision relied on a study that stated puberty blockers may damage a minor's ability to think and reason, and that the rationale for suppressing puberty at all remains unclear.

Mr. Secretary, are you worried that other countries are banning puberty blockers for children, while here in the United States the number of children on puberty blockers continues to increase each year, as you can see here?

Secretary BECERRA. Congresswoman, we rely on the best medical evidence in knowing what services to provide, or to support and provide reimbursement for. Those services——

Ms. MILLER. Your Department is marketing these drugs to children. The guidance on your website tells children how great puberty blockers are, and so you are getting—I want to stop people like you that are forcing these non-reversible treatments on children. I am asking on behalf of parents across the country.

Secretary BECERRA. Yes. If you would accurately portray what we were doing it would be easier to respond to your questions. You continue to mischaracterize what we have said.

Ms. MILLER. I am not mischaracterizing you or what you are promoting.

Secretary BECERRA. Read then what we are doing. Congresswoman, why do you not read what we are doing——

Ms. MILLER. You have put out this guidance. You are promoting the use of dangerous, toxic chemicals that are not reversible, that are experimental. You are promoting unnecessary surgical mutilation, and it is a fact that 80 percent of our youth that struggle with gender dysphoria end up growing out of it.

I can say that no rational or compassionate person would be promoting this. Joe Biden and his administration are attempting to force doctors and medical providers to go against their closely held religious beliefs, and are forcing toxic, experimental drugs on young children. It is a fact. These drugs and procedures have serious side effects and will take away their ability to ever have children.

The Biden administration is also distorting the ruling in Bostock to push the far-left political agenda. Justice Gorsuch was clear in his majority opinion that this ruling only applies to Title 7. It does not give Joe Biden license to push radical policies like this rule.

History will show how wrong you and Joe Biden are on this issue. Thank you, and I yield back to Dr. Foxx.

Chairwoman FOXX. Thank you. Mr. DeSaulnier, you are recognized.

Mr. DESAULNIER. Thank you, Madam Chair. Mr. Secretary, nice to see you as always. Wonderful job. Your work on reducing costs for Americans, I am somebody who benefits from that. Since being diagnosed with stage four leukemia 10 years ago my medication used to be one of those medications that was three to $400.00 more than the rest of the developed world, in spite of the fact that American taxpayers paid for most of the basic research.

I am grateful for that. Tell me the consequences, the most recent spending bill, appropriations did not fund the 21st Century Cures Act. How does that affect all the good work we have been doing for people like myself who are living longer lives because of their investments as taxpayers in cancer research and deployment?

Secretary BECERRA. Congressman, I have to before I answer the question just say you look good, and it is always good to see you, and when you are looking good.

Mr. DESAULNIER. You should run for office.

Secretary BECERRA. I just appreciate it because I remember our days when we were together, and it is always great to see that, you know, when fighters come out of this winning, so I am glad you are standing and fighting. In terms of the question, the delays in reauthorizing critical legislation that lets us continue the discoveries, continue making more readily available and reducing the costs of some of these lifesaving medications is just time that we are losing.

There is no reason. Everyone knows how the Cures Law has helped people like you and others. We should get to the task of reauthorizing it yesterday.

Mr. DESAULNIER. I want to ask you a question about another something near and dear to me as a survivor of suicide, your work on suicide prevention. We have had a lot of discussion here about mental health. The CDC's report that almost a third of adolescent girls in this country have seriously considered or attempted suicide.

You have an action plan. Can you speak to that?

Secretary BECERRA. Yes. Anytime you hear stories that 10-year-olds are contemplating suicide you have to wonder what is going on in this country and so we are, because of the President's commitment, we are able to devote more resources to help states try to tackle this. Again, we do not operate the programs directly at the Federal level.

You know, we are too far removed, but we support the states, and the local health departments, and mental health departments that provide these services. What we are doing is we are being more aggressive in trying to get moneys directly into some of these mental health programs for young people. I mentioned how we are trying to get into the schools with behavioral health programs.

We are also committing several hundred millions of dollars in workforce development, so we get more of the behavior health specialists that we need. I mentioned in my opening testimony, this President's budget would make it possible for us to hire 12,000 additional psychiatrists, psychologists, therapists and so forth.

Mr. DESAULNIER. Yes. I would love to work with you more. Madam Chair, you and I have discussed this when we had the gavel, and I was Chair of the HELP Subcommittee, we had good bipartisan talks about this, but since parity we have had a 300 percent increase and a reduction on the shame associated with suicide and mental health, but we have had a similar decrease in young people going into the field.

My Mental Health Matters Act, I would love to work with your Department and with the Chair, to figure out if we can make that, because it seems like a bipartisan consensus that we need to invest more in the deployment of behavioral health, and what we have learned about the neuroscience of how we operate.

I wanted to ask you a question about the Kaiser Foundation's report on denials of billing requests. I have had comments. A friend I went to college with who owns a primary care practice in Bethesda, bought it from his dad, his brother runs it. He called me and said we are spending all of our time on these denial of claims.

Kaiser says that almost 50 percent of claims of one insurer has been denied. There is another claim from Kaiser that almost 80 percent. I have heard this from my providers. My dentist told me this week that they spend all their time, these small firms, just trying to get—this came about, according to Kaiser, from actions that the previous administration did to undermine your ability to actually oversee this, and this—the majority party's inability to fund you at a level that we can hold the insurance companies accountable.

I really want to work on this. I talked to clerical people in my doctor's office, they said they are spending all this time just trying to work on claims that used to go through that were well substantiated, but you cannot provide the oversight to make the insurance companies—the inefficiency of this is outrageous.

Secretary BECERRA. Yes. What you are pointing out is the difference between in the Medicare program for example, what is traditional Medicare, Fee-for-Service, versus the managed care program called Medicare Advantage. Medicare Advantage, we do not have that sight that you are mentioning. We cannot dictate. We cannot tell them, hey, we hear you are not paying your bills.

Providers can bill directly under Fee-for-Service traditional Medicare to a Medicare program, and Medicare pays them directly. Under the managed care program, Medicare Advantage, we do not do that. We pay the insurers early before they even provide a service. Then they get into this hassle of prior authorization, all the rest, and providers have a heck of a time trying to get reimbursed by the insurance company.

Mr. DESAULNIER. People give up.

Secretary BECERRA. Yes.

Mr. DESAULNIER. Thank you, Madam Chair.

Chairwoman FOXX. Thank you. Mr. Burlison, you are recognized for 5 minutes.

Mr. BURLISON. Secretary Becerra, according to the Congressional Budget Office, they estimate that the ACA plans cost the taxpayers three times as much as an employer sponsored plan. With that being said, is it beneficial or better that we would encourage more

policies to migrate toward an employer-sponsored plan, as opposed to the ACA?

Secretary BECERRA. Congressman, remember there is a difference between an employer-sponsored plan, an ACA plan, the Medicare program, Medicaid, all of them are different. The reason that there may be a great cost in an ACA plan is because these are individuals that do not work for a large employer, cannot take advantage of the large pool of employees that would be part of a system, that the employer gets discounts because they are bringing a whole bunch of people into the system.

Mr. BURLISON. Would it not be great if they get the discount? The taxpayers win, they win. Is that not a good deal?

Secretary BECERRA. It would have been great, but remember before the Affordable Care Act came into play all these folks could not find insurance because the insurance carriers would not——

Mr. BURLISON. They did. I mean arguably, we had high risk pools, and I do not want to get into that. That is pretty detailed stuff, but would it not be great if we found a way to reduce the employer-sponsored plans by 29 percent? Obviously more people could be able to afford to get access to health insurance.

Secretary BECERRA. Reducing the cost of healthcare would be a great thing.

Mr. BURLISON. Especially in the private market, and then it would save the taxpayers even more, right? We are no longer paying for them to be on the ACA.

Secretary BECERRA. The more people who are insured, the less it costs all of us.

Mr. BURLISON. We have the association health plans, which was an innovative idea. They have—a lot of the associations in America have had a long-standing interest in allowing themselves to combine lies to create those larger pools that you are talking about. In 2018, the Department of Labor issued a final rule to expand access to these associated health plans, which actually did reduce the cost of insurance premiums by 29 percent.

Just recently, the Department of Labor issued a final rule to rescind that 2018 rule. How do you think that that is going to have an impact on the costs and the access of affordable care for patients?

Secretary BECERRA. Recognize that the actions that you are speaking about were done by the Department of Labor, not by the Department of Health and Human Services, but what I can tell you about the various types of offerings, health insurance offerings that are out there, what you want to make sure is they all provide a core level of services, the basic level essential services that anyone would want, preventative care for example, maternal healthcare, natal care.

We want to make sure that you are providing the basic services. If you start to go outside of the Medicare program, Medicaid program, employer insurance, or the Affordable Care Act, you start to get into the weeds, and the gray areas where these providers of these plans can avoid providing some of those basic services. That is the problem with some of these association-based plans.

Mr. BURLISON. No. I absolutely disagree. There is no difference between an association-based plan. When they go out to bid for pricing.

Secretary BECERRA. I guarantee you there are big differences.

Mr. BURLISON. There is a difference because they are able to negotiate in bulk. I have a different line of questioning I want to get to before time expires. Last year you testified before this Committee, and I asked about the 85,000 unaccompanied alien children that your Department was not able to regain contact with.

You made repeated comments that the moment that you were able to place them with the vetted sponsor, you lose custody. You do attempt to call them, correct?

Secretary BECERRA. Yes.

Mr. BURLISON. How many have you been able to contact?

Secretary BECERRA. Well, I would say that the majority we contact at some point, whether it is the child or the sponsor.

Mr. BURLISON. Do you have the number?

Secretary BECERRA. I could try to get you a number because again, they do not have to—they are not under—they are under no obligation to reach out to us.

Mr. BURLISON. You did prep for this right? Like last year, that was a course of dialog questions, that you got a lot of questions about.

Secretary BECERRA. Yes.

Mr. BURLISON. I assume that you were——

Secretary BECERRA. I prepped for budget questions, budget questions.

Mr. BURLISON. Right. You would say that this is a concern, that you would agree that it is concerning the number of children that we are not able to identify?

Secretary BECERRA. What I am concerned is that members in Congress continue to ask me if I am concerned. I would ask you are you concerned enough to give us authority, so we could actually track these kids? We do not have authority to track them.

Mr. BURLISON. When you are placing these children do you ask? Do you ascertain whether or not the homes that they are being placed into, that they are able to actually work if they are eligible to legally work in the United States? Is that one of the questions you ask?

Secretary BECERRA. Children should not be working. They should be going to school.

Mr. BURLISON. I am asking because why would you place them in a home where no one can provide any kind of support.

Secretary BECERRA. You cannot become a sponsor if you indicate that you do not have the wherewithal to support a child.

Mr. BURLISON. That means that they are able to legally work in the United States? Can you verify that?

Secretary BECERRA. We make sure that they have their income that would be needed to care for the child. That is part of the vetting process.

Mr. BURLISON. Legally?

Secretary BECERRA. You know, we are not INS, we are not the Department of Homeland Security. Our job is to find someone who can care for this child.

Mr. BURLISON. Surely you can connect with them. My time is expired.

Chairwoman FOXX. Thank you. Ms. Omar, you are recognized for 5 minutes.

Ms. OMAR. Thank you, Secretary Becerra, for being here with us today. Since Dobbs, Republican politicians have been attacking women's reproductive healthcare, and in turn jeopardizing the lives of millions of women. Can you tell us what steps HHS has taken to ensure that women continue to have access to comprehensive reproductive healthcare, including abortion?

Secretary BECERRA. Congresswoman, we have taken a number of steps. Obviously, everything will fall short of what the protections that Roe versus Wade had provided to women, but for example, we have gone all the way to the Supreme Court to protect a woman's access to medication abortion, Mifepristone. We have gone all the way to the Supreme Court protecting a woman's right to emergency care services.

We are continuing to enforce laws that require providers and insurers to offer contraception services to women. We just issued a rule that would protect the health information privacy of women and their provider, so that that cannot be used against them. I could go on, but I suspect you have more questions.

Ms. OMAR. No, thank you so much for that answer. I am really concerned about the epidemic of the opioid crisis that we are looking at that is shattering the lives of thousands of people across Minnesota. My family has lost close and personal friends to this epidemic. In Minnesota, opioid involved overdose deaths increased 43 percent from 2020 to 2022.

The number of deaths has more than doubled since 2019. Indigenous Minnesotans are dying at over nine times the rate of white Minnesotans, and black Minnesotans at over three times that rate, and we are seeing a disturbing increase in addiction rates among East African—the East African immigrant population.

I am deeply concerned about these disparities and about ensuring that hard to reach communities are receiving the care and services that they need. I see that in the budget you have requested 1.6 billion for the State Opioid Response Grant and two million for the Youth Prevention and Recovery Initiative, specifically.

Can you tell us what steps the agency is taking to make sure that the Federal funding is going toward culturally competent care? How are you going to serve the underserved populations?

Secretary BECERRA. Congresswoman, we are making every effort to try to encourage states to adopt culturally competent programs, so that they can reach the populations that are often neglected or underserved. We continue to try to stand up opportunities for them to get funding to increase the number of clinicians and professionals who are coming from communities where there is a shortage of those individuals.

We could use more resources to truly push the envelope on this, but we are making every effort, for example, to also collect data. That gives us a better sight on where there are absences of the professionals that we need. We are trying to also recruit people, help states recruit people who have lived experience, so that when they

go out to be the professional, they have gone through some of those experiences that they are now trying to help people with.

Ms. OMAR. Yes. It looks like those impacted are getting younger and younger. I know that there are resources that are focused on education and deterrence. What do you think can be done to better assist folks who are already addicted, as well as the parents considering that many of those suffering are under the age of consent and need their parent's approval for treatment?

Secretary BECERRA. I had mentioned on several occasions already how we are trying to get states to adopt Medicaid innovations that would allow us to use Medicaid dollars in a school to provide behavioral health services in a school, so a child and a family member do not have to wait until you find a doctor that you can send your child to help with substance abuse or mental health services.

We are hoping—there are about 15 states that have worked with us to change their programs, their Medicaid programs, to accept those dollars. We have several programs, one called Project Aware, that is specifically focused on children to try to help them address issues like drug use, suicide prevention, and we are trying to expand those services working with states to see if they will adopt them.

Ms. OMAR. Our kids are really in desperate need, so I hope those services reach them. Thank you so much.

Chairwoman FOXX. Thank you. Mr. Kiley, you are recognized for 5 minutes.

Mr. KILEY. Mr. Secretary, under Federal law folks who are here illegally in this country are not eligible for Medicaid benefits, but some states have circumvented this by using State funds to expand eligibility for their Medicaid programs to the entire population of undocumented immigrants. Do you support those initiatives?

Secretary BECERRA. Congressman, they have not circumvented any law, they are just using their own State resources to do what they want for the populations in their State.

Mr. KILEY. Do you support those initiatives?

Secretary BECERRA. Absolutely.

Mr. KILEY. You do? You support expanding eligibility like your own State of California has, at a cost of 3 billion dollars to every person who is in the State illegally?

Secretary BECERRA. The State has decided it wants to make sure as many of its people, if not all of them, have access to healthcare.

Mr. KILEY. You just said you support that. Is that an administration policy, or your policy?

Secretary BECERRA. You asked me, and I answered as an individual.

Mr. KILEY. You do. Okay. Do you know if the administration has a position on it? Do they agree with you and support that policy?

Secretary BECERRA. The administration would not interfere with a state's decision to use its own money.

Mr. KILEY. Sure. You said you support it, so does the administration support expanding eligibility for Medicaid programs to all undocumented immigrants?

Secretary BECERRA. Congressman, as you know, we use Federal dollars, and we make sure the Federal dollars are used properly. A State can use its State dollars as it wishes.

Mr. KILEY. Okay. You support it personally, but not necessarily the administration?

Secretary BECERRA. No. I do not want to speak for the administration because we would not have a position on how a State, your State, my State, uses its own dollars.

Mr. KILEY. I am sure you do, you would, I mean there are all kinds of positions the President has about what states are doing, but he has not spoken his position.

Secretary BECERRA. Okay. Then you can ask the President.

Mr. KILEY. Okay. You started your testimony by talking about COVID, and you said we can now manage it like the flu. There are 30 universities in this country that still have COVID–19 vaccine mandates for students. Do you think it is time they ended those?

Secretary BECERRA. They are managing it.

Mr. KILEY. I am sorry?

Secretary BECERRA. We are trying to manage COVID, and everyone can manage it as they see fit.

Mr. KILEY. Well, that is certainly not how the administration conducted its policy during the pandemic, there were all kinds of mandates and various programs. Is there any authority, health authority under your jurisdiction that at this point even recommends universities to have COVID vaccine mandates?

Secretary BECERRA. The recommendations principally put out by the CDC show best practices that everyone could employ.

Mr. KILEY. Right, so do they recommend vaccine mandates at universities right now?

Secretary BECERRA. The recommendations are pretty clear. States can then do what they wish.

Mr. KILEY. Is that a yes or no for universities?

Secretary BECERRA. It is the states have the ability to do what they believe is best for their populations.

Mr. KILEY. Just right now, you as the Secretary of Health and Human Services, you have no opinion on whether it is a good thing for these universities to continue their COVID vaccine mandates in May 2024?

Secretary BECERRA. Well, we have expressed what we think is best practice in those policies that have been articulated by the CDC.

Mr. KILEY. Okay. Is it best practice right now for a university to have a vaccine mandate for COVID or not?

Secretary BECERRA. Well, the best practices have been set out by CDC, then any entity, whether it is a university or State then decides how it wants to move forward.

Mr. KILEY. What is the best practice for a university? Should they have vaccine mandates now? Yes or no?

Secretary BECERRA. There are thousands of universities. I am not going to speak for thousands of universities.

Mr. KILEY. Are you familiar with the biolab that was discovered in Reedley, California, that was set up with links to China?

Secretary BECERRA. I am familiar with it.

Mr. KILEY. This was, you know, discovered last year, or maybe even sooner, and there were all kinds of pathogens there. It was actually set up by an international fugitive named Jesse Zhu who is currently under Federal indictment. Local officials found patho-

gens like E. Coli, hepatitis B, hepatitis C, HIV and malaria and others, and yet when local officials reached out to the CDC for help, they refused to provide it.

This is from a report from the Select Committee on the Chinese Communist Party. It says, "Based on their initial observation in March 2023, local officials began to reach out to additional Federal authorities for assistance. Local officials spent months repeatedly trying to obtain assistance from the CDC, but the CDC refused to speak with them."

On a number of occasions it was reported by local officials that the CDC hung up on them mid conversation. Why did the CDC not come in and try to help when local officials discovered the situation?

Secretary BECERRA. I do not think that is an accurate representation of what CDC has done.

Mr. KILEY. They did. You disagree with the Committee's report?

Secretary BECERRA. I do not think it is an accurate description of what CDC has done.

Mr. KILEY. I see. Did the CDC test the samples they found at the lab?

Secretary BECERRA. I would have to get back to you on what the CDC precisely did.

Mr. KILEY. According to the report here, the local officials asked them to test the samples, these dangerous pathogens, and they did not do so. Does that sound inaccurate to you?

Secretary BECERRA. I think you are leaving out a good part of the story.

Mr. KILEY. What part is that?

Secretary BECERRA. I would have to get back to you. I do not have a direct understanding right now. Again, I came to testify on the budget, but I can get back to you and let you know what CDC did, or did not do.

Mr. KILEY. Do you have confidence right now that there are not similar labs with links to the Chinese Communist Party in the United States?

Secretary BECERRA. Recognizing that these labs are licensed by the states, the 50 states, and not by the Federal Government, it would be difficult for me to answer that question. I do not—the states do not work for me.

Mr. KILEY. Well, I mean but you do have responsibility for public health in this country, and so right now as the Secretary of Health and Human Services, do you have confidence that there are not similar illegal biolabs like the one that was discovered in Reeley throughout this country?

Secretary BECERRA. I do not know what every State has in its governance rules for the establishment of some of these labs, so if the question is do I have confidence that all the states are doing the right thing, I have to say probably not.

Mr. KILEY. Thank you. I yield back.

Chairwoman FOXX. Ms. Hayes, you are recognized for 5 minutes.

Ms. HAYES. Thank you. Thank you Mr. Secretary for being here. I want to talk to you a little bit about social determinants of health, which as you know are conditions where the environment

that people are born in, live in, work in, learn, play, worship, affect their healthcare outcomes.

As of January 1, 2024, the Center for Medicare and Medicaid Services began requiring healthcare organizations to screen for the five risk factors, which they determined to be food, food insecurity, interpersonal safety, housing insecurity, transportation and utilities.

I know that the Department has done work in this area, but my concern is states are really unclear as to what this can look like. In California and West Virginia, they have done some of these things, but there really is no clear—I hesitate to use the word roadmap, because I know that the Department has a roadmap, but it is not clear guidance. The thing I want to ask you about today is that under the ACA 85 percent of premium dollars are directly toward patient care, and then the other 15 percent are the medical loss ratio formula.

The things I just talked about—those social determinants of health are not included under the patient care section. Is there—can you speak a little bit to how we can change that and start to look at some of those determinants as part of the entire healthcare spectrum?

Secretary BECERRA. Absolutely, and thank you for the interest in addressing social determinants of health. By statute we are either constrained or permitted to do a certain number of things. Social determinants of health, if you look through most statutes, are not included in the provisions of most statutes.

What we are doing is trying to elevate the issue of what can cause bad health, or bad health outcomes, which as you just mentioned, can include social determinants of health. We are making every effort we can to make sure that anyone who is out there doing healthcare recognizes that if you are not addressing these social determinants of health, you are missing the boat in trying to keep people healthy.

Ms. HAYES. Thank you. I appreciate that. I introduced legislation called the Social Determinants for Moms Act, which really talks about how all of these things, as they relate to maternal health, and my legislation was included as part of the Black Maternal Health Momnibus.

It asks for the creation of a task force to better address these things in this country. Do you think that the creation of a task force to at least collect data on these things would be a step in the right direction?

Secretary BECERRA. Absolutely. Although we need to do more because we need to be able to change statutes or regulations to include social determinants of health.

Ms. HAYES. Switching gears here a little bit, I want to talk about the final rule that was issued recently by the Department of Health and Human Services. Can a doctor be investigated criminally or administratively for providing care to me for cancer?

Secretary BECERRA. Can you repeat the question?

Ms. HAYES. Sure. Is it—let me see how I want to ask this question, I am trying to get somewhere. Can I be discriminated against for providing care if I had cancer?

Secretary BECERRA. For not providing you care?

Ms. HAYES. Yes?

Secretary BECERRA. Again, you have to put it in context. Is that—is the person working in a place that holds itself out as providing——

Ms. HAYES. As a woman. If I—I guess I am trying to get to the point if I had cancer, if I had heart disease, if I had a mental health condition, if I had osteoporosis, could a doctor, would a doctor be investigated for providing care? Would I be investigated for seeking care? Would I be investigated for obtaining care?

Secretary BECERRA. I think I hear what you are—if they are receiving reimbursement from the Federal Government, then they would have to offer you the care.

Mrs. HAYES. If I sought——

Secretary BECERRA. Unless they have a religious objection.

Mrs. HAYES. If I sought abortion care would I have the right to have that care or doctor deny me that care?

Secretary BECERRA. You would have the right to have that care if they are seeking reimbursement by a Federal department, Medicare, Medicaid, if it is required by law.

Mrs. HAYES. Thank you. If it is required by law, thank you. In my last few seconds, I do want to bring up something that I have heard talked about on the other side a lot about the care of unaccompanied minors at the border. I want to remind my colleagues that in the last administration we had a crisis of understaffing, of children being lost, of us not really knowing.

I want to commend the Department for some of the work that they have done to improve these programs. 24/7 case workers, increased shelter networks, increased post-release services. My time is running out, but I want to say that unlike the child welfare system, you do not have the ability to monitor children after they leave your custody, even if they are with a vetted sponsor.

Secretary BECERRA. That is correct.

Mrs. HAYES. So, I guess you could followup and say what are some legislative fixes that Congress could make to make sure that our connection to these children goes beyond the point where they are turned over to family members or loved ones, so that we can make sure that they are in fact safe, and not falling victim to unsavory actors or trafficking or some of the other things that have been brought up in this Committee hearing today.

Chairwoman FOXX. We will invite the Secretary to put those suggestions in writing. Ms. Chavez-Deremer, you are recognized, and I note you have your father with you today, and we welcome him.

Ms. CHAVEZ-DEREMER. Thank you. Thank you, Madam Chair. Secretary Becerra, the Low Income Household Water Assistance Program, administered through HHS makes a huge difference for low-income households, as you know, assisting with water and wastewater bills. It is really a great example of how government is working for the people.

For those who do not know, if the water is about to be cutoff due to inability to pay the bill, or something far too real, it makes it difficult for families. This program makes sure that that water can stay on. All Oregonians, all Americans, for that matter deserve reliable access to clean water.

In fiscal years 1921 through 1923, Congress provided 1.1 billion dollars for this program, helping over 1.6 million families. Even so, utility costs have been skyrocketing to compensate for the historic underpricing of water services, as well as to pay for the rising costs of infrastructure, aging, deferred maintenance, sporadic trends in customer bases, and even the ever-constant burdens of regulatory compliance.

The government needs to act, that is why Congressman Sorenson, and I introduced a bill to permanently authorize this program, so that safe and reliable water services always reached those who need it most. Mr. Secretary, can you speak to some of the highlights of this program's functionality at HHS? With that, do you foresee HHS continuing to adequately administer this program? Should it be authorized and funded in future years?

Secretary BECERRA. Congresswoman, thank you for the question, and congratulations on having your father here.

Ms. CHAVEZ-DEREMER. Thank you.

Secretary BECERRA. I remember the first time my dad came he was very proud, so I imagine he is extremely proud of your accomplishments.

Ms. CHAVEZ-DEREMER. Thank you.

Secretary BECERRA. Very important, you and I come from areas where often times there is a ton of water, and then sometimes there is drought.

Ms. CHAVEZ-DEREMER. Or at the same time.

Secretary BECERRA. At the same time, yes. We have to adjust the way we think of energy, electricity, we have to recognize that water is indispensable, and so we would love to work with Congress to make sure that we have a program in place that can continue to provide families with the resources they need to just basically live.

Ms. CHAVEZ-DEREMER. Great. Thank you. I want to move on to another subject that is important. HHS has played a critical role in cannabis reform, and I want to applaud both you and your team for that. Earlier this month the country took a huge step forward thanks to the research your agency conducted, the DEA finally rescheduled cannabis.

In response the Department of Justice for the first time in half a century has said it will treat Federal cannabis violations as low-level offenses. As a proud lead of the state's 2.0 Act, which would ensure that every State has its right to determine the best approach to cannabis within its borders, this was really good, welcoming news.

Federal guidance has always been a nightmare in this space, and it is more important than ever to create a safe and professional environment for one of the fastest growing industries in America. This has proven to be a responsible process, but unlike Oregon's approach which was to decriminalize all drugs at the same time, was not a good plan.

Three years ago, Oregonians voted for Measure 110. I hope you are familiar with what I am talking about because they told Oregonians that it would reduce drug abuse. Instead, drug abuse exploded and people fighting addiction have been left to fend for themselves. Then thankfully, there was a small fix in the legisla-

ture this year that would somewhat repeal and really answer the cries that people were asking, it was not the right approach.

Unfortunately, law enforcement, healthcare and homelessness providers and homelessness, which is a growing sector in our community, they're really suffering from this addiction. Mr. Secretary, as the former Attorney General of California, and now head of HHS, what are the lessons do you believe that were learned from Measure 110, if you are familiar, and as the United States is rapidly growing toward classifying cannabis with its possible Federal legalization, how can we ensure that Measure 110 will not be a mistake that is made across the country?

Secretary BECERRA. Congresswoman, you said a mouthful.

Ms. CHAVEZ-DEREMER. I know.

Secretary BECERRA. Let me see because I am aware of the measure. I do not know the details of it, I know that they are——

Ms. CHAVEZ-DEREMER. Let me give you the details.

Secretary BECERRA. Sure.

Ms. CHAVEZ-DEREMER. We recognize addiction is a serious problem. We know that access to drug treatment is important in a healthcare approach that is fair and reasonable, but that particular legislation means no arrests anymore, only given a citation.

For that citation, if you call 1–800-I-Need Help With Drug Addiction, you could pay, you know, forego your $100.00 fine. What did that lead to? It led to mass amounts of drugs on the streets, an open market, and we were not helping the people who needed it most. It did not work. That being said, Mr. Secretary, our Governor did not do us any good in Salem, and she kept Measure 110 on life support.

I find that unfortunate, but I need you to commit to my office that the states act in any future legislation will deal with it as you did in other areas, and not continue with really the failed process of decriminalization of cannabis in other ways as it followed Measure 110.

I would like your support and connection on that issue.

Secretary BECERRA. More than willing to work with you on some of these issues. Remember, the cannabis action has not yet been finalized, but more than willing to work with you. We work based off of evidence, and so whatever we do has to be evidence based.

Ms. CHAVEZ-DEREMER. Thank you. With that, Madam Chair, I yield back.

Chairwoman FOXX. Thank you. Ms. Leger Fernandez, you are recognized for 5 minutes.

Ms. LEGER FERNANDEZ. Thank you so much Chairwoman Foxx and Ranking Member Scott. It is great to see you again, Secretary Becerra, although I must admit it was a lot more fun when we were talking about rural health and there was mariachis, great art and food trucks, but here we are.

Secretary BECERRA. Those food trucks are not bad.

Ms. LEGER FERNANDEZ. For too long, and I know you were just a year earlier, the country has suffered from opioid epidemic, and 2022 nearly half of young adults, age 18 to 25 had either mental illness, or substance use disorder. I do not want to see another headline of a promising young person lost to overdose.

That is why I am introducing, and I am working with the Committee around my Campus Prevention and Recovery Services for Students Act. Right now, colleges must operate programs to support students struggling with addiction. My bill makes sure those programs are evidence based, and the Department of Education coordinates with SAMHSA.

Secretary Becerra, can you tell us why we need to focus on evidence-based programs to address addiction, and how SAMHSA can be a key partner to the Department of Education, and these schools?

Secretary BECERRA. Congresswoman, thank you for the work you do here because what we are finding, and we probably have anecdotal evidence in our own homes, that oftentimes young people do not connect the facts with what they are doing, what they are seeing.

They think it may not be a problem if you have four or five drinks and that that is not going to cause you any issues. Or they may not believe that there may be harm if you are taking particular drugs, even something like marijuana. It is important that we have data that shows what the true facts are so we can present that to our children, so they have a better understanding of what might come before them.

Ms. LEGER FERNANDEZ. Thank you. Working with SAMHSA will be key for us. At the CHC on the Road event we had extensive discussion on the risk of closures of rural hospitals. Over 30 percent of all rural hospitals in the country are at risk of closing. In my district alone, Alta Vista Regional closed its labor and delivery unit, Portales, the Roosevelt General Hospital reduced its staff hours.

One bright spot, however, is HRSA's Delta Region Community Health Systems, which provides assistance to strengthen local healthcare systems across the Mississippi Delta region. HRSA does not currently fund similar grants in any western rural communities.

Secretary Becerra, do you think that western rural states like New Mexico would benefit from a similar program, and how can we work together to make that happen?

Secretary BECERRA. One of the things that the President—President Biden has done is given us opportunities and resources to focus on rural healthcare systems because as you have said, they are very stressed, but we could use more support to make that happen. You mentioned that the Delta Region Community Health Systems program, which has been very successful.

I suspect there are other regions of the country similar in scope that could also benefit, so I would be more than willing to work with you on something like that.

Ms. LEGER FERNANDEZ. Okay we will look at that. I know it comes down to funding as well, and we need to remember, and people on this Committee need to remember we want to support some of the positive programs that you have heard on both sides of the dais here, it takes resources.

We both grew up in bilingual households and understand the importance of making sure our workforce is culturally and linguistically competent. In my district alone 34 percent of households

speak a non-English language at home, and we know immigrants—immigrants get the job done, right?

We are vital to our future success as a Nation, including adding seven trillion dollars to the economy in the next 10 years, seven trillion. One trillion dollars in government revenue, right? We are paying taxes. We are key. Immigrants are key to our success, so we must make sure that we can also serve them in our medical environments, take care of their healthcare because they so often take care of us.

Can you share with us how HHS is expanding the number of bilingual physicians?

Secretary BECERRA. Congresswoman, thank you for the question, and as a son of immigrants I can attest to what you have just said. What we are trying to do is make sure that as we expand the network of especially community health centers, that they are able to provide the services that are needed by the populations around them. More and more we are finding that to offer the linguistically and culturally competent care that is required, you really do need to bring in a workforce that can do that immediately.

We are trying to support those efforts to try to bring in more physicians, more nurses, more healthcare providers, who come from communities that are often disadvantaged.

We are also trying to make sure that we support services so that the communication between those communities and the healthcare providers are sufficient because sometimes if the communication is not sufficient, the wrong information gets passed, or insufficient information gets passed, and you could have terrible health outcomes. We know that there is a lot of work that we can do.

Ms. LEGER FERNANDEZ. Thank you very much. Indeed, bilingualism is a superpower, and I want to thank you for that work. My time is expired, and I yield back, Madam Chair.

Chairwoman FOXX. Thank you, Ms. Leger Fernandez. Mr. Bean, you are recognized for 5 minutes.

Mr. BEAN. Thank you very much, Madam Chair. A very good afternoon, Mr. Secretary, welcome back. I have got my very first question is something that unites us all, how about that. It also unites the American people because we're fired up. We are all fired up against people stealing our money.

Medicaid and Medicare fraud, how much? Do we know how much is being stolen before our eyes, Mr. Secretary?

Secretary BECERRA. We do not have a precise number, but we know that there are folks who are always gaming the system.

Mr. BEAN. It is a very big number, and how about this? I have got a report from the National Healthcare Anti-Fraud Association, there is such an association that does a little tracking. They say it is 100 billion. Does 100 billion sound about right, or is that just getting started?

Secretary BECERRA. You know, I have heard many numbers, but I would not be surprised.

Mr. BEAN. It is a big number. Mr. Secretary, the American people tell me we want our money back, and hopefully that we are going after it. CNBC just did a little news story where they interviewed crooks that are stealing our money, and they say—the crooks say, it is just so easy.

It is unbelievable. I know that the administration is pursuing and persecuting people, some will say that have not committed crimes at all, but what are we doing to go after bad guys that are stealing our money?

Are we putting them in jail? Are we going after them?

Secretary BECERRA. We are. We have a team at HHS who does investigations. By the way, we are proposing four billion dollars to help us do the investigation, for fraud detection. For every dollar we have asked we agree to return about three to five dollars to the taxpayers.

Mr. BEAN. Do we track that? We should put that on a website. This is how much money we have got back. Now when you find somebody that has committed fraud, do we kick them out of the program, and can we ban them for life? Do you do that, Mr. Secretary?

Secretary BECERRA. We try to remove those who have violated the law.

Mr. BEAN. I hope we do because we want our money back. There is an issue, you know this, the American people who have health insurance and are covered sometimes get surprised by medical billing. They think they either go in for a procedure, or have an emergency procedure, and they get multiple bills, yet they had health insurance.

Congress, 2 years ago, passed the No Surprises Act to say enough. The only surprise has been the implementation of your administration that is kind of fumbled the ball, or at least that is what doctors are telling me. They are telling me it is a big surprise that it is not done yet. Is this on your radar screen, Mr. Secretary, to fix this problem?

Secretary BECERRA. Absolutely. Everybody saw the new game in town, and everybody tried to get in, and only certain ones were eligible and so that is what caused some of the chaos.

Mr. BEAN. I hope you will consider that I meet with doctors. There are anesthesiologists, there are dermatologists, there is everybody here say it, we cannot get relief.

Secretary BECERRA. The good thing is, the consumers are now out of that food fight.

Mr. BEAN. Let us hope so, but people are not getting paid, and it is no fun to work for free, and that is what is happening. Mr. Secretary, Florida, and I represent the free State of Florida, the Florida Department of Children and Families just put out a report this week citing disturbing findings, and that is that NGO's, nongovernmental organizations operating under the guidance of the Office of Refugee Resettlement, under your leadership, are placing children in unsafe, unvetted settings.

Even worse, are explicitly prohibited from reporting concerns to law enforcement. Are you aware of this report?

Secretary BECERRA. Actually, the State of Florida took the initiative to remove the licensing requirement for these care centers, which does not make any sense.

Mr. BEAN. Well, it does not make any sense that this report has come out that is devastating. I know we have talked about the 85,000 kids that are missing that we cannot find that you have called. I know you are calling to try to locate them, but we are still

putting them, according to this report, we are putting them in places that you do not.

Secretary BECERRA. It is not accurate, but I understand what you are trying to say.

Mr. BEAN. 10–4, so you are aware of their report. I know just earlier you talked about if a kid comes to our border and crosses the line, and you gave the example of a 15-year-old kid. A 15-year-old kid wants a hearing. Then that 15-year-old kid is not sent back home, they are allowed to stay and given a hearing.

What if that kid is 12 years old and says I want a hearing. Would we do that for a 12 year old?

Secretary BECERRA. If an individual crosses the border and says I am seeking asylum by law——

Mr. BEAN. Even 12? 12? Okay. 9? 7? What age do we say you know what, you belong with your parents? What age? You said a 12 year old can do it. They cannot get a tattoo in America because they are not old enough, but you are saying a 12 year old can say I am leaving my family, and we keep them, so a 7-year old?

Would you say a 7-year old is enough to say I want a hearing, and you would not say you need to stay, we are not going to put you back with your parents? Is that what you are saying, Mr. Secretary?

Secretary BECERRA. It is not what I say, Congressman, it is what you and Congress have said, and by statute you say that if an individual requests asylum.

Mr. BEAN. Mr. Secretary, I just think it is unacceptable as a parent that if you have these young kids are coming in and we not only are losing them, but we are not putting them back with the family.

Secretary BECERRA. Then you have to change the law.

Mr. BEAN. Thanks for coming out today, and with that Madam Chair I yield back time.

Chairwoman FOXX. Thank you, Mr. Bean. Ms. Houchin, you are recognized for 5 minutes.

Ms. HOUCHIN. Thank you, Madam Chair. Thank you, Mr. Secretary for coming before us today. I am going to pick right up where Mr. Bean left off because I too am a mom who is very, very concerned about the number of kids who have gone missing, unaccompanied minors who have gone missing under your watch. You have said repeatedly.

Secretary BECERRA. Congresswoman, let me repeat again, no child has gone missing under our watch.

Ms. HOUCHIN. Excuse me, it is my time.

Secretary BECERRA. No child has gone missing under our watch, just to correct you.

Ms. HOUCHIN. No children have gone missing on your watch?

Secretary BECERRA. Under our watch, no child has gone missing.

Ms. HOUCHIN. You know where all of those 85,000 kids are?

Secretary BECERRA. Those children that are in our custody, we know where they are.

Ms. HOUCHIN. The ones that are in your custody, okay. You keep repeating that.

Secretary BECERRA. It is hard for me to contact people I do not have custody over.

Ms. HOUCHIN. Let me—this is my time, Mr. Secretary. I am looking at a report from Axios, back in 2021, and this says this is critical of the Trump administration. Roughly one in three calls made to release migrant kids and their sponsors went unanswered, raising questions about the government's ability to protect minors after they are released to family members, or others in the U.S.

Mark Greenberg, who oversaw the unaccompanied and minors' program during the Obama administration was briefed on Axios's findings and says that is very dismaying. If large numbers of children and sponsors are not being reached, that is a very big gap in efforts to help them. Under the Trump administration, Axios reported that there were 1,500 kids that he lost that could not be accounted for, 1,500 kids under the Trump administration.

Under your administration that number is close to 85,000. On March 1, 2023, the Homeland Security Act of 2022 transferred responsibility for the care and placement of unaccompanied children from the Commission of the Immigration and Naturalization Service to the Director of the Office of Refugee Resettlement.

Who does the Office of Refugee Resettlement, who does that Director report to?

Secretary BECERRA. Congresswoman, if you want us to have jurisdiction over these children you can give us that authority by law. Right now, we do not have the authority to follow these children, and that is why it is inaccurate for you to say that we have lost any of them.

Ms. HOUCHIN. Let me just go on. Let me just go on because I think that is inaccurate.

Secretary BECERRA. I wanted to correct the record because you have misstated what we do at ORR. I just wanted to correct the record, Congresswoman.

Ms. HOUCHIN. Excuse me, this is my time. Please stop filibustering.

Secretary BECERRA. I understand Congresswoman, I just want to correct the record of what you said.

Ms. HOUCHIN. Madam Chair? Office of Refugee Resettlement is under the Department of HHS, that is your department. Since then, since March 1 of 2003, ORR has cared for thousands of children incorporating "child welfare values." ORR takes into consideration the unique nature of each child's situation, and incorporates child welfare principles when making placement, clinical case management, and release decisions that are in the best interest of the child.

Are 85,000 missing children, is that in their best interest?

Secretary BECERRA. Again, Congresswoman, you are mischaracterizing what is going on.

Ms. HOUCHIN. I do not believe I am, sir. I worked in child welfare, and what is happening——

Secretary BECERRA. If you think 85,000 children are missing, why have you not tried to pass a law to make sure we could find them? If you are so concerned.

Ms. HOUCHIN. I believe that is what happening is you are releasing them from your custody. That is what I believe is happening.

Secretary BECERRA. No. We are doing what our law requires ma'am.

Ms. HOUCHIN. Is that under ORR authority that it is your responsibility to care for those children.

Secretary BECERRA. While they are in our custody.

Ms. HOUCHIN. It is your responsibility to watch out for them, it absolutely is.

Secretary BECERRA. Okay, but you do not recognize and understand the law. The law has not given us the authority to do what you just said, Congresswoman.

Ms. HOUCHIN. Let me go back to according to the FBI more than 98 percent of all children that go missing in the United States are found, however less than 1 percent of all migrant children reported missing to HHS between October 2019 and April 2023 have been found. This I would like to submit for the record, this is from the Center for Public Integrity.

A spike in reports of missing and runaway migrant kids. Beginning in 2020 up to 2022, we see if you can see a huge spike in the number of reports of missing and runaway migrant children, again, under HHS authority, only 1 percent of those——

Secretary BECERRA. They are not under HHS authority ma'am. I keep trying to clarify that for you.

Chairwoman FOXX. Without objection.

[The information of Ms. Houchin follows:]

The Center for Public Integrity

IMMIGRATION

Reporting on missing migrant children

How reporter Kristian Hernández uncovered a growing trend of missing migrant children in the U.S.

by **Kristian Hernández**
April 2, 2024

The Agua Blanca valley in Huehuetenango, Guatemala, in December 2018. This region has one of the highest child malnutrition rates in Central America and the most unaccompanied minors coming to the U.S. (Kristian Hernández / Center for Public Integrity)

Reading Time: 4 minutes

I started reporting on missing migrant children four years ago, almost by accident. I was trekking up a steep muddy road in the northern highlands of Guatemala, looking for the mother of a 16-year-old who drowned in the Rio Grande, when a man outside a small chapel greeted my fixer and me. The man waved and asked if we needed help.

We stopped for a minute to catch our breath. Half panting, I shared with the stranger that I was investigating a story for the Center for Public Integrity about **migrants who died crossing the U.S.-Mexico border**. The man, a local pastor, looked out over a vast valley and said there had been many cases there involving migrants who crossed into the U.S. and were never heard from again. Most, like the boy I was reporting on, were children who left on their own, looking for work in order to help their family escape poverty and hunger.

For the past year, I've been trying to find out what happened to the more than 700,000 migrant children who came to the U.S. alone during the past decade. Underpinning that was a question: Why did they embark on such a dangerous journey?

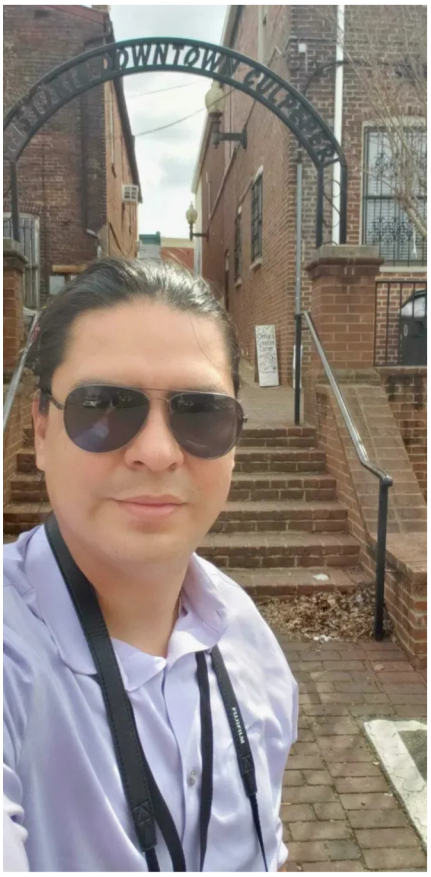
In order to understand what forces young children to leave their countries, I've **traced the long-established family networks that brought them here** and **studied the origins of child migrant labor in the U.S.** I've also tried to counter, through **their own voices**, the **lies and misconceptions about these children** reverberating from the halls of power.

As part of a 10-month investigation in collaboration with Scripps News, we uncovered that every year, **thousands of migrant children disappear** from their homes shortly after arriving in the U.S. But there is no clear local, state or federal government agency taking responsibility for searching for many of these missing children or investigating why a growing number have disappeared.

According to the FBI, more than 98% of all children that go missing in the U.S. are found. But the numbers for migrant children are grim. Less than 1% of the 3,340 migrant children reported missing to the U.S. Department of Health and Human Services between October 2019 and April 2023 have been found.

HHS's Office of Refugee Resettlement would not release information about where these kids were reported missing, so Scripps News investigative producer Karen Rodriguez and I filed dozens of open records requests with local law enforcement departments, large and small. But almost all of them denied our requests, citing open cases or juvenile privacy laws.

The small town of Culpeper, Virginia, was one of the few that gave us access. Thirty-five migrant children, mainly from Guatemala, have disappeared from there since 2017. Sgt. Norma McGuckin, a detective with the Culpeper Police Department, said that getting the children's faces on TV would help her find the 26 still missing.



Journalist Kristian Hernández pauses for a photo on a 2023 reporting trip in the small rural town of Culpeper, Virginia, where at least 35 unaccompanied migrant children have gone missing since 2017. (Kristian Hernández / Center for Public Integrity)

Scripps News reporters and I visited Culpeper several times to talk with local officials and sponsors the missing migrant kids had lived with before disappearing.

And our analysis of previously unreleased federal data of nearly 400,000 unaccompanied minor placements revealed how a growing number of these children were being sent to live with distant relatives and unrelated sponsors. These placements correlated with an unprecedented influx of unaccompanied minors during the Covid-19 pandemic, when the U.S.-Mexico border was closed to almost everyone except these children.

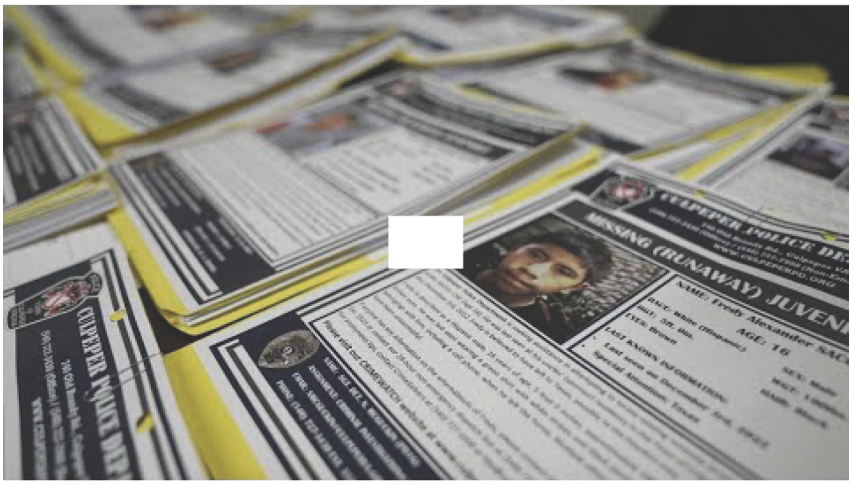
In Culpeper, many of the migrant kids reported missing were placed with strangers and ran away shortly afterward. The 15 children found by McGuckin left to live with family members in the U.S. or to find work. But the sponsors who reported the migrant children missing had very little information to help police find them.

It was like “looking for ghosts,” McGuckin said as she tried to describe the difficulties of her job. Sometimes she didn’t even have a photo of the missing child to make a flier that could be posted alongside pictures of other missing children.

As we continued our reporting and followed the sergeant’s work for months, we discovered major discrepancies in how the federal government shared information with law enforcement.

We contacted HHS, asking why it denied information in its case files to some investigative agencies. HHS denied multiple interview requests. However, we also brought our findings to the attention of

state and local officials and the Guatemalan Embassy in Washington, D.C., which raised the same concerns to the federal government.



Four months after our first inquiry, the Office of Refugee Resettlement, or ORR, updated its policy to allow local law enforcement immediate access to photos and potential contact information after a migrant child is reported missing.

But the most important thing we found after studying Culpeper: While thousands of migrant children are missing, they're not all being trafficked or exploited, as dozens of Republican U.S. lawmakers and state attorneys general have claimed for the past year.

Republican officials accused the Biden administration of losing 85,000 migrant children who came to the U.S. alone. But the 85,000 figure refers to the number of children who could not be reached during follow-up calls, also known as welfare checks, ORR representatives make after a child is released from federal custody. The number was reported by the **New York Times in February 2023**.

Our investigation found that ORR received 6,318 calls, mostly from sponsors, reporting missing or runaway migrant children between January 2018 and April 2023. We also found that the number of calls more than doubled every year since 2020.

The story provided the first real numbers behind the story of missing unaccompanied migrant children and highlights the systemic failures leading to their growing numbers nationwide. But most importantly, our story helped change a policy that was keeping investigators like McGuckin from accessing vital information that could help them find these kids.

I am proud to share that our story was republished by more than 50 news outlets since it went live on February 23, including news organizations on both extremes of the U.S. immigration debate. We are also providing data and tools to local reporters across the country to help them conduct their own investigations.

Investigative journalism takes time. It has many challenges and unexpected turns. But it's worth the investment because stories like this can help bridge the gap on issues such as immigration where people are so far apart that they've stopped listening to each other and fail to see the full picture.

Ms. HOUCHIN. Thank you, Madam Chair. I am extremely frustrated as a mom, as a former child caseworker, you know, it was—Democrats were very critical of Donald Trump and his administration when there were 1,500 kids that fell into this category. Under this administration there is an unbelievable number of 85,000 missing migrant children.

I would encourage the Department to not release these kids when they find placement, and to keep track of them for their own personal safety. With that I would like to yield the remainder of my time to Representative Owens.

Mr. OWENS. Thank you. Thank you so much. I just have to clarify a couple things. The rule that we talked about earlier says that the gender identity of sexuality is protected under Title six discrimination. I want to clarify. You mentioned that the doctors are not forced to, they are not punished. What about the institutions that hire these doctors?

If the institutions that hire these doctors tied into your Federal funds do not adhere to this discrimination that this rule is now tied to, are they defunded, are there taken away funds?

Secretary BECERRA. Congressman, I hope you understand the way the——

Mr. OWENS. One at a time. It is a yes or no, are you punishing the institution?

Secretary BECERRA. We are not punishing, no.

Mr. OWENS. There is no punishment for breaking the rule?

Secretary BECERRA. These institutions understand what they are supposed to do if they are going to take Federal dollars.

Mr. OWENS. Okay. You are going to punish—you take away the dollars, right?

Secretary BECERRA. No. We—they decide that if they want to take a Federal dollar, they must follow Federal rules.

Mr. OWENS. You will take away their dollars, they are deciding, but you are putting that out if they do not——

Chairwoman FOXX. Mr. Owens, we will ask the Secretary to please respond more thoroughly to the question.

Secretary BECERRA. Which question is that?

Chairwoman FOXX. From Mr. Owens. I will get—make sure that question is clarified. Thank you.

Secretary BECERRA. Thank you.

Chairwoman FOXX. Mr. Moran, you are recognized for 5 minutes.

Mr. MORAN. Thank you, Chairwoman. Secretary Becerra, I want to talk to you about something that I think is very bipartisan, so let us take a deep breath. I know a lot of stuff we talked about here today is partisan in nature, and frankly, a lot of it we disagree with. I think there is something we can agree on, and that is we can agree on the protection of children from child abuse.

We can agree that we should not just prevent it, but we should protect those that are in those situations and get them out as soon as possible. Would you agree with that?

Secretary BECERRA. I would.

Mr. MORAN. Yes. Mr. Secretary, the Child Abuse Prevention and Treatment Act, also know as CAPTA authorizes grants to states to assist communities to prevent child abuse and neglect. Your department is tasked with overseeing the implementation of CAPTA as you are aware.

I believe that as I mentioned everybody here should be on the same page with trying to prevent sexual abuse, and the exploitation of children. It is awful, and it should be stopped. I am sure you agree with that as you said, correct?

Secretary BECERRA. As I say, no child should be abused.

Mr. MORAN. That is right. I am sure you are also aware that a high number, a high percent of abusers are actually connected either by family or close friendships to those that they abuse. Are you aware of that as well?

Secretary BECERRA. I think you are accurate.

Mr. MORAN. Yes. The numbers that we see across the board is about 90 percent of those that are being abused are being abused by those that are closest to them, and that is just so despicable. In Texas, the average child spends about 7 hours a day in their school system. That means that most students are spending a good portion of their day, sometimes more with teachers and with staff, and school personnel than they are with their family members at home.

That provides an opportunity for them to cry out when necessary. That also provides an opportunity for those teachers and staff to recognize those students that are being abused throughout the day, and then to help step in, in that moment. Would you also agree with that?

Secretary BECERRA. You said a lot. For the most part I do believe that we have to make sure that we are providing ways for children to communicate that they are being abused, or to be able to spot the abuse.

Mr. MORAN. Yes. In fact, skilled personnel are critical to help identify child abuse cases. I think they account for about 52 percent of all identified child abuse cases that are actually reported. With that in mind, I strongly believe that lots of child sexual abuse can be prevented or stopped through our educational institutions with enhanced prevention policies and enhanced opportunities for guidance in that area.

Do you believe it is important for teachers, school employees, and other care givers who work with children to be educated about the signs of children being sexually abused?

Secretary BECERRA. I know in some areas of the country they do receive some training, but certainly I think the more that are teachers, and those who have—who are surrounded by children most of the time should have some training.

Mr. MORAN. Yes. I agree. Do you think additional resources for teachers, school employees, and other caregivers would be helpful in these efforts for them to be able to identify and report so that we can combat sexual abuse?

Secretary BECERRA. I think most teachers would say that that would be a good thing to provide the resources for them to be trained and have the resources to implement.

Mr. MORAN. I completely agree with you. In fact, Representative Wild, who is a Democrat from Pennsylvania and I, are working on this exact issue. I have reintroduced what is called the Jenna Quinn Law of 2024, named after Jenna Quinn, a sexual abuse survivor from Texas. This bill would allow HHS to use existing Federal funds to be used for eligible entities for increasing evidence based or information training on sexual abuse prevention.

It does exactly what you and I just agreed needs to actually happen, is we need to open up additional resources. No additional cost to taxpayers, but more resources here where schools and institutions can tap into these existing resources, and get education and training for their teachers so they can report these sexual abuses.

Data has shown that after this law passed in Texas, and it has passed in a lot of states, educators report abuse at almost four

times the rate than before. It sounds like good progress in my State.

Nearly every Committee member on this Committee in their own home State has enacted a version of this. Their states have enacted that version. I think it is time that we have a national strategy to stop child sexual abuse, and I think the Jenna Quinn Law of 2024 would be a good way to do it. I hope you will take a look at it.

With that I am going to reserve and yield the remainder of my time to the gentleman from Utah, Mr. Owens.

Mr. OWENS. Okay. Thank you so much. I just wanted to kind of on that last question I had for you. Are you saying then you are not going to punish the doctors that have religious freedom to say no to these operations. Is there any consequence to the institutions that are hiring these doctors? Yes or no?

Secretary BECERRA. Congressman, if you understand the way this works, an institution is seeking Federal reimbursement dollars.

Mr. OWENS. That Federal reimbursement would end if they do not——

Secretary BECERRA. They accept the reimbursement dollars under certain conditions. They have to follow the rules of Federal law.

Mr. OWENS. Those rules would be their employees have to make sure they do these operations.

Secretary BECERRA. They have to make sure they are offering services. If they hold themselves out——

Mr. OWENS. I am just going to say and then I will finish up. We have taken a lot of time for this one question. I think it is very stealthy the way you guys are approaching this. You are not hurting the doctor, but you are hurting their employee, that is what it comes down to. You are taking away their funds.

Secretary BECERRA. No. It is——

Mr. OWENS. The result is the same.

Secretary BECERRA. Congressman, it has been very direct, and again, people have conscious rights, religious rights.

Mr. OWENS. You are punishing the institution. I yield back, I think—I yield back.

Chairwoman FOXX. Mr. Scott, you are recognized for 5 minutes.

Mr. SCOTT. Thank you. Welcome again, Mr. Secretary. Mr. Secretary, you have got a lot of questions about problems at the border. A lot of complaints. Are you familiar with the legislation negotiated by Senator Lankford from Oklahoma?

Secretary BECERRA. Generally familiar with it, yes.

Mr. SCOTT. That would have solved a lot of problems. What happened to that bill?

Secretary BECERRA. Well, my understanding is that the Republican leadership in the House that they would not put it up for a vote, and the Republicans in the Senate, after the negotiations by a Republican Senator decided to bury it as well.

Mr. SCOTT. That they could continue to complain rather than actually do something. Is that right?

Secretary BECERRA. It would have addressed many of the issues that many of these members have raised.

Mr. SCOTT. Thank you. The nursing home rule, have you found any correlation between staffing and deaths in nursing homes, not just anecdotal, but on a statistical basis where there is a correlation between staffing and deaths in the nursing home?

Secretary BECERRA. Substantial.

Mr. SCOTT. Okay. You mentioned, and I think you got cutoff, how life was before the Affordable Care Act. People with preexisting conditions could not get insurance, insurance rates were skyrocketing every year, millions of people were losing their insurance every year. The benefits they could sell—they did not have any essential benefits.

We now have the lowest proportion of America with—the lowest uninsured. Do you have proposals to make it even better, to lower the number of people uninsured?

Secretary BECERRA. Absolutely.

Mr. SCOTT. Particularly in states without Medicaid expansion?

Secretary BECERRA. That is right. The 1.7 million Americans would have access. North Carolina just recently last year expanded Medicaid more than 600,000 of their population have qualified. They are almost at that number who have actually signed up now to get healthcare.

It is a remarkable thing when you can so quickly give people access to good quality care.

Mr. SCOTT. Thank you.

Secretary BECERRA. By the way, they also got a bonus check for 1.6 billion dollars for expanding Medicaid.

Mr. SCOTT. Thank you. You mentioned mental health, the historic investments in mental health. Is that in addition to the fact that we now have mental health parity, so the insurance policy, private insurance covers mental health, and more people have insurance, particularly under the Affordable Care Act and Medicaid expansion?

Are those investments in addition to those?

Secretary BECERRA. In addition. Although I think you recognize Congressman that most insurers are still not fully implementing the law that requires parity in treatment of mental health the way we treat physical health.

Mr. SCOTT. Are you trying to enforce that mental health parity?

Secretary BECERRA. We are trying to make it clear that that is the law.

Mr. SCOTT. Head Start is under the jurisdiction of Health and Human Services, not Education. What services are provided in the Head Start program that make it more appropriate for Health and Human Services than Education to be the appropriate department?

Secretary BECERRA. We provide a full spectrum of care within the Head Start program so it is not just the educational service because you are talking about children who are under the age of 5. What we are trying to do, and we have a proposed rule that is out there, that would try to make sure that every slot that has made available for each State for a Head Start child is used, because we have too many slots that are not being used.

We are also trying to make sure that we professionalize the Head Start workforce because too many of the teachers at Head Start are

being paid less than what you can make going to flip burgers in a fast food joint.

Mr. SCOTT. Do the services like vaccinations and things like that, do those extra services that you provide that would not be provided in Education, do those services make a difference?

Secretary BECERRA. Absolutely. All those additional services make a difference.

Mr. SCOTT. Childcare is a challenging problem for all families. Child Care and Development Block Grant provides childcare services for low-income families. Do all that qualify, can they get childcare assistance?

Secretary BECERRA. It is tough. The President's budget would make available childcare services to 16 million of our children who are lower income. It would provide them, their families with access to care where for about $10.00 a day they would get access to care, which probably saves them by the time the year is up, more than $7,000.00 on what the average cost of childcare would cost most families.

Mr. SCOTT. What have you done in 504 Rehabilitation Act to help those with disabilities?

Secretary BECERRA. For the first time in about 50 years, we have updated Section 504, which is so important to Americans with disabilities because it lets them be treated the way they should be, as Americans. Not as second-class Americans. A doctor cannot make a judgment that because you are disabled, they do not need to offer you some of the services they might offer to an able-bodied American.

It is going to be game changing for many Americans who for the longest time found themselves being treated as second-class or put at the end of the line because of their disability.

Mr. SCOTT. Thank you, Madam Chair.

Chairwoman FOXX. Thank you, Mr. Scott. Thank you, Mr. Becerra, for being here today. Without objection, there being no further business, the Committee stands adjourned.

[Whereupon, at 1:08 p.m., the hearing was adjourned.]

[Additional submissions by Chairwoman Foxx follows:]

May 15, 2024

The Honorable Virginia Foxx
Chair
House Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

The Honorable Bobby Scott
Ranking Member
House Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Foxx, Ranking Member Scott and Members of the House Committee on Education and the Workforce:

On behalf of Associated Builders and Contractors, a national construction industry trade association with 68 chapters representing more than 23,000 members, I appreciate the opportunity to comment on today's hearing, "Examining the Policies and Priorities of the Department of Health and Human Services." Providing quality health care benefits is a top priority for ABC and its member companies. ABC advocates for policies that would ensure employer-sponsored coverage is strengthened and remains a viable, affordable option for millions of hardworking Americans and their families.

As a member of the Partnership for Employer-Sponsored Coverage, ABC encourages Congress and HHS to consider principles and priorities that are important for ensuring employment-based health coverage thrives, including:

- Preserving and strengthening employer-sponsored health coverage
- Addressing medical costs and challenges to help keep coverage affordable
- Upholding the current tax treatment of employer-sponsored coverage
- Providing employers with compliance relief from burdensome regulations governing health coverage
- Promoting innovations and diversity of plan designs and offerings for employees

Federal tax exclusions are vital to the sustainability of employer-sponsored coverage. Current tax code preferences exclude employer payments for employment-based health coverage from an employee's income, allow for the pre-tax payment of an employee's share of premiums for employment-based health coverage and enable employers to deduct the cost of health coverage as a business expense. Capping or eliminating these exclusions would increase the cost of plans and could lead some to abandon their plans all together, harming employees who rely on their employer-sponsored coverage.

Additionally, ABC supports compliance relief for employers by streamlining the reporting requirements brought on by the Affordable Care Act. Internal Revenue Service employer information reporting requirements generate undue compliance burdens and costs for employers while creating a more difficult process for employees. Similarly, altering the definition of an applicable large employer and flexibility in the definition of a full-time employee under the employer mandate would enable employees to pick up extra hours, provide consistent federal definitions across different laws and enable businesses to hire more employees and grow their operations. Employment growth increases the employer plan pool and provides increased stability and predictability to changing premium trends.

Employer-sponsored coverage should continue to be the foundation of our nation's health coverage system. ABC appreciates the committee's efforts to examine HHS priorities and urges the department to consider the business community as it seeks to improve the health and well-being of Americans.

Sincerely,

Kristen Swearingen
Vice President, Legislative & Political Affairs

440 First St., N.W., Suite 200 | Washington, DC 20001 | (202) 595-1505 | abc.org

[Questions and responses for the record submitted by Secretary Becerra follows:]

COMMITTEE ON
EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6100

June 14, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Becerra:

Thank you again for testifying at the May 15 Committee on Education and the Workforce hearing on "Examining the Policies and Priorities of the Department of Health and Human Services."

Enclosed are additional questions submitted by Committee Members following the hearing. Please provide a written response no later than July 15, 2024, for inclusion in the hearing record. Responses should be sent to Alexander Knorr of the Committee staff, he can be contacted at Alexander.Knorr@mail.house.gov or (202) 225-7101.

Sincerely,

Virginia Foxx
Chairwoman

Enclosure

Questions for the Record for Xavier Becerra

Committee on Education and the Workforce Hearing
"Examining the Policies and Priorities of the Department of Health and Human Services"
May 15, 2024

Chairwoman Virginia Foxx (R-NC)

Health Coverage

1. During the hearing, I expressed concerns about the Department of Health and Human Services' (HHS) regulatory overreach with respect to self-insured health plans. As I noted, the recent Notice of Benefit and Payment Parameters final rule and the Section 1557 Nondiscrimination in Health Programs and Activities final rule saddle self-insured health plans with new Obamacare regulations. Under current law, self-funded plans are not subject to Section 1557 and are regulated by the Department of Labor (DOL). I asked you the following question during the hearing, but you did not provide an answer. Will you confirm it is HHS policy that self-insured health plans are not subject to HHS regulation, and will you commit to abandoning any unlawful HHS efforts to regulate self-insured health plans?

2. The *Inflation Reduction Act* (IRA) included $33 billion to expand subsidies for Obamacare plans for an additional three years. The President's budget calls for a permanent expansion of enhanced subsidies, which the Congressional Budget Office (CBO) estimates would cost $383 billion over the next decade. Why is HHS instead working to strengthen employer-sponsored health insurance, which is consistently more affordable and of higher quality than Obamacare plans?

3. Three out of four individuals in the *Affordable Care Act* (ACA) exchanges receive subsidies. Does this not demonstrate that these plans are unaffordable?

4. Premiums on the ACA exchanges are skyrocketing. Does the administration have a plan to lower the cost of ACA premiums that does not simply continue to pump money into the system through tax hikes?

5. According to CBO estimates, ACA plans per enrollee are three times more expensive for taxpayers than employer-sponsored health insurance. Do you believe that shifting enrollment from ACA plans to the employer-sponsored market would be beneficial for the federal budget? If so, what steps will HHS take to encourage migration to employer-sponsored health plans?

6. Small businesses rely on stop-loss insurance to provide more affordable, higher quality health care coverage to their employees by self-insuring. Do you agree that stop-loss coverage is a necessary tool for many businesses to self-insure? Why or why not?

7. The administration likes to call any form of health coverage it does not like "junk insurance," as shown by recent regulations to erode the association health plan and short-term, limited-duration insurance markets. Should the government dictate what is and is not beneficial insurance, or should individuals be able to make those decisions for themselves?

8. President Biden once said, "if you like your health care plan ... you can keep it. If in fact you have private insurance, you can keep it." President Obama made a similar promise, saying, "if you like your health care plan, you can keep it," which some outlets considered to be the "lie of the year" in 2013. Will President Biden keep his promise? Does the President want every American on an Obamacare individual market plan? How can the President keep his promise while his administration actively erodes the association health plan and short-term, limited-duration insurance markets and saddles employer-sponsored plans with costly regulations?

9. The Committee has taken steps to help employers ensure that the third-party administrators (TPA) they contract with operate transparently.

    a. What actions is the administration taking to require TPAs to share rates and settled claims amounts with those self-funded employers who have the fiduciary responsibility for their health care spend?

    b. When brokers offer "no-shop" commissions, how does this protect employers and ensure they are getting the best plan for their employees? What actions will the administration put in place to restrict no-shop commissions?

    c. Brokers are being asked to sign non-disclosure agreements with carriers stating they will not disclose their rates to anyone (including the employer they represent). What steps is the administration putting in place to make these practices illegal?

    d. How does the Section 1557 nondiscrimination protections impact self-funded plans, their carriers, and TPAs?

Telehealth

10. Telehealth, in many ways, was a silver lining of the COVID-19 pandemic. Many new patients gained access to these important services because HHS allowed employers to offer stand-alone telehealth coverage. However, telehealth-excepted benefits expired at the end of this past plan year, as the declared Public Health Emergency came to an end on May 11, 2023.

    a. Do you believe this flexibility helped workers gain access to care?

    b. Will you support this Committee's efforts to extend this flexibility going forward?

11. Your budget proposes a ban on telehealth facility fees.

    a. How does HHS justify such a ban?

    b. How would banning facility fees help reduce costs for employers?

    c. Can you provide additional details on the estimated $2.3 billion in savings such a ban would provide the federal government?

    d. Could you elaborate on the meaning of "other outpatient services" to which the proposed ban refers?

Association Health Plans

12. Congressional Republicans have a longstanding interest in allowing associations and businesses to band together to purchase affordable health insurance coverage through association health plans (AHPs). In 2018, HHS issued a final rule to expand access to AHPs. Before a court invalidated the rule, 35 new AHPs were formed, which saw average savings of 29 percent. On April 30, DOL issued a final rule which rescinds the 2018 rule, robbing Americans of an innovative way to access high-quality, low-cost health care.

    a. To what extent do you anticipate that DOL's final rule reversing the expansion of AHPs will raise costs?

    b. Does HHS have any estimates of how many people will be prevented from accessing affordable health coverage due to the new rule?

13. AHPs are an effective way to expand health care coverage options to small businesses and to reduce premiums. Unfortunately, the Biden administration recently released a rule to erode the AHP marketplace.

    a. In your opinion, are Obamacare plans the only acceptable form of insurance?

    b. Why is the Biden administration so intent on taking away innovative coverage models from employers and individuals?

Short-Term Limited-Duration Insurance

14. On April 3, HHS, DOL, and the Department of the Treasury (the Tri-Agencies) jointly published final rules severely reducing access to short-term, limited duration insurance. The final rules stated: "These final rules might also lead to an increase in the number of individuals without some form of health insurance coverage.... Those individuals who become uninsured or obtain coverage in unregulated markets could face an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and

potentially worse health outcomes." How many Americans will become uninsured because of these regulations?

Surprise Billing

15. This Committee's efforts helped lead to the passage of the historic *No Surprises Act* (NSA). However, the law's Independent Dispute Resolution (IDR) process has been mired in litigation, delays, and faulty implementation. Data shows that 77 percent of disputes are ruled in favor of providers, and the Brookings Institution now anticipates that the IDR process will raise costs and premiums, contrary to the law's goals. I asked you the following question during the hearing, but you did not provide a responsive answer. What is HHS doing to improve the operations of the IDR process under the NSA, and are you concerned that the law's current implementation will raise health care costs for employers and employees?

16. I am concerned that, due to current implementation, some companies are using the NSA's IDR process as a moneymaking scheme. The IDR process has been flooded by disputes from just a few large billing consultants and physician-staffing firms. The top 10 dispute-initiating parties submitted 73 percent of the out-of-network payment disputes.

    a. Are you worried that some players are abusing the IDR system?

    b. How are smaller providers disadvantaged if the IDR system is overwhelmed by disputes from large billing consultants and staffing firms?

    c. Do you share my concerns that current implementation of the IDR process may further fuel health care consolidation?

17. There is a lot of frustration from providers, employers, and insurers about the administration's implementation of the NSA's IDR process.

    a. Why has implementation been such a challenge?

    b. Why did HHS so severely underestimate how many disputes would enter the IDR process?

    c. Did the Tri-Agencies' November 2023 proposed rule address these implementation challenges, and can you provide an update on HHS' work to improve IDR operations?

    d. How is the administration ensuring that IDR entities are appropriately and clearly communicating with payers and providers regarding the outcomes of claim disputes?

    e. How is the administration conducting oversight of IDR entities' decision-making?

f. How is the administration handling medical necessity denials for claims which would otherwise be eligible for IDR, particularly for air ambulance services?

18. In addition to protecting against surprise medical bills, the NSA included other important patient protections. The law requires health plans and issuers to provide an advanced explanation of benefits (AEOB) detailing the estimated costs for a scheduled service. However, the Centers for Medicare and Medicaid Services (CMS) has not yet implemented this requirement. Please provide an update on CMS's timeline to implement the AEOB requirement via rulemaking.

19. The NSA's IDR program was intended to be funded through administrative fees from disputing parties. Why does the President's budget request an additional $500 million for NSA implementation when the program is supposed to be self-funded?

Mental Health Parity

20. I have serious concerns about HHS' 2023 proposed rules regarding mental health parity. The proposed rules do little to expand access to quality mental health care while burdening employers with more paperwork requirements.

    a. Do you share my concerns that conditioning mental health parity compliance on reimbursement rates will raise premiums and health care costs, while doing little to alleviate provider shortages?

    b. Should health plans serving areas with mental health provider shortages be given a safe harbor from parity compliance?

    c. Do you support efforts to expand telehealth to help alleviate mental health provider shortages, particularly in rural areas?

21. There is bipartisan consensus on the need to boost mental health care in this country. However, I worry that the administration's recent rule on the *Mental Health Parity and Addiction Equity Act* (MHPAEA) will layer plans with more burdensome regulations, which will raise costs and reduce access to mental health care. What is the administration's timeline for releasing the mental health parity final rule?

22. Under parity requirements, mental health and substance use disorders must be treated the same as physical health. Why does the proposed mental health parity rule include a test for non-quantitative treatment limits (NQTLS), which will allow health plans to perform utilization review on inpatient medical care half the time—but none of the time for mental health and substance use disorder care?

23. The current mental health parity proposal will likely eliminate the ability for health plans to employ utilization management techniques in mental health and substance use disorder care, especially in outpatient settings. These techniques can help ensure people get the

right care at the right time. Was HHS' intent to eliminate the ability of health plans to perform utilization management in mental health and substance use disorder care?

24. I have read some of the health plans and employer comments on the proposed mental health parity rule, and they asked for a sample NQTL analysis that they can use as a guide when doing their analyses. Will HHS commit to working with DOL to make these samples publicly available before the compliance date of the pending final rule?

25. A fundamental proposed change in the proposed rule is adding the Substantially All/ Predominant test to NQTLs. This means that in order for health plans and issuers to apply management techniques such as prior authorization and concurrent review to MH and SUD benefits, these techniques must be applied to 2/3rd or more of the medical/surgical (M/S) benefits in the same classification. This reinterprets the parity statute to subject NQTLs to the quantitative tests currently applied to quantitative treatment limits. It will be impossible to operationalize these tests and will remove nearly all insurer tools to ensure patients receive safe and appropriate care. Please explain why the Tri-Agencies proposed 2/3rds—as opposed to 50 percent or 20 percent for an NQTL test. For example, if value-based purchasing is only used with 61 percent of M/S providers in a classification, is it foreclosed for all behavioral health providers in that same classification?

26. The proposed mental health parity rule shifts the focus from comparing methodologies to comparing outcome measures like denial rates and actual amounts paid to providers. This approach goes well beyond the intent of the MHPAEA and suggests that any disparate outcome equals noncompliance. Please explain why the Tri-Agencies proposed to change from their position that disparate outcomes could be indicative of a parity violation to the proposal's position that says that disparate outcomes are per se violations for certain NQTLs.

Drug Pricing

27. The President's budget request proposes to extend Medicare's $35 out-of-pocket cap for insulin to the commercial market. If enacted, this proposal would cost taxpayers an estimated $1.3 billion over 10 years. Will extending this cap to the commercial market raise premiums for individuals in small- and large-group plans?

28. The 340B drug-pricing program is intended to pass on savings and improve health outcomes for low-income patients. However, there are reports that hospitals and pharmacies are selling these drugs to commercially insured patients to pad their bottom lines, using employer-sponsored plans to subsidize the 340B program at the expense of workers' premiums. The President's budget includes funding for oversight and auditing of covered entities.

    a. Please provide an update on these oversight efforts.

    b. Should hospitals be able to use the 340B program to pad their bottom lines?

c. What protections will you put in place to ensure that providers are only using the government-set price drugs for eligible patients?

29. According to a study from the University of Chicago, government price controls in the *Inflation Reduction Act* will result in 342 fewer cures reaching the market, which will take 330 million years off Americans' lives. What is the Biden administration's plan to ensure that patients will not lose out on access to lifesaving cures and that America will continue to be the world leader in medical innovation?

30. In *HIV and Hepatitis Policy Institute v. HHS*, a federal district court struck down a rule allowing health insurers not to count drug manufacturer copay assistance towards a beneficiary's out-of-pocket costs. In light of this ruling, what is HHS' policy and enforcement stance regarding use of copay accumulator and maximizer programs within self-funded health plans?

31. Pharmacies are experiencing significant reimbursement cuts due to modifications in the methodology that Medicaid uses to establish the national average drug acquisition cost (NADAC). It has been reported that since being implemented in April, pharmacies have seen a 16 percent decrease in generic NADACs with an additional decrease seen in May. NADAC must ensure stable and predictable reimbursements. Please provide clarification on the rationale behind these changes and the lack of public notice and stakeholder input.

Market Consolidation and Decreased Competition

32. As of May 2024, only 11 hospitals have been fined for violating the final hospital price transparency rule. Additionally, it appears that overall compliance with this rule is lacking.

    a. Why has HHS not done more to enforce the hospital price transparency rule?

    b. Does the Biden administration support congressional efforts to codify this rule in the *Lower Costs, More Transparency Act*?

33. Premiums for employer-sponsored health plans increased 7 percent this year. The RAND Corporation, CBO, and other economists have identified provider consolidation as a main driver of health care cost increases. Perverse economic incentives have driven hospitals to acquire provider offices and incorrectly bill for services.

    a. Do you believe that this is a problem for employers and workers?

    b. Would you agree that hospitals should not be allowed to charge facility fees to commercial payers for outpatient services?

c. Does the Biden administration endorse congressional efforts to ensure that health services are charged on a site-neutral basis?

34. Price transparency is vital for employers to make better decisions in choosing and administering employee health plans. HHS is indefinitely deferring enforcement of a rule requiring plans to make drug prices public and to submit them to HHS. Should Congress codify this rule to ensure transparency for drug prices?

35. Prescription drug middlemen like pharmacy benefit managers (PBMs) are raking in profits while evading congressional scrutiny. This Committee has taken a leading role in improving the transparency of PBMs, including through the *Lower Costs, More Transparency Act*. Please provide an update on HHS oversight of PBMs.

Religious Freedom, Gender, and Abortion

Gender Identity and Religious Freedom

36. The recent Title IV-B and IV-E rule requires "Designated Placements," a new category of foster care providers deemed by HHS to be safe and appropriate for LGBTQ+ children. Under the rule, foster care providers who may have religious freedom or conscience concerns regarding your LGBTQ+ policy are permitted to request an accommodation, but ultimately that request must be reviewed by the HHS Office of General Counsel. What conditions would allow foster parents with certain religious beliefs to bypass HHS' "Designated Placements" category requirement?

37. HHS' FY 2025 budget document states, "the proposal includes financial penalties and mandatory corrective action for any state or contract that delays, denies, or otherwise discourages individuals from being considered or serving as foster or adoptive parents based on the above categories." Is that policy in direct contradiction to the finalized rule requiring "Designated Placements" to be the default provider group to LGBTQ+ children?

38. On April 9, Dr. Hilary Cass published the Cass Review, an independent review of gender identity services for children and young people commissioned by England's National Health Service. The review found that thousands of vulnerable young people were given life-altering treatments with "no good evidence on the long-term outcomes of interventions to manage gender-related distress." Another study published on March 23, 2024, by physicians and researchers at the Mayo Clinic reported mild-to-severe sex gland atrophy in puberty blocker-treated children.

    a. What longitudinal studies or systematic reviews of scientific studies has HHS overseen or funded on the effects of puberty blocker usage on youth gender treatments?

    b. Is HHS aware of the long-term effects of puberty blockers for this particular population?

c. What effects do puberty blockers have on the brain development of children?

d. What effects do puberty blockers have on fertility?

e. Are puberty blockers reversible?

f. Can puberty blockers cause permanent sterility in a healthy girl or boy?

g. Why would our federal medical institutions support use of puberty blockers if they have not done the public the service of understanding their long-term effects?

39. Should Americans be able to practice their religious faith free from discrimination?

40. Does the freedom to practice religious faith free from discrimination also exist in the practice of medicine? If so, why does the Biden administration continue its efforts to violate American's religious beliefs through abortion, contraceptive, and gender-reassignment mandates?

Border Crisis and Child Labor

41. According to U.S. Customs and Border Protection data, the CBP encountered more than 137,000 unaccompanied minors at the southern border in FY 2023, a substantial increase compared to just five years ago. As has been reported in the New York Times and other publications, this increase in unaccompanied minors led to the rise in employment of these minors in dangerous jobs in violation of the *Fair Labor Standards Act*. President Biden has implemented an open border policy and even recently admitted the border is not secure. Why has the Task Force to Combat Child Labor (Interagency Task Force)—on which HHS is a member with DOL and the Department of Homeland Security (DHS)—failed to protect so many unaccompanied minors?

42. I am frankly shocked at the lack of coordination between DOL, HHS, and DHS when it comes to protecting the health and safety of unaccompanied migrant children after they have entered the United States. It is the responsibility of HHS to ensure that these children are placed with responsible caregivers after they leave HHS. Yet, it appears as though many of these children were placed with human traffickers and were forced to work in dangerous jobs. This was so prevalent that HHS stopped placing children with sponsors in certain zip codes.

a. Did DOL warn HHS that these children were at risk for human labor trafficking at any time during this administration?

b. Do you believe that HHS properly vetted the sponsors of unaccompanied children who were found to be exploited by human labor traffickers?

c. Did HHS follow all protocols when vetting sponsors for unaccompanied children?

d. Did HHS' failure to vet sponsors contribute to the increase in child labor trafficking?

e. If a child who was under the care of HHS' Unaccompanied Children Program is found to be a victim of human labor trafficking, is the sponsorship immediately terminated, and does the federal government reclaim custody of the child?

f. Are there circumstances under which the child will be returned to the original sponsor?

g. Are there circumstances under which the child will be returned to an immediate relative of the original sponsor? And, if so, what is the vetting process for these individuals?

h. Do some human traffickers promise young children that they can go to school or work in the United States to lure them into being trafficked?

i. Is HHS placing children with members of gangs and cartels, including MS-13?

j. Is it true that HHS has released multiple unaccompanied children to the same address or building?

k. What action is HHS taking to ensure that individuals are not sponsoring multiple children and that multiple children are not being released to the same address?

43. HHS' FY 2025 budget shows a carryover in unaccompanied children program funding of $1.6 billion from FY 2023 to FY 2024. Considering the alarming rate at which unaccompanied children have entered the United States over the last year, can you explain why HHS had so much unused funding?

44. In February 2023, HHS and DOL announced the formation of an Interagency Taskforce to combat child labor exploitation—a move to save face after the neglect of both agencies resulted in illegal child labor scenarios with sad consequences. Part of HHS' responsibility was to expand post-release services to unaccompanied children.

    a. What services have been expanded, and what were the costs of those services?

    b. Are unaccompanied children given materials to explain child labor laws and a way to contact HHS to report any safety concerns?

45. HHS completed an audit of the failed vetting process for potential sponsors—a process that previously resulted in HHS releasing unaccompanied children into the custody of child labor law violators.

    a. What changes have been made as a result of this audit?

b. What changes have been made to release unaccompanied children to individuals who have previously sponsored children?

Head Start

46. HHS' Head Start Workforce proposed rule seeks to make wage and benefit changes to Head Start performance standards in a purported effort to retain the program's workforce. Part of HHS' solution is to implement pay parity for Head Start education staff with public school teachers and set a minimum pay floor of $15 per hour. HHS acknowledges that, "there will be a substantial cost associated with enacting the proposed [wage] standards at current Head Start funded enrollment levels." But the proposal argues the policy changes are "necessary" while admitting, "one potential impact could be a reduction in Head Start slots."

    a. Is it the policy of this administration that Head Start should serve fewer low-income children in order to pay workers more?

    b. What is HHS' plan for children and families who lose access to Head Start due to your reduction in slots?

47. The Head Start statute goes out of its way to describe parent and family engagement in Head Start services. In HHS' recent Head Start Workforce proposed rule, there is even language that claims to ensure "programs are consulting and engaging with current parents and families to be involved in the methods the program uses." However, the proposed rule strikes §1302.44(a)(3) from current regulations, which requires that parent consent be obtained for mental health consultation. Does HHS intend to complete mental health consultations on children without parental consent?

48. Continuous quality improvement (CQI) is a staple of the Head Start program, yet HHS' "Head Start Workforce" proposed rule includes several highly prescriptive and onerous requirements that walk away from the focus on CQI and empowering local communities to do what is best for their children and families. How will the Biden administration ensure the new rule will maintain or strengthen local autonomy and CQI?

Universal Preschool

49. The Biden administration continues to propose universal preschool in FY 2025 with $5 billion in mandatory funding. However, several economic impact studies[1] warn that a

[1] [1] Brown, Jessica, "Does Public Pre-K Have Unintended Consequences on the Child Care Market for Infants and Toddlers?" (Dec. 8, 2018). Princeton University Industrial Relations Section Working Paper 626 finds "a back-of-the-envelope calculation indicates that for every seven 4-year-olds who shifted from day care centers to public pre-K, there was a reduction of one day care center seat for children under the age of 2." Malik, Rasheed, "The Effects of Universal Preschool in Washington, D.C." (Sept. 2018) American Progress Report. "[universal preschool] has the potential to affect the supply and cost of child care for infants and toddlers…private child care providers have traditionally cross-subsidized their smaller infant and toddler rooms by serving one or two full classrooms of preschoolers. Without that revenue, some providers may need to increase prices or enroll fewer children." Costa,

universal preschool program—which aims to pull a majority of 3- and 4-year-olds into a new federal government education system—will have disastrous effects on already strained child care providers. Since HHS also houses federal child care programs through the Child Care Development Fund (CCDF) and Child Care Development Block Grant (CCDBG), has the HHS completed any economic impact studies on the proposed universal preschool program?

Child Care

50. It is no secret that our nation's child care industry is strained at best and broken at worst. The HHS budget requests $10 billion in FY 2025 to expand the federal child care program to include families with annual incomes up to $200,000.

    a. Why is it appropriate to subsidize child care for the wealthy?

    b. A family of four with an annual income of $200,000 is living 641 percent above the federal poverty guidelines. CCDBG eligibility rules require family income at or below 85 percent of state median income. How is a $200,000 income limit appropriate for participation in federally subsidized child care?

51. On March 1, 2024, HHS finalized a rule that makes significant changes to CCDF copayments. Statute clearly articulates that "the State will establish and periodically revise…a sliding fee scale that provides for cost sharing by the families that receive child care services."

    a. How does a copay cap at 7 percent of household income adhere to the "sliding scale" requirement in statute?

    b. HHS has historically recommended - not required - a 7 percent income threshold. Why the abrupt change?

52. This cap at 7 percent of household income will burden lead agencies with the tuition differential, further straining an already fraught child care system.

    a. What supports will HHS put in place to help states manage the new requirement?

Daniela Viana, et. al. "Economic Effects from Preschool and Childcare Programs" (August 2021) Penn Wharton Budget Model. "We find that a combined universal childcare and preschool program produces GDP which is 0.2 percent lower than the current baseline in 2051 while increasing government debt by 5.9 percent." In "Economic Effects of Expanding Subsidized Child Care and Providing Universal Preschool" (November 23, 2021) the Congressional Budget Office estimated that expansion of federal subsidies for child care and providing universal preschool at no cost for eligible children (as presented and passed by the House of Representatives in H.R. 5376) "would increase federal deficits by $381.5 billion from 2022 to 2031." Additionally, for those parents with incomes above an eligibility threshold, even modestly so, the study states "the higher costs of unsubsidized [child] care would discourage work."

b. Will the potential reduction of the number of available slots open to children be an acceptable solution for states that cannot carry this financial burden?

c. With the increased child care costs to states, has HHS estimated how many child care slots might be lost? Is there a reduced case load estimate?

Rep. Joe Wilson (R-SC)

1. The Increasing Organ Transplant Access Model (the IOTA Model) is a proposed mandatory initiative aimed at enhancing access to kidney transplants for patients with kidney disease while also reducing Medicare expenditures. Key objectives of this model include encouraging transplant hospitals to utilize more available kidneys for transplantation, facilitating transplants from living donors, and promoting equitable access to kidney transplants.

   Under this model, participating transplant hospitals are held accountable for their performance. They could receive upside risk payments from CMS, fall into a neutral zone (where neither upside nor downside risk payments apply), or owe downside risk payments to CMS based on their final performance score. This score would be calculated out of 100 points across three domains:1. Achievement: Reflecting the number of kidney transplants performed; 2. Efficiency: Based on the organ offer acceptance rate ratio; and 3. Quality: Assessed using metrics such as the CollaboRATE Shared Decision-Making Score, Colorectal Cancer Screening, Three-Item Care Transition Measure, and post-transplant composite graft survival rate.

   The model aims to improve care delivery capabilities, enhance efficiency, and ultimately enhance the quality of care provided by kidney transplant hospitals selected for participation. It is set to begin on January 1, 2025. Given the criteria used in the IOTA Model please answer the following questions in regard to the metrics used to measure OPOs under CMS-3380-F.

   a. In the proposed Increasing Organ Transplant Access Model (IOTA Model), CMS creates financial incentives for transplant centers with above average performance, a 'neutral zone' median performance and downside financial risk for below average performance. In stark contrast, CMS provides OPOs with no incentive for neutral zone and high performance and creates a penalty for median performance with automatic decertification for below average performance. Why has CMS taken such a drastically different policy approach for two components within the same system? Will CMS reconsider its approach to OPO performance metrics?

   b. In the proposed IOTA Model, CMS sets up 3 domains (achievement, efficiency and quality) with multiple measurable factors to assess transplant center performance. Moreover, CMS intends to risk adjust these measurements to ensure actual program performance rather than the underlying patient population. Does CMS plan to reconsider the current OPO metrics which establishes a single

domain (achievement) and does not risk adjust for underlying patient population? If not, why?

c. In the proposed IOTA Model, CMS explicitly recognizes that transplant program behavior drives whether or not kidneys are accepted and used for transplant. If so, why are OPOs held accountable and subject to automatic decertification based on a transplant rate that is actually measuring transplant center behavior outside of OPOs responsibility and control? Will CMS commit to changing the OPO performance metric to be consistent with its policy approach in IOTA?

Rep. Glenn Grothman (R-WI)

1. For more than 30 years, the 340B Drug Pricing Program has helped eligible providers stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services to the patients and communities they serve. Hospitals use 340B savings to provide, for example, free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication management and community health programs. Despite significant oversight from HRSA and the program's proven record of decreasing government spending and expanding access to patient care, some want to scale it back or drastically reduce the benefits that eligible providers and their patients receive from the program. Secretary Becerra, what steps is HHS taking to protect the 340B program from these attacks and ensure the program continues to help providers stretch limited resources and provide more comprehensive services to more patients?

2. As of today, more than 60% of Wisconsin's nursing homes would not meet one, two or all three of the minimum staffing standards. What is HHS's plan for assisting nursing homes to meet these standards when the people, especially RN's, do not currently exist?

    a. How does HHS expect facilities to pay for the standard? It is an unfunded mandate. Many facilities operate on thin margins or at a loss because they must rely on Medicaid as their chief payment source.

3. Providers have found the survey process (aka the yearly facility inspection of regulatory compliance and quality assurance) has gotten more and more punitive in nature, where it seems like the goal is to punish a facility rather than advancing quality care. Being overly punitive is counterproductive to what should be the mutual goal of all parties – to advance quality care. Is the purpose of CMS's nursing home survey/enforcement process primarily meant to be punitive, or is it meant to identify and correct areas of concern/noncompliance in an effort to advance quality of care?

4. The CMS FY 25 Prospective Payment System (PPS) Proposed Rule for nursing homes includes an important 4.1% PPS rate increase, but it also includes new opportunities for CMS to pile on financial penalties that could financially cripple many providers. Do you believe CMS's new proposal to create more opportunities to financially devastate nursing homes via high Civil Money Penalties (CMPs – aka fines) will make it harder for

providers to ensure quality care and access to care in communities across Wisconsin and across the country?

5. HRSA began a shortage designation modernization project more than 10 years ago. It had projected to start removing HPSAs under this new methodology during COVID but delayed the implementation until the end of last year when it decided to proceed. As a result, a number of hospitals and other health care facilities lost their HPSA designation in 2024, at a time when healthcare workforce shortages seem to be stabilizing but remain critical for many provider types. We expect more areas will lose their HPSA designation under this next cycle as it progresses this year. HRSA also recently announced it would be increasing loan repayment amounts for those eligible under the National Health Service Corps Loan Repayment Program, which is beneficial for those who retain their HPSAs but does nothing for those who lose access to it. Nearly all sectors are experiencing workforce shortages, and the HPSA tools help health care compete, given the additional challenges the sector faces, such as requirements to staff hospitals and emergency departments 24/7.

    a. Certainly there's value in attempting to modernize data collection. However, did HRSA consider recalibrating how it calculates HPSA scores when it found out the number of areas losing access to HPSA benefits given the new way data is reported and collected by HRSA? Has HRSA considered what impact this continued policy of withdrawing HPSAs will have on the health care workforce?

    b. What can HHS do to help areas that lose their HPSA but still have workforce needs?

Rep. Rick Allen (R-GA)

1. Back in February, the National Association of Attorneys General sent a letter to Congressional leaders on behalf of a bipartisan group of 39 attorneys general, including Georgia AG Chris Carr, urging action on pharmacy benefit manager (PBM) practices. Their letter outlined several PBM business practices, such as spread pricing and tying their own compensation to the list price of medicine, that are increasing costs for millions of patients, employers, and community pharmacies not only in my state but across the country.

    a. Secretary Becerra, since you've mentioned on record that HHS is currently enforcing the Drug Price Transparency rule, I am assuming you also agree something needs to be done to protect patients and stakeholders from such practices. YES, or NO?

    b. Even though you've previously stated that HHS is actively enforcing the Drug Price Transparency rules, we have been waiting years for any enforcement. What is your department doing to directly help community pharmacists and patients, especially those who are in rural and underserved communities, who are being squeezed by PBMs and their bad practices?

2. I recently sent a letter to the Department of Labor regarding so-called alternative funding programs, or AFPs. AFPs intentionally steer beneficiaries toward manufacturer or independent charitable patient assistance programs intended for the uninsured or underinsured. Third-party vendors are increasingly advising employers to turn to AFPs as a solution for high specialty drug costs, while advising plan sponsors to exclude coverage for many of these specialty drugs, forcing enrollees to navigate patient assistance programs to maintain access to their medication. In short, I am concerned that AFPs may mislead employers, make it more challenging for patients to access lifesaving specialty medications, and wrongfully utilize patient assistance funds for their gains. Has HHS taken any actions to address AFPs?

3. Congress passed the No Surprises Act to create transparency in medical billing. However, according to the GAO, the Department's implementation of the No Surprises Act has led to "over 61 percent of the 490,000 filed claims remaining unresolved as of June of 2023." And thanks to this Administration's failed fiscal policies, clinicians are facing increased costs, and the thousands of claims that are held up in the Federal Independent Dispute Resolution (IDR) Process are further exacerbating their financial problems. What will your department do to ensure payment is processed in a timely manner once a resolution is reached in the IDR process so that they can avoid the added burden of reaching out to HHS?

Rep. Aaron Bean (R-FL)

1. Mr. Secretary, I am a co-sponsor of the bipartisan HELP Copays Act (H.R. 830), which would ban copay accumulator adjustment programs and mitigate copay maximizer programs. You recently testified before our colleagues on the House Energy & Commerce Subcommittee on Health on April 17, and in response to a question about the 2023 District Court ruling over copay accumulators from Rep. Buddy Carter, you said, "We will comply with the law; that's our obligation," and "We are going to follow the court ruling wherever we can." However, I was troubled to learn that you went on to confuse the issue, saying that this was an issue in the Medicare program, where you should know that copay coupons are prohibited.

    a. Will your department issue guidance stating that the 2020 Notice of Benefit and Payment Parameters regulation regarding copay accumulators is in effect and that CMS will enforce a ban on copay accumulator adjustment programs except in cases where a generic is available?

    b. If you plan to issue guidance, when can we expect this guidance?

Ranking Member Robert C. "Bobby" Scott (D-VA)

1. On Tuesday, May 21, 2024, the Office of Community Services and the Administration for Children and Families within the Department of Health and Human Services (HHS)

issued a final report related to the state of Florida's administration of the Low Income Home Energy Assistance Program (LIHEAP), the Low Income Household Water Assistance Program (LIHWAP), and the Community Services Block Grant (CSBG) following reports of significant service disruptions in spring of 2023.[2] These programs collectively serve some of our most vulnerable individuals and families. Now that HHS has issued its final report, it is important that the Committee understand the full scope of what occurred in Florida and what will be done to ensure that program participants do not face further disruption.

a. Can you tell the Committee how long LIHEAP and LIHWAP service disruptions in the state lasted? What is the estimated amount of energy and water assistance benefits that were not distributed during that time period? How many people in the state were impacted by Florida's shutdown of LIHEAP and LIHWAP, including those who were unable to apply for or receive LIHEAP and LIHWAP assistance?

b. Media reports and accounts from stakeholders indicate that Community Action Agencies (CAAs) in Florida, which administer the CSBG program as well as other safety net programs, faced a lapse in funding for several weeks, causing service disruptions and staff furloughs. How many CAAs had to shutter their operations due to the state of Florida's funding lapses? How many CAA staff were furloughed? For how long were CAAs shut down? How many CAAs took out credit to cover expenses?

2. The *No Surprises Act* greatly expanded the responsibilities of both the Department of Health and Human Services and the Department of Labor to protect consumers from surprise medical billing. In addition, the law includes several consumer protections on issues, such as health care price transparency, health plans' obligation to maintain accurate provider directories, and continuity of care requirements.

a. How would this year's proposed budget support on-going implementation and enforcement of the *No Surprises Act*?

b. What would the impact be if Congress does not extend the implementation funding provided by the *Consolidated Appropriations Act, 2021*?

Rep. Suzanne Bonamici (D-OR)

1. Community Action Agencies (CAAs) provide essential services and programs that meet the unique needs of their local communities and empower low-income individuals and

[2] Margie Menzel, *Budget snafu leaves agencies serving Florida's poor without a safety net*, WFSU News (Apr. 18, 2023), https://wusfnews.wusf.usf.edu/politics-issues/2023-04-18/budget-snafu-leaves-agencies-serving-floridas-poor-without-a-safety-net. *See* also Alex Harris, *Florida froze program to help with power bills. Advocates worry it could happen again*, Miami Herald (Aug. 23, 2023), https://www.miamiherald.com/news/local/environment/article277473348.html. *See* also Low Income Assistance Programs Temporarily Suspended, Citrus County Board of County Commissioners, https://www.citrusbocc.com/news_detail_T12_R2013.php (last visited May 21, 2024).

families to achieve economic stability. Unfortunately, the slow distribution of federal Community Service Block Grant (CSBG) allotments from state agencies limits CAAs' reach. In 2015, the Department of Health and Human Services (HHS) adopted guidance for state and federal accountability measures, which includes a measure on timely payments of grant and subgrant funding. This metric evaluates payments from HHS to the states and from states to the CAAs. Despite these actions by HHS to address this issue, local agencies remain frustrated by the slow distribution of funds from their state.

a) How can HHS improve delivery of federal CSBG funds to local CAAs in a timely manner?

2. HHS recently requested comments on a proposed revision of the CSBG annual report in an effort to reduce the administrative burden of reporting; however, the annual report is a component and not the entirety of federal CSBG reporting requirements.

a) How is HHS working to reduce excess paperwork across the board, especially for smaller CAAs, and streamline reporting systems for local agencies that administer multiple programs, such as Head Start and Low-Income Home Energy Assistance, in addition to CSBG?

b) Many local CAAs work with state agencies that administer CSBG and related programs, how will HHS prevent duplicative state reporting requirements on CAAs?

Questions for the Record for Xavier Becerra

Committee on Education and the Workforce Hearing
"Examining the Policies and Priorities of the Department of Health and Human Services"
May 15, 2024

Chairwoman Virginia Foxx (R-NC)

Health Coverage

Question #1
During the hearing, I expressed concerns about the Department of Health and Human Services' (HHS) regulatory overreach with respect to self-insured health plans. As I noted, the recent Notice of Benefit and Payment Parameters final rule and the Section 1557 Nondiscrimination in Health Programs and Activities final rule saddle self-insured health plans with new Obamacare regulations. Under current law, self-funded plans are not subject to Section 1557 and are regulated by the Department of Labor (DOL). I asked you the following question during the hearing, but you did not provide an answer. Will you confirm it is HHS policy that self-insured health plans are not subject to HHS
regulation, and will you commit to abandoning any unlawful HHS efforts to regulate self- insured health plans?

Response:
People deserve access to equitable health care, free of discrimination, consistent with the law. This work is led by the HHS Office for Civil Rights (OCR) and Section 1557 does not authorize OCR or CMS to require a health plan not otherwise subject to section 1557 to comply with the statute.

The Public Health Service Act (PHS Act) section 2791(d)(8)(C) defines the term "Non-Federal governmental plan" as a governmental plan that is not a Federal governmental plan. Some examples of non-Federal governmental plans are group health plans that are sponsored by states, counties, school districts, and municipalities. Under 45 C.F.R. § 146.145(a), a "group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise." Non-Federal governmental plans can operate as self-funded group health plans, purchase a fully insured group health insurance product, or consist of a mixture of self-funded and fully insured options.

Non-Federal governmental plans are not regulated the same way as insurance companies or private employer health plans. The statutory framework for enforcement of non-Federal governmental plans was established in Part A of title XXVII of the PHS Act with the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Patient Protection and Affordable Care Act, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, enacted on March 30, 2010, (collectively known as the Affordable Care Act or ACA) reorganized, amended, and added to the provisions of Part A of title XXVII of the PHS Act. On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA), which included the No Surprises Act, was signed into law. The No Surprises Act (NSA) provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise bills arise most frequently. The CAA added provisions that apply to group health plans and health insurance issuers in the group and individual market in a new Part D of title XXVII of the PHS Act. Accordingly, non-Federal governmental plans are subject to the provisions of Part A of title XXVII of the PHS Act, including any changes made by the ACA and NSA.

The provisions of title XXVII of the PHS Act that apply to group health plans that are non-Federal governmental plans are enforced by the Centers for Medicare & Medicaid Services (CMS), on behalf of HHS, under PHS Act section 2723(b)(1)(B) using the procedures described in 45 C.F.R. §150.301, et seq. Pursuant to this authority, CMS may investigate, work with the plan to implement corrective action, or impose civil monetary penalties for any non-Federal governmental plan that fails to comply with applicable PHS Act requirements.

Question #2
The *Inflation Reduction Act* (IRA) included $33 billion to expand subsidies for Obamacare plans for an additional three years. The President's budget calls for a
permanent expansion of enhanced subsidies, which the Congressional Budget Office (CBO) estimates would cost $383 billion over the next decade. Why is HHS instead
working to strengthen employer-sponsored health insurance, which is consistently more affordable and of higher quality than Obamacare plans?

Question #3
Three out of four individuals in the *Affordable Care Act* (ACA) exchanges receive subsidies. Does this not demonstrate that these plans are unaffordable?

Question #4
Premiums on the ACA exchanges are skyrocketing. Does the administration have a plan to lower the cost of ACA premiums that does not simply continue to pump money into
the system through tax hikes?

Question #5
According to CBO estimates, ACA plans per enrollee are three times more expensive for taxpayers than employer-sponsored health insurance. Do you believe that shifting
enrollment from ACA plans to the employer-sponsored market would be beneficial for
the federal budget? If so, what steps will HHS take to encourage migration to employer- sponsored health plans?

Question #6
Small businesses rely on stop-loss insurance to provide more affordable, higher quality health care coverage to their employees by self-insuring. Do you agree that stop-loss coverage is a necessary tool for many businesses to self-insure? Why or why not?

Response to Questions 2-6:
More than 21.4 million people selected or were automatically re-enrolled in an Affordable Care Act (ACA) Marketplace health plan nationwide during the 2024 Marketplace Open Enrollment Period (OEP) that ran from November 1, 2023-January 16, 2024 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2024 Marketplace OEP than ever before, and millions of working families are saving $800 a year on their premium due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 5.2 million people who are new to the Marketplaces for 2024, and 16.2 million people who had active 2023 coverage and made a plan selection for 2024 coverage or were automatically re-enrolled. 5.1 million more consumers signed up for coverage during the 2024 OEP compared to the 2023 OEP, a 31% increase. Nationwide, the number of new consumers selecting Marketplace coverage during the 2024 OEP increased by 41%, to 5.2 million from 3.7 million in the 2023 OEP.

This year, individuals benefited from a highly competitive Marketplace. For the third consecutive year,

consumers continue to have more choices of health insurance issuers. For plan year 2024, 96% of HealthCare.gov consumers have access to three or more health insurance issuers, up from 93% in plan year 2023. At the same time CMS created policies aimed to mitigate choice overload and present consumers with meaningful plan choices. New standardized plan options were available beginning in 2023 through HealthCare.gov, which helped consumers compare and select plans. ACA plans are serving a demonstrated need for Americans who may not have the option to enroll in employer-sponsored coverage.

To build on this success, the FY 2025 budget would invest in making private insurance even more affordable. The FY 2025 budget proposes to permanently extend the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget would provide Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the Affordable Care Act, paired with financial incentives to ensure States maintain their existing expansions. The budget would build on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget would extend the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

With respect to the use of stop-loss insurance by employers with self-insured group health plans, the Department of Labor is the agency primarily tasked with administration of requirements applicable to private employer sponsored self-insured group health plans under Title I of ERISA.

Question #7

The administration likes to call any form of health coverage it does not like "junk insurance," as shown by recent regulations to erode the association health plan and short- term, limited-duration insurance markets. Should the government dictate what is and is not beneficial insurance, or should individuals be able to make those decisions for themselves?

Response:

See response to question 8 and response to Questions 12-13.

Question #8

President Biden once said, "if you like your health care plan ... you can keep it. If in fact you have private insurance, you can keep it." President Obama made a similar promise, saying, "if you like your health care plan, you can keep it," which some outlets considered to be the "lie of the year" in 2013. Will President Biden keep his promise? Does the President want every American on an Obamacare individual market plan? How can the President keep his promise while his administration actively erodes the association health plan and short-term, limited-duration insurance markets and saddles employer-sponsored plans with costly regulations?

Response (7-8):

Patients and their families deserve the security of knowing that the insurance they buy will be there for them when they need it. Short-term, limited-duration insurance (STLDI) is a type of health insurance that is designed to fill temporary gaps in coverage when an individual is transitioning from one source of coverage to another. STLDI is excluded from the definition of individual health insurance coverage under the Public Health Service Act and, therefore, is generally not subject to the applicable federal individual market consumer protections and requirements for comprehensive coverage under the ACA and other federal laws. For example, STLDI is not subject to the prohibition on discrimination based on health status, prohibition of preexisting condition exclusions, and the prohibition on lifetime and annual dollar limits on essential health benefits. Thus, individuals

who enroll in STLDI are not guaranteed these key consumer protections under the ACA. STLDI policies tend to offer limited benefit coverage and have relatively low actuarial values. These plans therefore expose enrollees to the risk of high out-of-pocket health expenses and medical debt.

On April 3, 2024, the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released final rules regarding STLDI and independent, noncoordinated excepted benefits coverage. These final rules finalize some of the amendments set forth in the July 12, 2023, proposed rules. These regulatory amendments further the goals of the ACA by improving access to affordable and comprehensive coverage, strengthening health insurance markets, and promoting consumer understanding of their coverage options. Because STLDI and fixed indemnity insurance are sold outside of the Exchanges and are generally not subject to the Federal consumer protections and requirements for comprehensive coverage, consumers may have limited information about the limitations, value, and quality of the coverage being sold, and it might be mistakenly viewed as a substitute for comprehensive coverage.

Question #9
The Committee has taken steps to help employers ensure that the third-party administrators (TPA) they contract with operate transparently.

a) What actions is the administration taking to require TPAs to share rates and settled claims amounts with those self-funded employers who have the fiduciary responsibility for their health care spend?

b) When brokers offer "no-shop" commissions, how does this protect employers and ensure they are getting the best plan for their employees? What actions will the administration put in place to restrict no-shop commissions?

c) Brokers are being asked to sign non-disclosure agreements with carriers stating they will not disclose their rates to anyone (including the employer they represent). What steps is the administration putting in place to make these practices illegal?

d) How does the Section 1557 nondiscrimination protections impact self-funded plans, their carriers, and TPAs?

Response:
A group health plan is subject to Section 1557 if it is a recipient (or subrecipient) of Federal financial assistance as set forth under 45 C.F.R. § 92.2(a)(1). See 89 Fed. Reg. 37522, 37620 (May 6, 2024). A health insurance issuer is subject to Section 1557 if it is a recipient (or subrecipient) of Federal financial assistance as set forth under 45 C.F.R. § 92.2(a)(1). Section 1557 applies to all the operations of a recipient principally engaged in the provision or administration of health insurance coverage or other health-related coverage as set forth under the definition of "health program or activity" at 45 C.F.R. § 92.4, including its third-party administrator activities for a self-funded group health plan. See 89 Fed. Reg. 37522, 37541, 37625 (May 6, 2024).

HHS does not regulate TPAs. The Department of Labor has jurisdiction over TPAs if they are acting as fiduciaries for an ERISA group health plan.

The Department of Labor is the agency primarily tasked with administration of requirements applicable to private employee benefit health plans under Title I of ERISA, including certain service providers who provide "brokerage services" or "consulting" to ERISA-covered group health plans.

Question #10

Telehealth

Telehealth, in many ways, was a silver lining of the COVID-19 pandemic. Many new patients gained access to these important services because HHS allowed employers to offer stand-alone telehealth coverage. However, telehealth-excepted benefits expired at the end of this past plan year, as the declared Public Health Emergency came to an end on May 11, 2023.

a) Do you believe this flexibility helped workers gain access to care?

b) Will you support this Committee's efforts to extend this flexibility going forward?

Response:
The Departments of HHS, Labor, and the Treasury recognize that telehealth and other remote care services can be an important tool in the delivery of healthcare. The COVID-19 pandemic posed critical challenges to the delivery of healthcare services as jurisdictions issued stay-at-home orders and providers limited their operations in order to minimize the risk of exposure to and the community spread of COVID-19. The Departments generally encouraged use of these telehealth services during the COVID-19 pandemic to help ensure that plans and issuers were able to provide a robust variety of treatment, including for mental health and substance use disorder services, and to ensure that consumers were able to access the healthcare services they needed.

As noted in the 2022 Mental Health Parity and Addiction Equity Act (MHPAEA) Report to Congress, the Departments continue to recommend that Congress consider ways to permanently expand access to telehealth and remote care services, while ensuring that individuals receiving telehealth or remote care are still covered by important consumer protections that might not otherwise apply to stand-alone telehealth benefits. Telehealth has become a vital means of providing health care, including mental health and substance use disorder care, especially in light of the COVID-19 pandemic. Nonetheless, there are noteworthy barriers to ensuring access to telehealth services, including limited broadband access and interstate licensing requirements. The Departments look forward to working with Congress and stakeholders to identify ways to achieve this goal.

Question #11
Your budget proposes a ban on telehealth facility fees.

a) How does HHS justify such a ban?
b) How would banning facility fees help reduce costs for employers?
c) Can you provide additional details on the estimated $2.3 billion in savings such a ban would provide the federal government?
d) Could you elaborate on the meaning of "other outpatient services" to which the proposed ban refers?

Response:
As hospitals expand ownership of outpatient and physician office settings, consumers are seeing an uptick in fees for more than just the care provided to them. These "facility fees" are increasingly a driver of healthcare costs in America, and are leading to consumers being charged as though they received treatment in a hospital even if they never entered one. This proposal would prohibit hospitals from billing unwarranted facility fees for telehealth services and for certain other outpatient services.

Question #12

Association Health Plans

Congressional Republicans have a longstanding interest in allowing associations and businesses to band together to purchase affordable health insurance coverage through association health plans (AHPs). In 2018, HHS issued a final rule to expand access to AHPs. Before a court invalidated the rule, 35 new AHPs were formed, which saw average savings of 29 percent. On April 30, DOL issued a final rule which rescinds the 2018 rule, robbing Americans of an innovative way to access high-quality, low-cost health care.

a) To what extent do you anticipate that DOL's final rule reversing the expansion of AHPs will raise costs?

b) Does HHS have any estimates of how many people will be prevented from accessing affordable health coverage due to the new rule?

Question #13

AHPs are an effective way to expand health care coverage options to small businesses and to reduce premiums. Unfortunately, the Biden administration recently released a rule to erode the AHP marketplace.

a) In your opinion, are Obamacare plans the only acceptable form of insurance?

b) Why is the Biden administration so intent on taking away innovative coverage models from employers and individuals?

Response (12-13):
The Department of Labor is the agency primarily tasked with administration of requirements applicable to private employee benefit health plans under Title I of ERISA.

Short-Term Limited-Duration Insurance

Question #14

On April 3, HHS, DOL, and the Department of the Treasury (the Tri-Agencies) jointly published final rules severely reducing access to short-term, limited duration insurance. The final rules stated: "These final rules might also lead to an increase in the number of individuals without some form of health insurance coverage.… Those individuals who become uninsured or obtain coverage in unregulated markets could face an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes." How many Americans will become uninsured because of these regulations?

Response:
On April 3, 2024, HHS, Labor, and the Treasury (collectively, the Departments) released final rules regarding short-term, limited-duration insurance (STLDI) and independent, noncoordinated excepted benefits coverage. These final rules finalize some of the amendments set forth in the July 12, 2023, proposed rules. These regulatory amendments further the goals of the ACA by improving access to affordable and comprehensive coverage, strengthening health insurance markets, and promoting consumer understanding of their coverage options.

Patients and their families deserve the security of knowing that the insurance they buy will be there for them when they need it. STLDI is a type of health insurance that is designed to fill temporary gaps in coverage when an individual is transitioning from one source of coverage to another. STLDI is excluded from the definition of individual health insurance coverage under the Public Health Service Act and, therefore, is generally not subject to the applicable federal individual market consumer protections and requirements for comprehensive coverage under the ACA. For example, STLDI is not subject to the prohibition on discrimination based on health status, prohibition of preexisting condition exclusions, and the prohibition on lifetime and annual dollar limits on essential health benefits. Thus, individuals who enroll in STLDI are not guaranteed these key consumer protections under the ACA.

The Departments acknowledge that some individuals who purchase STLDI policies may lose coverage and have to wait until the next annual individual market open enrollment period to purchase comprehensive coverage (for example, if an individual with STLDI purchased after September 1, 2024, exhausts their renewal or extension options or is unable to enroll in STLDI offered by a different issuer in a 12-month period) or may choose to become uninsured. Some individuals might also seek coverage in unregulated markets. Those individuals who become uninsured or obtain coverage in unregulated markets could face an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes. The Departments find, however, that the overall risk that some individuals may become uninsured or lose coverage because of the above circumstances is outweighed by the fact that a substantial number of individuals will likely benefit as a result of the final rules' STLDI provisions. Overall, the Departments are of the view that STLDI serves better as a bridge between different sources of comprehensive coverage than as an alternative to comprehensive coverage.

Surprise Billing

Question #15
This Committee's efforts helped lead to the passage of the historic *No Surprises Act* (NSA). However, the law's Independent Dispute Resolution (IDR) process has been mired in litigation, delays, and faulty implementation. Data shows that 77 percent of disputes are ruled in favor of providers, and the Brookings Institution now anticipates that the IDR process will raise costs and premiums, contrary to the law's goals. I asked you the following question during the hearing, but you did not provide a responsive answer. What is HHS doing to improve the operations of the IDR process under the NSA, and are you concerned that the law's current implementation will raise health care costs for
employers and employees?

Question #16
I am concerned that, due to current implementation, some companies are using the NSA's IDR process as a moneymaking scheme. The IDR process has been flooded by disputes from just a few large billing consultants and physician-staffing firms. The top 10 dispute- initiating parties submitted 73 percent of the out-of-network payment disputes.

a) Are you worried that some players are abusing the IDR system?
b) How are smaller providers disadvantaged if the IDR system is overwhelmed by disputes from large billing consultants and staffing firms?
c) Do you share my concerns that current implementation of the IDR process may further fuel health care consolidation?

Question 17

There is a lot of frustration from providers, employers, and insurers about the administration's implementation of the NSA's IDR process.

a) Why has implementation been such a challenge?
b) Why did HHS so severely underestimate how many disputes would enter the IDR process?
c) Did the Tri-Agencies' November 2023 proposed rule address these implementation challenges, and can you provide an update on HHS' work to improve IDR operations?
d) How is the administration ensuring that IDR entities are appropriately and clearly communicating with payers and providers regarding the outcomes of claim disputes?
e) How is the administration conducting oversight of IDR entities' decision-making?
f) How is the administration handling medical necessity denials for claims which would otherwise be eligible for IDR, particularly for air ambulance services?

Response to Questions 15-17:

The Departments are continuing to work to address specific issues critical to improving the Federal IDR process in response to feedback and challenges noted by interested parties. On October 27, 2023, the Departments released proposed rules on new processes and polices related to the operation of the Federal IDR process which we believe would expedite the processing of disputes by certified IDR entities. The "Federal Independent Dispute Resolution (IDR) Operations" proposed rules address specific issues critical to improving the functioning of the Federal IDR process in response to feedback and challenges noted by interested parties. Overall, if finalized, the proposed rules would facilitate improved communications between payers, providers, and certified IDR entities; adjust specific timelines and steps of the Federal IDR process; establish new batching provisions; create more efficiencies; and change the administrative fee structure to improve accessibility of the process. It is the Departments' intention that together, these proposals, if finalized, would result in improved operations of the Federal IDR process and more timely payment determinations.

The comment period for the proposed rules, closed on January 2, 2024 but it was subsequently reopened from January 22, 2024, to February 5, 2024, to provide additional time for interested parties to consider and comment on any implications of the IDR Fees final rules. The Departments are in the process of reviewing the comments received.

In addition, we have made numerous updates to the Federal IDR process since it opened, and we always welcome open dialogue with our stakeholders regarding the functionality of the Federal IDR portal. The Departments understand that there are additional functionalities that would help disputing parties engage more efficiently with the Federal IDR process. We will continue to explore changes to Federal IDR portal functionalities to address feedback from interested parties.

The number of disputes initiated through the Federal IDR portal over the first six-month period of 2023 was 13 times greater than the Departments initially estimated the number of disputes initiated would be over the course of a full calendar year and has grown each quarter. The majority of disputes were initiated by a small number of initiating parties or their representatives. The top ten initiating parties represented approximately 78% of all disputes initiated in the first six months of 2023. Many of the top initiating parties are (or are represented by) large practice management companies, medical practices, or revenue cycle management companies representing hundreds of individual practices, providers, or facilities. The top three initiating parties represent thousands of clinicians across multiple states and accounted for approximately 58% of all disputes submitted in the first six months of 2023. Increased dispute submissions from these top initiating parties in 2023 contributed to the overall increase in dispute volume in the first six months of 2023.

For example, to address the high volume of disputes, the Departments worked to improve and automate how the Federal IDR portal operates, as well as provide technical assistance and guidance to certified IDR entities and disputing parties to make the process run more smoothly. For example, the Departments made major updates to the Federal IDR portal, including updating webforms to capture information to aid in eligibility determinations, expanding data validations to ensure disputing parties are inputting accurate information, updating system functionality to accommodate changing requirements as a result of court rulings (including temporarily suspending the Federal IDR portal functionality to ensure that guidance and IT systems were consistent with court orders), automating email communications to reduce delays between disputing parties and certified IDR entities, and improving how the Departments respond to inquiries from certified IDR entities and disputing parties.

The Departments' work to respond to initial IDR process challenges is yielding substantial results. Certified IDR entities have scaled up their operations to address the high volume of disputes. Certified IDR entities rendered 83,868 payment determinations in the first six months of 2023, more than five times the number of payment determinations made in all of 2022 (16,238). Certified IDR entities have increased their payment determination output each quarter compared to the prior quarters. Certified IDR entities made 26,741 payment determinations in the first quarter of 2023, 64% more than the prior quarter, and made 57,127 payment determinations in the second quarter of 2023, which was more than twice the number from the prior quarter. Certified IDR entities closed 134,036 disputes in the first six months of 2023. Disputes were closed for several reasons, including: a payment determination was made, the dispute was determined ineligible for the Federal IDR process, the dispute was withdrawn, parties reached a settlement, or the dispute was closed for administrative reasons, such as unpaid fees. Despite the increase in the number of payment determinations, due to the high volume of disputes initiated, some disputing parties are still awaiting eligibility and payment determinations. The Departments' objective is to help certified IDR entities and disputing parties obtain resolution on disputes as expeditiously as possible.

For each calendar quarter in 2022 and each calendar quarter in subsequent years, the Departments are required to publish on a public website certain information about the Federal IDR process. This information includes the following:

1. The number of Notices of IDR Initiation submitted during the calendar quarter.
2. In the case of items or services that are not air ambulance services, the size of the provider practices and the size of the facilities submitting Notices of IDR Initiation during the calendar quarter.
3. The number of Notices of IDR initiation for which a final determination was made, including for each final determination:
    a. A description of each item and service or air ambulance service (as applicable);
    b. The geographic area in which the items and services were provided;
    c. The amount of the offer submitted by each party expressed as a percentage of the qualifying payment amount (QPA);
    d. Whether the offer selected by the certified IDR entity was the offer submitted by the plan or issuer (as applicable) or was the offer submitted by the nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services (as applicable) and the amount of the selected offer expressed as a percentage of the QPA;
    e. In the case of items or services that are not air ambulance services, the category and practice specialty of each provider or facility involved in furnishing such items and services;
    f. In the case of air ambulance services, the air ambulance vehicle type; including the clinical capability level of such vehicle;
    g. The identity of the health plan or health insurance issuer, provider, or facility;

   h. The length of time in making each determination; and
   i. The compensation paid to the certified IDR entity.
4. The number of times the payment amount determined (or agreed to) exceeds the QPA, specified by items and services.
5. The amount of expenditures made by the Departments during the calendar quarter to carry out the Federal IDR process.
6. The total amount of administrative fees paid during the calendar quarter.
7. The total amount of compensation paid to certified IDR entities during the calendar quarter.

The Departments are committed to publishing this required data, bringing transparency to the Federal IDR process, and providing important information to the public, disputing parties, and Congress.

Since first launching the Federal IDR portal, the Departments have made, and will continue to make, adjustments to operations and policy, including through regulations (such as the operations and fees rules described above), as the Departments find more ways to refine and improve the Federal IDR process. As a result of system enhancements that the Departments have implemented over the past year, the Departments have been able to extract all the data necessary to begin publishing the quarterly report required under the NSA. On February 15, 2024, the Departments released the first set of detailed Public Use Files containing all required data elements for quarterly reports, covering the first two calendar quarters of 2023, as well as supplemental data to improve transparency around the Federal IDR process.

Question #18

In addition to protecting against surprise medical bills, the NSA included other important patient protections. The law requires health plans and issuers to provide an advanced explanation of benefits (AEOB) detailing the estimated costs for a scheduled service.

However, the Centers for Medicare and Medicaid Services (CMS) has not yet implemented this requirement. Please provide an update on CMS's timeline to implement the AEOB requirement via rulemaking.

Response:

On September 16, 2022, the Centers for Medicare & Medicaid Services (CMS), along with the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) and the Office of Personnel Management (OPM) published a Request for Information (RFI) that sought comments from interested parties on a number of issues related to AEOB and insured Good Faith Estimate (GFE) provisions, including recommendations on exchanging data between providers and facilities to payers, and the economic impacts of implementing these requirements. The Departments and OPM received 285 comments from providers, payers, vendors, consumer and patient advocates, and other stakeholders. The Departments and OPM are carefully considering this feedback as we engage in rulemaking on these provisions.

The Departments and OPM are working to implement the GFE and AEOB requirements in stages. Using this approach, the Departments and OPM can better ensure each stage is informed by thorough research and collaboration with impacted stakeholders and, importantly, supported by appropriate technical standards for data sharing between providers and payers. This deliberate, incremental approach will ensure that patients get meaningful and actionable information about their care. The Departments and OPM are incorporating lessons learned from implementing the uninsured (or self-pay) GFE provisions as well as industry feedback from the

preliminary development of GFE and AEOB data exchange standards as we develop proposed rules on insured GFE and AEOB provisions and technical requirements. The Departments and OPM have been, and continue to be, engaged in a number of efforts that will help inform successful rulemaking and implementation of the insured GFE and AEOB requirements.

Question #19
The NSA's IDR program was intended to be funded through administrative fees from disputing parties. Why does the President's budget request an additional $500 million for NSA implementation when the program is supposed to be self-funded?

Response:
To implement the No Surprises Act, the Departments scaled up expertise and resources for rulemaking, technical builds, enforcement, and staffing. Section 103 of the NSA directed the Departments to establish a Federal IDR process that would be funded by administrative fees that are estimated to account for the estimated costs of carrying out the Federal IDR process. However, the Federal IDR process is only one part of the NSA, which contains a number of other provisions that protect consumers from surprise medical bills and promote transparency in health coverage. While the original appropriation expires at the end of 2024, most of the statutory requirements added by the No Surprises Act and Title II Transparency provisions are permanent and the Departments will have ongoing responsibilities. Some of these responsibilities include enforcement of critical consumer protections against surprise billing and cannot be funded with IDR administrative fees.. Without additional dedicated funding, the Departments may need to phase-down or phase-out certain enforcement efforts, including investigation and resolution of some health plan and provider complaints. For example, HHS may have to significantly adjust its staffing of the No Surprises Help Desk, curtailing consumers' and providers' access to a crucial resource for information about NSA requirements and protections, and leaving them without a central point of contact to submit complaints. HHS further may limit its provider enforcement activities, leaving consumer complaints of illegal balance bills and other violations of the NSA unanswered.
Other impacts include:
Plan enforcement activities, including market conduct exams related to late payments by non-prevailing parties following a payment determination;
Policy development and program implementation related to the NSA's advanced explanations of benefits (AEOBs);
Prescription drug data collection, preventing HHS from collecting, analyzing, and publishing findings about prescription drug pricing and the impact of prescription drug rebates on patient out-of-pocket costs; and
Air ambulance data collection.

Mental Health Parity

Question #20
I have serious concerns about HHS' 2023 proposed rules regarding mental health parity.
The proposed rules do little to expand access to quality mental health care while burdening employers with more paperwork requirements.

Do you share my concerns that conditioning mental health parity compliance on reimbursement rates will raise premiums and health care costs, while doing little to alleviate provider shortages?
Should health plans serving areas with mental health provider shortages be given a safe harbor from parity compliance?

Do you support efforts to expand telehealth to help alleviate mental health provider shortages, particularly in rural areas?

Question #21
There is bipartisan consensus on the need to boost mental health care in this country. However, I worry that the administration's recent rule on the *Mental Health Parity and Addiction Equity Act* (MHPAEA) will layer plans with more burdensome regulations, which will raise costs and reduce access to mental health care. What is the administration's timeline for releasing the mental health parity final rule?

Response 20-21:
Ensuring robust access to mental health care has been a bipartisan priority for almost 16 years, since the 2008 enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA), a landmark law that called for mental health care benefits covered by health plans to be provided in parity with medical/surgical benefits health care benefits, and which was strengthened on a bipartisan basis in 2020 with the enactment of the Consolidated Appropriations Act, 2021 (CAA, 2021). Yet today, too many Americans still struggle to find and afford the mental health care they need. Of the 21% of adults who had any mental illness in 2020, less than half received mental health care; fewer than one in ten with a substance use disorder received treatment. Research shows that people with private health coverage have a hard time finding a mental health provider in their health plan's network. Despite the repeated bipartisan efforts aimed at strengthening mental health parity, insurers too often make it difficult to access mental health treatment, causing millions of consumers to seek care out-of-network at significantly higher costs and pay out of pocket, or defer care altogether.

On July 25, 2023, the Departments of Labor, Health and Human Services, and the Treasury (the Departments) proposed rules to amend regulations implementing MHPAEA. The proposed rules reinforce MHPAEA's fundamental goal of ensuring that individuals have comparable access to mental health and substance use benefits and medical/surgical benefits health benefits. The proposed rules, if finalized, would increase parity in access to in-network mental health and substance use disorder care as compared to medical/surgical care and eliminate greater barriers to access to mental health and substance use disorder care as compared to medical/surgical care that keep people from getting the care they need, when they need it. The Departments recognize that telehealth has become a vital means of providing health care, including mental health and substance use disorder care, especially in rural areas, and in light of the COVID-19 pandemic. In the 2023 MHPAEA proposed rules, the Departments solicited comments on issues related to rural Americans' access to providers of mental health and substance use disorder services and telehealth. For example, the Departments solicited comments on ways that telehealth or other remote care services can be used to enhance access to mental health and substance use disorder treatment under the Departments' existing authority for both routine and crisis care for behavioral health conditions, including through parity requirements with respect to financial requirements and treatment limitations.

In 2020, Congress enacted the CAA, 2021, which made changes to MHPAEA to require group health plans (plans) and health insurance issuers offering group or individual health insurance coverage (issuers) that include both medical/surgical benefits and mental health or substance use disorder benefits and impose nonquantitative treatment limitations (NQTLs) on mental health and substance use disorder benefits to perform and to document comparative analyses of the design and application of NQTLs. The Departments' proposed rules, if finalized, would make clear that plans and issuers need to evaluate the outcomes of their coverage rules to make sure that the NQTLs that plans and issuers apply do not create material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits. This would include looking at data such as claims denials, as well as in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers

accepting new patients), and provider reimbursement rates. These NQTL comparative analyses would show plans and issuers where they are failing to meet requirements under MHPAEA. Where they fail to meet the requirements of the law, plans and issuers would be required to improve parity in access to mental health and substance use disorder care – for example, by including more mental health professionals in their networks.

The proposed rules would, if finalized, provide specific examples that make clear that plans and issuers cannot impose more restrictive prior authorization requirements, other medical management techniques, or network participation requirements that make it harder for people to access mental health and substance use disorder benefits than their medical/surgical benefits. Under the proposed rule, health plans would have to use similar factors in setting out-of-network payment rates for mental health and substance use disorder providers as they do for medical providers. The comment period on these proposed rules closed on October 17, 2023.

As stated in the 2022 and 2023 MHPAEA Reports to Congress, the Departments continue to recommend that Congress consider ways to permanently expand access to telehealth and remote care services. As noted above, telehealth has become a vital means of providing health care, including mental health and substance use disorder care, especially in light of the COVID-19 pandemic. Nonetheless, there are noteworthy barriers to ensuring access to telehealth services, including limited broadband access and interstate licensing requirements. The Departments look forward to working with Congress and stakeholders to identify ways to achieve this goal.

Question #22
Under parity requirements, mental health and substance use disorders must be treated the same as physical health. Why does the proposed mental health parity rule include a test for non-quantitative treatment limits (NQTLs), which will allow health plans to perform utilization review on inpatient medical care half the time—but none of the time for mental health and substance use disorder care?

Question #23
The current mental health parity proposal will likely eliminate the ability for health plans to employ utilization management techniques in mental health and substance use disorder care, especially in outpatient settings. These techniques can help ensure people get the right care at the right time. Was HHS' intent to eliminate the ability of health plans to perform utilization management in mental health and substance use disorder care?

Question #24
I have read some of the health plans and employer comments on the proposed mental health parity rule, and they asked for a sample NQTL analysis that they can use as a guide when doing their analyses. Will HHS commit to working with DOL to make these samples publicly available before the compliance date of the pending final rule?

Question #25

A fundamental proposed change in the proposed rule is adding the Substantially All/ Predominant test to NQTLs. This means that in order for health plans and issuers to apply management techniques such as prior authorization and concurrent review to Mental Health and Substance Use Disorders benefits, these techniques must be applied to 2/3rd or more of the medical/surgical (M/S) benefits in the same classification. This reinterprets the parity statute to subject NQTLs to the quantitative tests currently applied to quantitative treatment limits. It will be impossible to operationalize these tests and will remove nearly all insurer tools to ensure patients receive safe and appropriate care. Please explain why the Tri-Agencies proposed 2/3rds—as opposed to 50 percent or 20 percent for an NQTL test. For example, if value-based purchasing is only used with

61 percent of M/S providers in a classification, is it foreclosed for all behavioral health providers in that same classification?

Question #26
The proposed mental health parity rule shifts the focus from comparing methodologies to comparing outcome measures like denial rates and actual amounts paid to providers. This approach goes well beyond the intent of the MHPAEA and suggests that any disparate outcome equals noncompliance. Please explain why the Tri-Agencies proposed to change from their position that disparate outcomes could be indicative of a parity violation to the proposal's position that says that disparate outcomes are per se violations for certain NQTLs.

Response 22-26:
On July 25, 2023, the Departments of Labor, Health and Human Services, and the Treasury (the Departments) proposed rules to amend regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and proposed new regulations implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under MHPAEA, as amended by the Consolidated Appropriations Act, 2021. The proposed rules would amend the existing NQTL standard to prevent group health plans and health insurance issuers offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits from using NQTLs to place greater limits on access to mental health and substance use disorder benefits as compared to medical/surgical benefits. As part of these changes, the proposed rules would require plans and issuers to collect and evaluate relevant data in a manner reasonably designed to assess the impact of NQTLs on access to mental health and substance use disorder benefits and medical/surgical benefits, and propose a special rule for NQTLs related to network composition. The proposed rules also would amend existing examples and add new examples on the application of the rules for NQTLs to clarify and illustrate the protections of MHPAEA. In addition, the proposed rules would set forth the content requirements for NQTL comparative analyses and specify how plans and issuers must make these comparative analyses available to the Departments, as well as to an applicable State authority, and participants, beneficiaries, and enrollees. The Departments also solicited comments on whether there are ways to improve the coverage of mental health and substance use disorder benefits through other provisions of Federal law. The comment period closed on October 17, 2023.

Drug Pricing

Question #27
The President's budget request proposes to extend Medicare's $35 out-of-pocket cap for insulin to the commercial market. If enacted, this proposal would cost taxpayers an
estimated $1.3 billion over 10 years. Will extending this cap to the commercial market raise premiums for individuals in small- and large-group plans?

Response:
The Inflation Reduction Act limits Medicare beneficiary cost-sharing to $35 per covered insulin product for a month's supply. The President's FY 2025 Budget includes a proposal to extend the cap on patient cost-sharing to insulin products in commercial markets. This would allow more of the over 37 million Americans with diabetes to lock in this lower cost.

Question #28
The 340B drug-pricing program is intended to pass on savings and improve health outcomes for low-income patients. However, there are reports that hospitals and
pharmacies are selling these drugs to commercially insured patients to pad their bottom lines, using employer-

sponsored plans to subsidize the 340B program at the expense of workers' premiums. The President's budget includes funding for oversight and auditing of covered entities.

Question #28a
Please provide an update on these oversight efforts.

Response:
HRSA places the highest priority on the integrity of the 340B Program and continually works to strengthen oversight of the Program within its current authority. Specifically, the FY 2025 President's Budget proposes to enhance program integrity by requiring covered entities to annually report to HRSA how savings achieved through the 340B Program benefits the communities they serve and provide HRSA with regulatory authority to implement this requirement.

Approximately 14,000 covered entities and over 800 manufacturers participate in the Program. HRSA audits 200 covered entities, including their off-site, outpatient facilities and contract pharmacies, annually using a risk-based selection method, executes targeted audits where potential compliance issues may exist, and employs a number of approaches to oversee covered entity compliance of the 340B Program.

Since 2012, HRSA has completed over 2,200 covered entity audits, including reviews of over 29,000 offsite outpatient facilities, over 58,000 contract pharmacies, and 46 manufacturer audits. The results of these audits are available on the HRSA website.

Question #28b
Should hospitals be able to use the 340B program to pad their bottom lines?

Response:
The 340B Program enables safety net health care providers to generate savings on their purchases of prescription drugs to support a broader array of services for the individuals and communities they serve.

Question #28c
What protections will you put in place to ensure that providers are only using the government-set price drugs for eligible patients?

Response:
HRSA currently assesses covered entities' eligibility when they seek to join the program, reviews compliance with program requirements annually, and conducts program integrity audits of covered entities. These efforts include oversight regarding compliance with the statutory prohibition on covered entities reselling or transferring 340B drugs to ineligible patients. The President's Budget also included a legislative proposal to require covered entities to report on the amount and use of their 340B savings. Additionally, HRSA has engaged in risk-based program integrity efforts focused on hospitals that were at higher risk of compliance issues due to volume of purchases; number of off-site, outpatient sites; or prior audit findings.

Question #29
According to a study from the University of Chicago, government price controls in the *Inflation Reduction Act* will result in 342 fewer cures reaching the market, which will take 330 million years off Americans' lives. What is the Biden administration's plan to
ensure that patients will not lose out on access to lifesaving cures and that America will continue to be the world leader in medical innovation?

Response :
HHS supports continued drug innovation and believes it is vitally important that beneficiaries have access to innovative new therapies. The statute provides that drugs that have been approved by the FDA for at least seven years, or biologicals that have been licensed by the FDA for at least 11 years, are eligible for negotiation. Any drugs or biologicals selected for negotiation will have been on the market for quite some time.

The law requires CMS to exclude certain orphan drugs when identifying qualifying single source drugs, referred to as the orphan drug exclusion. Section 1192(e)(3)(A) of the Act describes a drug that qualifies for the orphan drug exclusion as "a drug that is designated as a drug for only one rare disease or condition under section 526 of the Federal Food, Drug, and Cosmetic Act and for which the only approved indication (or indications) is for such disease or condition." The draft guidance for the second cycle of negotiations can be accessed at: https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.

CMS has been regularly engaging with members of the public to get their feedback so that we are implementing the Drug Price Negotiation Program in a thoughtful way that both improves drug affordability and accessibility for people with Medicare and supports innovation. We plan to get public input throughout the implementation of the Drug Price Negotiation Program to make sure that we know what is occurring in the market.

HHS remains strongly committed to doing what we can, such as through recommendations in guidance documents for industry and stakeholder engagement activities, to maintain and promote the robustness of the development pipeline for safe and effective drugs, including biological products to treat patients, including those with rare diseases. For example, FDA has published more than 18 guidances since 2018 on topics that are highly relevant to drug, including biological product development for rare diseases. Some recent examples of draft and final guidance documents include:

- 2023 Draft Guidance for Industry*: Clinical Trial Considerations to Support Accelerated Approval of Oncology Therapeutics*
- 2023 Draft Guidance for Industry: *Considerations for the Design and Conduct of Externally Controlled Trials for Drug and Biological Products*
- 2022 Guidance for Industry: *Human Gene Therapy for Neurodegenerative Diseases*
- 2022 Draft Guidance for Industry: *Tissue Agnostic Drug Development in Oncology*

Question #30
In *HIV and Hepatitis Policy Institute v. HHS*, a federal district court struck down a rule allowing health insurers not to count drug manufacturer copay assistance towards a beneficiary's out-of-pocket costs. In light of this ruling, what is HHS' policy and enforcement stance regarding use of copay accumulator and maximizer programs within self-funded health plans?

Response:
HHS intends to address, through rulemaking, issues left open by the Court's opinion, including whether financial assistance provided to patients by drug manufacturers qualifies as "cost sharing" under the Affordable Care Act. Pending the issuance of a new final rule, HHS does not intend to take any enforcement action against issuers or plans based on their treatment of such manufacturer assistance.

Question #31

Pharmacies are experiencing significant reimbursement cuts due to modifications in the methodology that Medicaid uses to establish the national average drug acquisition cost (NADAC). It has been reported that since being implemented in April, pharmacies have seen a 16 percent decrease in generic NADACs with an additional decrease seen in May. NADAC must ensure stable and predictable reimbursements. Please provide clarification on the rationale behind these changes and the lack of public notice and stakeholder input.

Response:
Since 2011, the Centers for Medicare & Medicaid Services (CMS) has produced a monthly NADAC file that almost all states use to set payment rates for pharmacies for covered outpatient drugs under the fee-for-service Medicaid program. The NADAC files are drawn from a voluntary, confidential, monthly survey that collects drug ingredient costs from retail community pharmacies based on their invoice prices. Recent NADAC rates from the April and May 2024 files show a decrease in the average costs of some drugs. CMS has confirmed the fluctuation is due to an increased number of, and more diverse set of, retail pharmacies responding to the survey for these two months.

Market Consolidation and Decreased Competition

Question #32
As of May 2024, only 11 hospitals have been fined for violating the final hospital price transparency rule. Additionally, it appears that overall compliance with this rule is lacking.

a. Why has HHS not done more to enforce the hospital price transparency rule?
b. Does the Biden administration support congressional efforts to codify this rule in the *Lower Costs, More Transparency Act*?

Response:
Enforcing the hospital price transparency requirements is a high priority for CMS in order to increase competition and bring down costs. It is imperative that consumers can access cost information to shop for care and save money and for employers to use data to negotiate more competitive rates. The hospital price transparency regulation became effective January 1, 2021, and requires each hospital operating in the United States to make public its standard charges for the items and services it provides. After significant outreach and technical assistance to hospitals, hospitals have made substantial progress since the hospice price transparency regulation went into effect in January 2021.

In CMS' enforcement of the hospital price transparency rules, the agency's goal is to increase access to useful, meaningful information for consumers and ensure hospitals are following through on their obligations to make information available. CMS is working closely with hospitals to bring them into compliance, and the agency in the process of examining further improvements to the program, including ways that CMS enforcement could be used to increase compliance. Between September and November 2022, CMS conducted website assessments of 600 hospitals randomly sampled from Homeland Infrastructure Foundation-Level Data. Of the 600 acute care hospitals sampled for the 2022 analysis, 493 (82 percent) posted a consumer-friendly display that met the consumer-friendly display website assessment criteria, 490 (82 percent) posted a machine-readable file that met the website assessment criteria, and 421 (70 percent) did both. The results of this website assessment suggest that there has been substantial progress in hospitals' implementation efforts since the Hospital Price Transparency regulation first went into effect, although approximately 30 percent of hospitals must still do more

to achieve full compliance. CMS is working closely with hospitals to bring them into compliance, and the agency in the process of examining further improvements to the program, including ways that CMS enforcement could be used to increase compliance.

In the CY 2024 Hospital Outpatient Prospective Payment System (OPPS), CMS finalized policies to strengthen compliance and improve the public's understanding and automated use of hospital information. CMS finalized a requirement for hospitals to display their standard charge information by conforming to a CMS template layout, data specifications, and data dictionary. These changes will increase standardization to help deliver on the promise of hospital price transparency, improve hospitals' ability to comply, enhance the public's ability to aggregate information (for example, for use in consumer-friendly displays), and streamline CMS's ability to enforce the requirements. Additionally, CMS finalized several regulatory additions and modifications to its enforcement provisions to improve CMS enforcement capabilities and increase transparency. These include submission of certification by an authorized hospital official as to the accuracy and completeness of the data in the machine-readable file and submission of additional documentation as needed to determine hospital compliance; submission of an acknowledgement of receipt of the warning notice in the form and manner and by the deadline specified; notification to health system leadership of compliance action; and publication on the CMS website CMS' assessment of a hospital's compliance, any compliance action taken and the status or outcome of such action, and notifications sent to health system leadership.

As of September 2023, CMS had issued approximately 989 warning notices and 631 requests for CAPs since the initial regulation went into effect in January 2021. Approximately 346 hospitals were determined by CMS after a comprehensive compliance review to not require any compliance action and approximately 738 hospitals received a closure notice from CMS after having addressed deficiencies indicated in a prior warning notice or a request for a CAP following an initial comprehensive compliance review. At the time of the publication of the CY 2024 OPPS/ASC proposed rule, we had imposed CMPs on four hospitals and publicized those CMP impositions on our website.

Question #33
Premiums for employer-sponsored health plans increased 7 percent this year. The RAND Corporation, CBO, and other economists have identified provider consolidation as a main driver of health care cost increases. Perverse economic incentives have driven hospitals to acquire provider offices and incorrectly bill for services.

a) Do you believe that this is a problem for employers and workers?
b) Would you agree that hospitals should not be allowed to charge facility fees to commercial payers for outpatient services?
c) Does the Biden administration endorse congressional efforts to ensure that health services are charged on a site-neutral basis?

Response:
We understand this is an increasing concern, particularly as consolidation and closures continue to impact cost and access to care. CMS is happy to provide technical assistance on any legislation you have on this issue.

With respect to facility fees, as hospitals expand ownership of outpatient and physician office settings, consumers are seeing an uptick in fees for more than just the care provided to them. These "facility fees" are increasingly a driver of healthcare costs in America, and are leading to consumers being charged as though they received treatment in a hospital even if they never entered one. The FY 2025 Biden-Harris Budget would prohibit hospitals from billing unwarranted facility fees for telehealth services and for certain other outpatient services.

Question #34
Price transparency is vital for employers to make better decisions in choosing and administering employee health plans. HHS is indefinitely deferring enforcement of a rule requiring plans to make drug prices public and to submit them to HHS. Should Congress codify this rule to ensure transparency for drug prices?

Response:
On August 20, 2021, the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) released FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (FAQs Part 49) announcing the deferral of enforcement regarding certain requirements, including the requirement that plans and issuers publish machine-readable files related to prescription drugs, pending further consideration by the Departments. In deferring enforcement of this requirement, the Departments noted the enactment of the prescription drug requirements under section 204 of division BB of the Consolidated Appropriations Act, 2021 (CAA), and stakeholder concern about potentially duplicative and overlapping reporting requirements for prescription drugs.
On September 27, 2023, the Departments released FAQs About Affordable Care Act Implementation Part 61 (FAQs Part 61) rescinding Q1 of FAQs Part 49, which had expressed the Departments' general policy of deferring enforcement of the TiC Final Rules' prescription drug machine-readable file requirement pending further consideration in a future rulemaking by the Departments. The Departments will address enforcement decisions under the relevant requirements of the TiC Final Rules on a case-by-case basis, as the facts and circumstances warrant.

Question #35
Prescription drug middlemen like pharmacy benefit managers (PBMs) are raking in profits while evading congressional scrutiny. This Committee has taken a leading role in improving the transparency of PBMs, including through the *Lower Costs, More Transparency Act*. Please provide an update on HHS oversight of PBMs.

Response:
HHS will be releasing a report which will include information on the impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs. The department looks forward to continuing to work with you on reforms to ensure that there are no unnecessary costs in our health care system.

In April 2022, CMS finalized a policy that requires Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale, so that the beneficiary can also share in the savings. Specifically, CMS redefined the negotiated price as the baseline, or lowest possible, payment to a pharmacy, effective January 1, 2024. CMS is applying the finalized policy across all phases of the Part D benefit. This policy reduces beneficiary out-of-pocket costs and improves price transparency and market competition in the Part D program. We additionally published a memo to all Part D plan sponsors via CMS's Health Plan Management System (HPMS) on November 6, 2023, titled "Application of Pharmacy Price Concessions to the Negotiated Price at the Point of Sale Beginning January 1, 2024,"[1] which reiterates and emphasizes several key points related to this policy. In this memo, we strongly encouraged Part D plan sponsors to consider options such as payment plans or alternate payment arrangements in advance of the January 1, 2024, effective date and to provide a straightforward means of requesting such an arrangement. We additionally emphasized that Part D plan sponsors must meet the prompt payment requirements at 42 CFR § 423.520 and

[1] Available at https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-november-6-10

pharmacy access standards at 42 CFR § 423.120.

More recently, we reiterated these points in our December 14, 2023, "CMS Letter to Plans and Pharmacy Benefit Managers."[2] In this letter, we identified several concerns about practices by some plans and PBMs that threaten the sustainability of pharmacies and impede access to care. We encouraged plans and PBMs to work with pharmacies to alleviate these issues and safeguard access to care.

Our authority to specifically regulate pharmacy reimbursement from PBMs is limited. Section 1860D-11(i) of the Social Security Act prohibits CMS from interfering with the negotiations between drug manufacturers, pharmacies, and prescription drug plan sponsors and generally prohibits CMS from instituting a price structure for the reimbursement of covered part D drugs. However, CMS will continue to explore opportunities to bring transparency and market reforms that are within our statutory authority.

Religious Freedom, Gender, and Abortion
Gender Identity and Religious Freedom

Question #36
The recent Title IV-B and IV-E rule requires "Designated Placements," a new category of foster care providers deemed by HHS to be safe and appropriate for LGBTQ+ children.
Under the rule, foster care providers who may have religious freedom or conscience
concerns regarding your LGBTQ+ policy are permitted to request an accommodation, but ultimately that request must be reviewed by the HHS Office of General Counsel. What
conditions would allow foster parents with certain religious beliefs to bypass HHS' "Designated Placements" category requirement?

Response
This rule does not require any foster parents with a religious objection to serving as a Designated Placement to seek a religious accommodation to continue to participate in the program. The rule welcomes faith-based organizations and religious foster parents to continue participation in the program, and the Administration for Children and Families (ACF) anticipates that many will choose to do so. The obligation to provide an environment that supports the child's LGBTQI+ status or identity under this rule applies only to those providers who have chosen to be Designated Placements. We anticipate that numerous faith-based organizations and religious foster parents will choose to be Designated Placements. But this rule does not require any provider to make that choice, and it does not impose any penalty or adverse consequence on providers with religious objections to serve as a Designated Placement. Indeed, the final rule states: "Nothing in this section shall be construed to require or authorize a State or Tribe to penalize a provider in the titles IV–E or IV–B programs because the provider does not seek or is determined not to qualify as a Designated Placement under this section." It makes clear that nothing in the rule requires or authorizes a state or tribe to penalize a provider that—for whatever reason—chooses not to be a Designated Placement. Rather, the rule places the responsibility on states and tribes—rather than on providers—to find Designated Placements for LGBTQI+ identifying children.

Question #37
HHS' FY 2025 budget document states, "the proposal includes financial penalties and mandatory corrective action for any state or contract that delays, denies, or otherwise discourages individuals from being considered or serving as foster or adoptive parents
based on the above categories." Is that policy in direct contradiction to the finalized rule requiring "Designated Placements" to be the default provider group to LGBTQ+children?

[2] https://www.cms.gov/newsroom/fact-sheets/cms-letter-plans-and-pharmacy-benefit-managers

Response
No, there is no contradiction. The final rule requires that title IV-E/IV-B agencies ensure a Designated Placement is available for all LGBTQI+ children in foster care who request or would benefit from such a placement and specifies the Designated Placement requirements for such children. It does not require that any specific provider become a Designated Placement for any child.

In contrast, the rule prohibits the state from discriminating against current or prospective foster or adoptive parents on the basis of their religious beliefs, sexual orientation, gender identity, gender expression, or sex. The financial penalties and mandatory corrective action would apply if the state delays, denies, or otherwise discourages individuals from being considered or serving as foster or adoptive parents based on these categories.

Question #38
On April 9, Dr. Hilary Cass published the Cass Review, an independent review of gender identity services for children and young people commissioned by England's National
Health Service. The review found that thousands of vulnerable young people were given life-altering treatments with "no good evidence on the long-term outcomes of
interventions to manage gender-related distress." Another study published on March 23, 2024, by physicians and researchers at the Mayo Clinic reported mild-to-severe sex gland atrophy in puberty blocker-treated children.

a. What longitudinal studies or systematic reviews of scientific studies has HHS overseen or funded on the effects of puberty blocker usage on youth gendertreatments?
b. Is HHS aware of the long-term effects of puberty blockers for this particular population?
c. What effects do puberty blockers have on the brain development of children?
d. What effects do puberty blockers have on fertility?
e. Are puberty blockers reversible?
f. Can puberty blockers cause permanent sterility in a healthy girl or boy?
g. Why would our federal medical institutions support use of puberty blockers if they have not done the public the service of understanding their long-term effects?

Response:
a. NIH has funded observational research studies to gather data about the short- and long-term effects of treatments that transgender youth and their parents have chosen in consultation with their medical providers.
b. Evidence from an NIH-funded observational study suggests puberty blockers have important mental health benefits for transgender youth, including reduced symptoms of depression and anxiety and higher rates of mental wellbeing, compared to youth who were not able to access puberty blockers. Puberty blockers are also used to treat cisgender girls with early onset puberty (i.e., entering puberty too early) and adolescent girls with endometriosis. Studies of puberty blockers in these contexts suggests no long-term physical health consequences[3,4] and in endometriosis, can halt disease progression and relieve debilitating pain.[5]
c. NIH has not funded any studies on the impact of puberty blockers on brain development.
d. NIH has not studied the fertility impacts of puberty blockers for transgender youth. However, as mentioned above, puberty blockers are also used to treat cisgender girls with early onset puberty and conditions like endometriosis. Studies of puberty blockers in these contexts suggest that there are no long-term fertility impacts of using puberty blockers.

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8686727/
[4] https://pubmed.ncbi.nlm.nih.gov/24033561/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5997553/

e. Puberty blockers are reversible and ceasing to take puberty blockers will resume normal puberty[6,7].
f. There is no evidence to suggest that puberty blockers will lead to long-term sterility.
g. NIH is currently funding observational studies to understand the long-term health consequences of the use of puberty blockers. Studying puberty blockers on a range of outcomes is crucial to building our evidence base and improving our understanding of their long-term impacts so that children and their parents can make informed decisions about their use.

Question #39
Should Americans be able to practice their religious faith free from discrimination?

Response:
Yes. The Department's Office for Civil Rights enforces a range of civil rights, conscience, and religious freedom statutes and takes seriously the responsibility to effectively enforce each one. Within the last year, OCR has strengthened protections for conscience and religious freedom through the publication of three final rules including *Safeguarding the Rights of Conscience as Protected by Federal Statutes* (effective March 11, 2024), *Health and Human Services Grants Regulation* "HHS Grants Rule" (effective June 3, 2024), and Section 1557 of the Affordable Care Act: *Nondiscrimination in Health Program and Activities* (effective July 5, 2024).

The *Safeguarding the Rights of Conscience as Protected by Federal Statues* final rule clarifies the process for enforcing federal conscience laws and strengthens protections against conscience and religious discrimination in health care.

The HHS Grants Rule and Section 1557 of the Affordable Care Act final rules reiterate that a recipient may rely on applicable Federal protections for conscience and religious freedom, and that a particular application of a provision of either rule is not required when such protections apply.

Question #40
Does the freedom to practice religious faith free from discrimination also exist in the practice of medicine? If so, why does the Biden administration continue its efforts to violate American's religious beliefs through abortion, contraceptive, and gender-
reassignment mandates?

Response:
Yes, the freedom to practice religious faith from discrimination certainly exists in the practice of medicine. That freedom is protected by various laws and regulations, including several conscience and religious freedom statutes that are enforced by the Department's Office for Civil Rights including the Church Amendments; Public Health Service Act, Section 245; The Weldon Amendment; and the Affordable Care Act. If a provider believes their Federally protected conscience or religious freedom rights have been violated, they may file a complaint with the Office for Civil Rights here.

Border Crisis and Child Labor

Question #41

[6] https://pubmed.ncbi.nlm.nih.gov/8198390/
[7] https://pubmed.ncbi.nlm.nih.gov/30112593/

According to U.S. Customs and Border Protection data, the CBP encountered more than 137,000 unaccompanied minors at the southern border in FY 2023, a substantial increase compared to just five years ago. As has been reported in the New York Times and other publications, this increase in unaccompanied minors led to the rise in employment of these minors in dangerous jobs in violation of the *Fair Labor Standards Act*. President Biden has implemented an open border policy and even recently admitted the border is not secure. Why has the Task Force to Combat Child Labor (Interagency Task Force)— on which HHS is a member with DOL and the Department of Homeland Security (DHS)—failed to protect so many unaccompanied minors?

Question #42

I am frankly shocked at the lack of coordination between DOL, HHS, and DHS when it comes to protecting the health and safety of unaccompanied migrant children after they have entered the United States. It is the responsibility of HHS to ensure that these children are placed with responsible caregivers after they leave HHS. Yet, it appears as though many of these children were placed with human traffickers and were forced to work in dangerous jobs. This was so prevalent that HHS stopped placing children with sponsors in certain zip codes.

Did DOL warn HHS that these children were at risk for human labor trafficking at any time during this administration?
Do you believe that HHS properly vetted the sponsors of unaccompanied children who were found to be exploited by human labor traffickers?
Did HHS follow all protocols when vetting sponsors for unaccompanied children?

Did HHS' failure to vet sponsors contribute to the increase in child labor trafficking?

If a child who was under the care of HHS' Unaccompanied Children Program is found to be a victim of human labor trafficking, is the sponsorship immediately terminated, and does the federal government reclaim custody of the child?

Are there circumstances under which the child will be returned to the original sponsor?

Are there circumstances under which the child will be returned to an immediate relative of the original sponsor? And, if so, what is the vetting process for these individuals?

Do some human traffickers promise young children that they can go to school or work in the United States to lure them into being trafficked?

Is HHS placing children with members of gangs and cartels, including MS-13?

Is it true that HHS has released multiple unaccompanied children to the same address or building?

What action is HHS taking to ensure that individuals are not sponsoring multiple children and that multiple children are not being released to the same address?

Response (41-42):

In fulfilling its sponsor placement responsibilities, HHS employs thorough sponsor screening and vetting processes for each category of sponsors that are based on child-welfare principles. To that end, ORR has implemented and funded seven-day-a-week case management, which seeks to ensure comprehensive staff support and that every child's case is worked on even after normal business hours. Additionally, ORR has made technological improvements to build in safeguards, streamline processes, and make it easier to identify potential

child welfare concerns during sponsor suitability assessments.

ORR identifies potential sponsors for unaccompanied children in different categories of cases: Category 1 includes parents or legal guardians; Category 2 includes brothers, sisters, grandparents, or other immediate relatives; Category 3 includes distant relatives or unrelated individuals; and Category 4 includes unaccompanied children for whom a sponsor has yet to be identified.

ORR's sponsor suitability assessment process includes verifying the sponsor's relationship to the child; speaking with the child's parents when possible; conducting separate interviews with the child and sponsor; collecting supporting documentation to verify the sponsors' information; and administering background and address verification checks—which include public records and sex offender registry checks for all sponsors, as well as FBI fingerprint checks in certain cases.

To verify the identity of a sponsor, all potential sponsors must submit original versions or legible copies of government-issued identification documents. For verification of the relationship claimed with the unaccompanied child, the potential sponsor must also provide at least one form of evidence such as a birth certificate, marriage certificate, death certificate, court records, guardianship records, hospital records, school records, or a written affirmation of relationship from a Consulate. All sponsors are required to comply with each provision of the Sponsor Care Agreement, under which, the potential sponsor agrees to provide for the physical and mental well-being of the child, ensure the child's presence at all future immigration proceedings, notify local law enforcement or local child protective services if the child has been or is at risk of being subjected to abuse, abandonment, neglect, or maltreatment, and notify the National Center for Missing and Exploited Children if the child disappears, has been kidnapped, or runs away.

While ORR's custodial responsibilities end when a child is discharged from ORR care, ORR has policies in place to promote unaccompanied children's well-being after they have been released as they transition into a new community. This includes providing children with multiple ways to connect following their sponsor placement, such as through Safety and Well-being calls, post-release services (PRS), legal services, and the ORR National Call Center (ORRNCC), which connects children and sponsors with community resources and is required to report all safety concerns to ORR and other federal, state, and/or local entities. ORR has now expanded PRS to historic levels. In FY 2021, an average of just over 20 percent of children were offered access to PRS. Today all children are currently being referred for such services. Similarly, ORR has increased the number of unaccompanied children receiving direct, ORR-funded legal representation, which is another protective measure against labor trafficking.

ORR and ACF's Office of Trafficking in Persons (OTIP) work closely with DOL, through the joint Memorandum of Agreement between HHS and DOL, to share information about child labor exploitation under the Fair Labor Standards Act (FLSA), including particular trends or cases within the Department of Labor's jurisdiction.

When ORR receives a report of suspected labor exploitation or trafficking, all formal reports are provided to the Department of Homeland Security (DHS) Homeland Security Investigations Division, the DHS Center for Countering Human Trafficking, and OTIP. DOL does not have enforcement authority under the anti-trafficking laws, but when it encounters possible human trafficking during the course of its investigations, it provides that information to OTIP so that OTIP may connect individuals with appropriate benefits and services. In addition, ORR requires care providers to create a Significant Incident Report within 24 hours of all suspected trafficking or exploitation concerns, which is used to notify stakeholders and OTIP. ORR also requires that ORRNCC notify local law enforcement and child welfare agencies when it receives concerns about unaccompanied

children who have been released from ORR's custody.

While ORR does not have the authority to remove a child from their home and retake federal custody after releasing a child to a vetted sponsor, ORR does everything it can to notify local law enforcement and child welfare agencies of children who may be in need of child protective services or be victims of criminal offenses. Local law enforcement and child welfare agencies are the entities with the authority to determine whether to remove a child that is not in government custody from their current home based on alleged abuse, neglect, or other welfare concerns.

Per the Trafficking Victims Protection Act, any Federal, State, or local official with concerns that a foreign national child may be a victim of human trafficking are required to notify HHS (via OTIP) within 24 hours to facilitate assistance. Per the Trafficking Victims Protection Reauthorization Act of 2022, which added labor trafficking to the definition of child abuse and neglect, mandatory reporters are or will soon be required to report known and suspected instances of child labor trafficking under state law.

Question #43
HHS' FY 2025 budget shows a carryover in unaccompanied children program funding of $1.6 billion from FY 2023 to FY 2024. Considering the alarming rate at which unaccompanied children have entered the United States over the last year, can you explain why HHS had so much unused funding?

Response:
In furtherance of its mission not only to provide for the care and custody of unaccompanied children but also for eligible refugee populations as authorized by Congress, ORR provides services to all eligible populations, regardless of its projected capacity. As such, ORR received supplemental funding to meet the needs of Cuban arrivals during an historic influx in FY 2022. Since base appropriations are inadequate to serve arrivals and referrals, Congress provided $2.4 billion in emergency supplemental funding and a $1.775 billion anomaly in the continuing resolution in FY 2023 to help ORR fulfill its statutory and legal obligations in FY 2023 and FY 2024, which ORR estimates spending down before the end of FY 2024. ORR does not have the discretion to choose how many eligible beneficiaries it serves because ORR is mandated to serve them all. Additionally, carryover funding is necessary every year to support states that have provided services to ORR eligible populations in the months immediately preceding the end of the prior fiscal year. For the ORR Refugee Program Bureau's cash and medical assistance grant, states provide cost estimates and receive quarterly funding allocations during the designated fiscal year. After the close of the fiscal year, any difference between costs incurred by the state and funds provided by ORR are reconciled and states must be fully reimbursed. As a result, ORR must always have a substantial amount of carryover funds to ensure these reimbursements can be made.

Question #44
In February 2023, HHS and DOL announced the formation of an Interagency Taskforce to combat child labor exploitation—a move to save face after the neglect of both agencies resulted in illegal child labor scenarios with sad consequences. Part of HHS's responsibility was to expand post-release services to unaccompanied children.

a. What services have been expanded, and what were the costs of those services?
b. Are unaccompanied children given materials to explain child labor laws and a way to contact HHS to report any safety concerns?

Response:
The Interagency Taskforce to Combat Child Labor Exploitation, led by the Department of Labor (DOL), works to improve cross-training, outreach, education, and health outcomes of children that could be subject to child

labor violations under the Fair Labor Standards Act. As part of this effort, DOL and HHS entered into a Memorandum of Agreement (MOA) on March 23, 2023, regarding interagency data sharing to enhance the well-being of children and the enforcement of federal child labor laws. The MOA formalizes how the Departments' work together to help identify communities and employers where children may be at risk of child labor exploitation, aid investigations with information that could help identify circumstances where children are unlawfully employed, and further facilitate coordination to ensure that when DOL detects child labor trafficking victims or potential victims, they have access to critical services through OTIP. As part of this effort, ORR collaborates with DOL to share enforcement information under the laws that DOL's Wage and Hour Division enforces. Further, ORR, DOL, and ACF's Office of Trafficking in Persons (OTIP) collaborate on potential macro-level solutions, such as how to potentially detect patterns and ways that information provided could inform policies and procedures. Through this collaboration, some children who are still minors have received expedited referrals for additional PRS through ORR, and OTIP has assessed the individual's eligibility for services available through their program. Where needed, ORR also places appropriate flags so that individuals of concern cannot sponsor a child in the future.

In April 2023, HHS and DOL also developed and distributed new materials and trainings to provide information to children and sponsors about child labor laws in the United States so that children and vetted sponsors understand the laws on labor rights and restrictions to working in the United States. HHS and DOL have also worked collaboratively to provide training to ORR and OTIP contractors, grantees, and service providers on the child labor protections of the Fair Labor Standards Act. These efforts are ongoing.

In addition to increasing its efforts to better inform children, sponsors, and providers about child labor exploitation, ORR has worked with its ORRNCC to require a follow-up call for unaccompanied children previously released to vetted sponsors who contact the helpline with safety concerns. The ORRNCC has also incorporated language into its materials to ensure that such children who call them understand which authorities their safety concerns will be reported to and will connect the child with local resources as available.

Question #45
HHS completed an audit of the failed vetting process for potential sponsors—a process that previously resulted in HHS releasing unaccompanied children into the custody of child labor law violators.

What changes have been made as a result of this audit?
What changes have been made to release unaccompanied children to individuals who have previously sponsored children?

Response:
ORR continuously reviews its vetting policies and procedures for ways to improve its processes to promote the safety and well-being of children and to be more efficient and effective. For instance, on June 2, 2023, HHS released the results of its audit of the vetting process for potential sponsors who have previously sponsored an unaccompanied child, to ensure all necessary safeguards are in place without unnecessarily keeping children in government-funded, congregate care settings. In October 2023, ORR awarded a contract to an outside entity to conduct future in-depth reviews of random samples of case files by sponsor category for all children released from ORR care from January 2021–December 2022. Also, on June 2, 2023, HHS announced additional efforts to protect the safety and well-being of unaccompanied children, including a new ORR program and accountability team, now termed the Integrity and Accountability team, which will further enhance ORR's work to assess and address potential exploitation risks faced by unaccompanied children.

Moreover, on February 13, 2024, ORR published policy and procedure revisions that enhance its sponsor vetting requirements. Among other enhancements, these revisions require parent and legal guardian (Category 1) sponsors to provide proof of address documentation (already a requirement for all other sponsors) and also requires, at minimum, sex offender registry checks for all adult household members and adult caregivers, including in Category 1 cases. Further, the revisions require, at minimum, proof of identity and criminal history public records background checks for all adult household members and adult caregivers, with a narrow exception for certain Category 1 cases such as where there are no safety concerns. These recent revisions strengthen and expand home study policies and guidance to include mandatory home studies for potential sponsors of more than two children, regardless of the potential sponsor's relationship to the children. The February 2024 policy revisions supersede Field Guidance 10, 11, and 15. ORR's robust sponsor vetting requirements are also set forth in the UC Program Foundational Rule 45 CFR Part 410, Subpart C.

Head Start

Question #46
HHS' Head Start Workforce proposed rule seeks to make wage and benefit changes to Head Start performance standards in a purported effort to retain the program's workforce. Part of HHS' solution is to implement pay parity for Head Start education staff with public school teachers and set a minimum pay floor of $15 per hour. HHS acknowledges that, "there will be a substantial cost associated with enacting the proposed [wage] standards at current Head Start funded enrollment levels." But the proposal argues the policy changes are "necessary" while admitting, "one potential impact could be a reduction in Head Start slots."

Is it the policy of this administration that Head Start should serve fewer low- income children in order to pay workers more?

Response to #46a:
In recent years, Head Start programs have experienced significant and persistent underenrollment where the number of children actually served is far less than the number of children they are funded to serve, leaving a large number of slots unfilled due in large part to widespread staffing shortages. As Head Start programs work to improve their actual enrollment levels, many are also requesting reductions in their funded enrollment. Head Start programs are trying to right-size their funded enrollment to match their community needs, staffing realities, and fiscal constraints. The Office of Head Start (OHS) is also concerned about quality in Head Start, including child safety incidents and the ability to recruit and retain staff that meet the teacher qualification requirements in the Head Start Act and can support enriching interactions and early learning experiences.

If the proposed rule becomes final, OHS expects that most of the costs associated with the rule, when fully phased in after seven years, will be covered within the existing funding allocation for Head Start assuming a full cost of living adjustment (COLA) investment is provided each year and programs right size their funded enrollment to match actual enrollment levels. We estimate that many programs can approach full implementation of the policies when phased in by 2031 without additional appropriations (beyond COLA increases to account for inflation) by reducing their funded enrollment levels to align with their actual enrollment. Those programs would then have the ability to reinvest the resources associated with the reduced slots within their existing budgets to increase wages and compensation for staff. Based on the Notice of Proposed Rulemaking (NPRM) estimates, reducing funded enrollment would result in about 1 percent fewer

funded slots than FY 2023 actual enrollment. Thus, if Head Start receives no additional funding from Congress beyond a full COLA each year—as represented by the $543.7 million included in the President's Budget for FY 2025—a one percent reduction in currently filled slots would be needed to reach full implementation of the policies in the proposed rule by 2031. It is also important to note that these projections are based on standard COLA rates; the actual amount of COLA needed per year is subject to change based on updated measures of inflation.

b. What is HHS' plan for children and families who lose access to Head Start due to your reduction in slots?

Response to #46b:
No children currently enrolled in Head Start will be removed from programs as a result of these proposed policies. If these policies are enacted in a final rule and programs must reduce their funded enrollment levels in response, they will do so by eliminating slots already vacant or by lowering the number of slots available in future years. All children and families who are currently enrolled can remain in the Head Start program in accordance with the existing eligibility and enrollment requirements.

Question #47
The Head Start statute goes out of its way to describe parent and family engagement in Head Start services. In HHS' recent Head Start Workforce proposed rule, there is even language that claims to ensure "programs are consulting and engaging with current
parents and families to be involved in the methods the program uses." However, the proposed rule strikes §1302.44(a)(3) from current regulations, which requires that parent consent be obtained for mental health consultation. Does HHS intend to complete mental health consultations on children without parental consent?

Response:
The existing phrasing of §1302.44(a)(3) implies that mental health consultants provide treatment when, in fact, they provide consultation services to adults (e.g., classroom teachers) and do not require parental consent because the child is not directly receiving the service. Mental health consultation is designed to support teachers and staff in supporting children's mental and behavioral health needs. Programs will continue to be required to apply the advanced authorization regulations for health, mental health, and developmental procedures.

Question #48
Continuous quality improvement (CQI) is a staple of the Head Start program, yet HHS' "Head Start Workforce" proposed rule includes several highly prescriptive and onerous requirements that walk away from the focus on CQI and empowering local communities to do what is best for their children and families. How will the Biden administration ensure the new rule will maintain or strengthen local autonomy and CQI?

Response:
HHS believes that the proposed rule supports the Continuous Quality Improvement (CQI) efforts of Head Start programs. The proposed rule ensures that the Head Start Program Performance Standards represent all necessary elements for high-quality programming, while retaining the level of local flexibility and discretion to which Head Start programs are accustomed. Several of the new policies proposed in the NPRM will help guide programs in their CQI efforts, including by focusing their community assessments on the most relevant data, reflecting on whether the program's approach to mental health is meeting the specific needs of their community, and allowing for the leadership of each program to guide the creation and implementation of employee engagement practices. The NPRM also proposes to remove the requirement that Head Start programs participate in their State or local quality rating and improvement systems, allowing for a more flexible approach that

recognizes the high standards of Head Start programs and reduces the duplication of efforts. HHS continues to support and value the need for local flexibility in Head Start and will provide tailored training and technical assistance to Head Start programs as they implement strategies for CQI.

Universal Preschool

Question #49

The Biden administration continues to propose universal preschool in FY 2025 with $5 billion in mandatory funding. However, several economic impact studies[8] warn that a universal preschool program—which aims to pull a majority of 3- and 4-year-olds into a new federal government education system—will have disastrous effects on already
strained child care providers. Since HHS also houses federal child care programs through the Child Care Development Fund (CCDF) and Child Care Development Block Grant (CCDBG), has the HHS completed any economic impact studies on the proposed universal preschool program?

Response:

The President's Budget request would fund states to expand access to high-quality child care to more than 16 million young children and dramatically expand access to and increase the quality of preschool so that all of the approximately four million 4-year-old children in the United States have access to high-quality, voluntary, universal, free preschool, with the flexibility for states to expand preschool to three-year-olds once high-quality preschool is fully available for four-year-old children.

Importantly, high-quality preschool would be offered through a mixed delivery system that builds on and strengthens the current ecosystem of early care and education providers. Preschool would be offered in the setting of the parent's choice—from public schools to child care providers to Head Start. This mixed delivery approach would offer a wide range of quality settings to provide choices for families, build on the expertise and capacity of existing providers—including community-based child care providers, schools, Head Start, and family child care homes—and leverage existing Federal, state and local funding to enhance existing services and expand access to high-quality preschool.

High-quality early care and education from birth to kindergarten entry is one of the most significant and impactful investments we can make as a nation. When children have access to high-quality early learning programs, the benefits extend across their lifespan they are more likely to succeed in school, graduate from high school, and go on to college. Early learning programs also make it easier for parents— especially mothers—to become employed, boosting family earnings and promoting economic stability and well-being.

Unfortunately, early care and education programs, including both child care and preschool, are financially out of reach for many children and families, and current federal investments in child care and early learning fall far short of meeting the true need. Most U.S. children do not have access to public preschool, with less than half of all four-year-old children and just 17 percent of all three-year-old children attending publicly funded preschool. The Head Start program—which provides high-quality early childhood education and comprehensive services to children birth to five to those most in need—is funded to reach just half of income-eligible preschool-aged

[8] Brown, Jessica, "Does Public Pre-K Have Unintended Consequences on the Child Care Market for Infants and Toddlers?" (Dec. 8, 2018). Princeton University Industrial Relations Section Working Paper 626 finds "a back-of- the-envelope calculation indicates that for every seven 4-year-olds who shifted from day care centers to public pre- K, there was a reduction of one day care center seat for children under the age of 2." Malik, Rasheed, "The Effects of Universal Preschool in Washington, D.C." (Sept. 2018) American Progress Report. "[universal preschool] has the potential to affect the supply and cost of child care for infants and toddlers…private child care providers have traditionally cross-subsidized their smaller infant and toddler rooms by serving one or two full classrooms of preschoolers. Without that revenue, some providers may need to increase prices or enroll fewer children." Costa,

children (i.e., three- and four-year-olds) and less than 10 percent of income-eligible infants and toddlers. Higher-income children are more likely to attend preschool because their families can afford to pay for it, leaving too many children in low-income families and children of color behind.[9]

The early childhood workforce is essential to delivering high-quality early care and education programs, yet child care, Head Start, and preschool programs across the country are facing unprecedented challenges recruiting and retaining qualified educators due to persistently low wages that do not recognize the value and importance of their work, as well as historic racial, ethnic, linguistic, and economic barriers to accessing degree and credentialing programs. Through increased investment in child care, preschool and Head Start, this proposal will help improve compensation for early educators across settings towards a wage that can enable recruitment and retention of staff and increase the supply of high-quality early care and education options for families.

Together, investments in high-quality affordable child care and preschool will advance the President's goal of ensuring that all families can access affordable, high-quality early care and education, helping children learn, giving families breathing room, and growing the economy.

Child Care

Question #50
It is no secret that our nation's child care industry is strained at best and broken at worst. The HHS budget requests $10 billion in FY 2025 to expand the federal child care program to include families with annual incomes up to $200,000.

Why is it appropriate to subsidize child care for the wealthy?

A family of four with an annual income of $200,000 is living 641 percent above the federal poverty guidelines. CCDBG eligibility rules require family income at or below 85 percent of state median income. How is a $200,000 income limit appropriate for participation in federally subsidized child care?

Response:
The President's FY 2025 Budget would expand access to high-quality child care for lower- and middle-income families, such that families with the lowest incomes pay nothing and most families pay no more than $10 per day for child care, while helping to support the economy and improve outcomes for children in families. This proposal would save the average family over $600 per month, per child, and reduce the family's child care costs by nearly two thirds. Research has documented that reducing the cost of child care for families can increase labor force participation, employment, and earnings among parents.[10]

Our current child care system is untenable. Child care costs are a significant and destabilizing financial strain on low- and middle-income families. Yet, the child care workforce is deeply underpaid for the essential work they do and child care providers struggle to fully staff their programs because of challenges recruiting and retaining staff. Subsidizing child care costs for low- and middle-income families will facilitate a stronger U.S. economy, strengthen family economic stability and security, and support businesses and communities, while allowing parents the freedom to select high-quality child care for their children that meets their families' needs.

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[9] See for example https://www.aecf.org/blog/low-preschool-enrollment-rates-threaten-to-worsen-student-achievement

[10] Morrissey T. Child care and parent labor force participation: a review of the research literature. Rev Econ Househ 2016. doi:10.1007/s11150-016-9331-3.

Working families across income levels currently struggle to find and pay for high-quality child care. Difficulty in finding high-quality, affordable early care and education leads some parents to drop out of the labor force entirely, reduce their work hours, or turn down promotion opportunities. In very large counties, the average price of center-based child care for an infant ($17,171) and a toddler ($13,500) would together represent over 15 percent of a family's income at $200,000, and some families at this income level would need to pay for more than two children.[11] For families with incomes at $100,000, the cost burden would be even higher, with care for an infant and a toddler representing more than 30 percent of their family income. Research has documented that reducing the cost of child care for families can increase labor force participation, employment, and earnings among parents. The President's Council of Economic Advisers found that recent federal investments in child care increased labor force participation among mothers of young children by roughly three percentage points, equivalent to over 300,000 more women in the labor force.

Child care that is reliable, high-quality, and affordable allows parents to make ends meet, advance in their careers, and stay in the workforce, while offering children the opportunity to benefit from enriching learning environments that support healthy child development. This investment would help hundreds of thousands of women with young children enter or re-enter the workforce more quickly and reduce child care costs to allow parents the freedom to select a high-quality child care option for their children to provide a strong foundation for learning and health across the child's lifespan.

Question #51
On March 1, 2024, HHS finalized a rule that makes significant changes to CCDF copayments. Statute clearly articulates that "the State will establish and periodically revise…a sliding fee scale that provides for cost sharing by the families that receive child care services."

How does a copay cap at 7 percent of household income adhere to the "sliding scale" requirement in statute?

HHS has historically recommended - not required - a 7 percent income threshold. Why the abrupt change?

Response to #51a:
Under the 2024 Child Care and Development Fund (CCDF) Final Rule, Lead Agencies are still required to establish and periodically revise a sliding fee scale as articulated by the statute. The 2024 Final Rule ensures that the upper end of that sliding fee scale is affordable for families and not a barrier to accessing CCDF.

Response to #51b:
The Biden Administration prioritizes lowering family costs for child care. Despite the Child Care and Development Block Grant (CCDBG) Act requiring that Lead Agency sliding fee scales be affordable for families and not a barrier to families accessing CCDF, the majority of states still allowed for some co-payments above seven percent of a family's income and could allow co-payments that were even as high as 27 percent of a family's income. By prohibiting co-payments above seven percent of household income, the 2024 Final Rule helps minimize cost barriers for families accessing CCDF and supports affordability.

Question #52
This cap at 7 percent of household income will burden lead agencies with the tuition differential, further straining an already fraught child care system.

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[11] Landivar, C. L., Graf, N.L., and Rayo, A. Childcare Prices in Local Areas: Initial Findings from the National Database of Childcare Prices. Women's Bureau, U.S. Department of Labor and American Community Survey 2014-2018, U.S., Census Bureau (prices represented in 2022 real dollars using the CPI-U for child care). Retrieved at://www.dol.gov/sites/dolgov/files/WB/NDCP/508_WB_IssueBrief-NDCP-20230213.pdf.

What supports will HHS put in place to help states manage the new requirement?
b. Will the potential reduction of the number of available slots open to children be an acceptable solution for states that cannot carry this financial burden?

With the increased child care costs to states, has HHS estimated how many child care slots might be lost? Is there a reduced case load estimate?

Response:
The Office of Child Care (OCC) and its technical assistance partners continually offer support to Lead Agencies to implement CCDF regulations. This includes in-person opportunities convenings, peer sharing opportunities, and targeted and tailored technical assistance to provide additional opportunity for Lead Agencies to learn and seek support for full CCDF implementation.

Additionally, while the 2024 Final Rule went into effect on April 30, 2024, HHS recognizes that Lead Agencies may need additional time to plan and thoughtfully implement required changes. Therefore, HHS has used its authority under the CCDBG Act to allow Lead Agencies to apply for temporary waivers from provisions in the 2024 Final Rule in certain circumstances. Capping co-payments at seven percent of family income (§ 98.45(b)(5) and § 98.45(l)(3)) is one of the allowable provisions for this temporary waiver. Guidance for state and territory waivers (ACF-OCC-CCDF-PI 24-03) was released on April 24, 2024, and guidance related to Tribal Nations will be issued separately.

The CCDBG statute is clear that family co-payments cannot be a barrier to child care access for families participating in CCDF. Families with low incomes on average pay between nine and 31 percent of their incomes for child care, while families with higher incomes pay between six and eight percent. Families participating in CCDF should not be required to pay a greater share of their income than higher income families.

As part of the regulatory process, HHS conducted a Regulatory Impact Analysis and calculated that the seven percent cap would result in an annualized transfer of $12.6 million from families who would otherwise pay unaffordable co-pays or forgo care to Lead Agencies. This analysis estimates implementing the seven percent cap requirement may lead to a caseload reduction of up to 1,870 slots annually at the highest point of implementation (e.g., all states implementing the requirement). The individual state impact varies depending on where Lead Agencies are in the implementation process. For example, 15 Lead Agencies had set their co-payments to seven percent or less before the 2024 Final Rule and would presumably not need to make any policy changes to meet this new requirement. In addition, Lead Agencies have significant flexibility in how they allocate CCDF resources, which will affect the impact of the policy changes included in the 2024 Final Rule.

The Biden administration continues to call on Congress to make significant long-term investments so that all families can afford and access the high-quality child care that meets their needs.

Rep. Joe Wilson (R-SC)

Question #53
The Increasing Organ Transplant Access Model (the IOTA Model) is a proposed mandatory initiative aimed at enhancing access to kidney transplants for patients with kidney disease while also reducing Medicare expenditures. Key objectives of this model include encouraging transplant hospitals to utilize more available kidneys for transplantation, facilitating transplants from living donors, and promoting equitable access to kidney

transplants.

Under this model, participating transplant hospitals are held accountable for their performance. They could receive upside risk payments from CMS, fall into a neutral zone (where neither upside nor downside risk payments apply), or owe downside risk payments to CMS based on their final performance score. This score would be calculated out of 100 points across three domains:1. Achievement: Reflecting the number of kidney transplants performed; 2. Efficiency: Based on the organ offer acceptance rate ratio; and
3. Quality: Assessed using metrics such as the CollaboRATE Shared Decision-Making Score, Colorectal Cancer Screening, Three-Item Care Transition Measure, and post- transplant composite graft survival rate.

The model aims to improve care delivery capabilities, enhance efficiency, and ultimately enhance the quality of care provided by kidney transplant hospitals selected for participation. It is set to begin on January 1, 2025. Given the criteria used in the IOTA Model please answer the following questions in regard to the metrics used to measure OPOs under CMS-3380-F.

In the proposed Increasing Organ Transplant Access Model (IOTA Model), CMS creates financial incentives for transplant centers with above average
performance, a 'neutral zone' median performance and downside financial risk for below average performance. In stark contrast, CMS provides OPOs with no
incentive for neutral zone and high performance and creates a penalty for median performance with automatic decertification for below average performance. Why has CMS taken such a drastically different policy approach for two components within the same system? Will CMS reconsider its approach to OPO
performance metrics?

In the proposed IOTA Model, CMS sets up 3 domains (achievement, efficiency and quality) with multiple measurable factors to assess transplant center
performance. Moreover, CMS intends to risk adjust these measurements to ensure actual program performance rather than the underlying patient population. Does CMS plan to reconsider the current OPO metrics which establishes a single domain (achievement) and does not risk adjust for underlying patient population? If not, why?

In the proposed IOTA Model, CMS explicitly recognizes that transplant program behavior drives whether or not kidneys are accepted and used for transplant. If so, why are OPOs held accountable and subject to automatic decertification based on a transplant rate that is actually measuring transplant center behavior outside of OPOs responsibility and control? Will CMS commit to changing the OPO
performance metric to be consistent with its policy approach in IOTA?

Response:
CMS proposed the Increasing Organ Transplant Access (IOTA) Model for transplant hospitals in a Notice of Proposed Rulemaking, Alternative Payment Model Updates and the Increasing Organ Transplant Access Model, released on May 8, 2024 with an opportunity for public comment. CMS anticipates receiving robust comment on the proposed rule from stakeholders.

The IOTA Model, as proposed, is complementary to other models tested by the Innovation Center, such as the ESRD Treatment Choices (ETC) and Kidney Care Choices (KCC) Models, and to other CMS and HRSA initiatives, including holding organ procurement organizations accountable for their performance, with the collective goal of achieving improvements in processes among transplant hospitals that would spur an increase in both deceased donor and living donor kidney transplantation and reduce population health disparities. While

the IOTA Model and the OPO rule both are focused on improving the number of transplants and health outcomes, they are distinct in terms of the levers they use to support performance improvement. The IOTA Model proposes performance-based payments that hold transplant hospitals selected as the IOTA participants financially accountable for improvements in access to both deceased and living donor kidney transplantations. CMS will carefully review all of the comments on the proposed rule before issuing a final rule regarding the IOTA model.

Rep. Glenn Grothman (R-WI)

Question #54

For more than 30 years, the 340B Drug Pricing Program has helped eligible providers stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services to the patients and communities they serve. Hospitals use 340B savings to provide, for example, free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication
management and community health programs. Despite significant oversight from HRSA and the program's proven record of decreasing government spending and expanding access to patient care, some want to scale it back or drastically reduce the benefits that eligible providers and their patients receive from the program. Secretary Becerra, what steps is HHS taking to protect the 340B program from these attacks and ensure the program continues to help providers stretch limited resources and provide more comprehensive services to more patients?

Response:
The 340B Program is an integral component of the safety-net system in our country, from health centers, to Ryan White clinics, rural hospitals, and children's hospitals. These clinics and hospitals are foundational to our country's health care system, focusing on our most vulnerable, underserved, and isolated patient populations. The President's Budget Request includes legislative proposals to sustain and strengthen the Program.

Question #55
As of today, more than 60% of Wisconsin's nursing homes would not meet one, two or all three of the minimum staffing standards. What is HHS's plan for assisting nursing homes to meet these standards when the people, especially RNs, do not currently exist?

How does HHS expect facilities to pay for the standard? It is an unfunded
mandate. Many facilities operate on thin margins or at a loss because they must rely on Medicaid as their chief payment source.

Response:
Staffing in LTC facilities is a persistent concern, especially among low-performing facilities that are at most risk for providing unsafe care. Numerous studies have shown that staffing levels are closely correlated with the quality of care that LTC facility residents receive.[12] CMS believes that national minimum nurse staffing standards in LTC facilities are necessary at this time to protect resident health and safety and ensure residents' needs are met. We intend to promote safe, high-quality care for all residents regardless of geographic location. At the same time, CMS acknowledges the unique challenges that rural LTC facilities face, especially related to

[12] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services.

staffing, and recognizes the need to strike an appropriate balance that considers the current challenges some LTC facilities are experiencing.

CMS expects that LTC facilities will be able to meet the comprehensive staffing requirements, inclusive of the minimum staffing standards, 24/7 Registered Nurse (RN) requirement, and enhanced facility assessment. Flexibilities included in the rule include a staggered implementation timeline of up to five years based on geographic location. Additionally, eligible facilities that are facing a significant staffing hardship, despite their best efforts to hire and a financial commitment to staffing, will be able to qualify for exemptions to these minimum staffing standards.

CMS will monitor the implementation of the finalized requirements including, but not limited to, the minimum staffing standards, 24/7 RN requirement, exemption process, and definition of rural, as they are implemented over the next several years, and assess the effectiveness of the requirements in improving safety and quality.

Question #56
Providers have found the survey process (aka the yearly facility inspection of regulatory compliance and quality assurance) has gotten more and more punitive in nature, where it seems like the goal is to punish a facility rather than advancing quality care. Being overly punitive is counterproductive to what should be the mutual goal of all parties – to advance quality care. Is the purpose of CMS's nursing home survey/enforcement process primarily meant to be punitive, or is it meant to identify and correct areas of concern/noncompliance in an effort to advance quality of care?

Question #57
The CMS FY 25 Prospective Payment System (PPS) Proposed Rule for nursing homes includes an important 4.1% PPS rate increase, but it also includes new opportunities for CMS to pile on financial penalties that could financially cripple many providers. Do you believe CMS's new proposal to create more opportunities to financially devastate nursing homes via high Civil Money Penalties (CMPs – aka fines) will make it harder for providers to ensure quality care access to care u communities across Wisconsin and across the country.

Response to Questions #56 and #57
The Biden-Harris Administration is committed to ensuring that all residents living in Medicare and Medicaid nursing homes receive safe, high-quality care. Specifically, In February 2022, alongside a suite of other reforms, CMS committed to expanding financial penalties and other enforcement sanctions to improve the safety and quality of care in the Nation's nursing homes.

Nursing home oversight is one of CMS's most important tasks, and resident safety is CMS's top priority in nursing homes and all facilities that participate in the Medicare and Medicaid programs. Monitoring patient safety and quality of care in nursing homes requires coordinated efforts between the federal government and the states, and CMS works in partnership with state survey agencies to oversee nursing homes, since these agencies are generally also responsible for state licensure. While it is critical to hold nursing homes accountable for the quality of care they provide, CMS's goal is not to punish nursing homes, but to bring them into compliance and ensure they can continue to provide care to the residents who rely on the facility for their home. Our policies and our work with state survey agencies reflect this goal.

As a part of this effort, in the Fiscal Year 2025 Skilled Nursing Facility Prospective Payment System proposed rule, CMS proposed to expand existing nursing home enforcement authority to enhance the safety and quality of care provided in the nation's nursing homes. These revisions will allow CMS to expand the mix and number of penalties in response to situations that put residents' health and safety at risk and, therefore, encourage facilities

to promptly correct and maintain lasting compliance with CMS's health and safety requirements. CMS believes these revisions will allow for more consistent imposition of Civil Monetary Penalties and better alignment of those penalties with the noncompliance that occurred. This also ensures that CMS retains the authority to impose CMPs related to the nature of the harm that is caused by—or could be caused by—a facility's noncompliance and the length of such noncompliance, rather than the date that a standard survey was conducted or a finding of noncompliance was identified, even if the administration of imposing the CMP occurs after another survey has been conducted.

It is important to note, however, that these CMPs are still subject to statutory daily limits, and CMS can exercise discretion with regard to a nursing home's financial condition in determining the appropriate CMP. CMS remains focused on improving the health and safety of nursing home residents by ensuring quality care and ensuring access to care with these policies.

Question #58
HRSA began a shortage designation modernization project more than 10 years ago. It had projected to start removing HPSAs under this new methodology during COVID but delayed the implementation until the end of last year when it decided to proceed. As a result, a number of hospitals and other health care facilities lost their HPSA designation in 2024, at a time when healthcare workforce shortages seem to be stabilizing but remain critical for many provider types. We expect more areas will lose their HPSA designation under this next cycle as it progresses this year. HRSA also recently announced it would be increasing loan repayment amounts for those eligible under the National Health Service Corps Loan Repayment Program, which is beneficial for those who retain their HPSAs but does nothing for those who lose access to it. Nearly all sectors are experiencing workforce shortages, and the HPSA tools help health care compete, given the additional challenges the sector faces, such as requirements to staff hospitals and emergency departments 24/7.

Certainly, there's value in attempting to modernize data collection. However, did HRSA consider recalibrating how it calculates HPSA scores when it found out the number of areas losing access to HPSA benefits given the new way data is reported and collected by HRSA? Has HRSA considered what impact this continued policy of withdrawing HPSAs will have on the health care workforce?

What can HHS do to help areas that lose their HPSA but still have workforce needs?

Response:
HRSA calculates scores using our online portal, the Shortage Designation Management System. The System contains standard national data sets, and State Primary Care Offices (PCOs) and facilities can provide HRSA with supplemental data. Additionally, we calculate Health Professional Shortage Area (HPSA) scores based on methodology that includes three disciplines: primary care, dental health, and mental health.

Three scoring criteria are common across all HPSA disciplines:

- Population-to-provider ratio
- Percent of population below 100% of the Federal Poverty Level (FPL)
- Travel time to the nearest source of care outside the HPSA designation area

HRSA collaborates closely with State PCOs and stakeholders, providing technical assistance, conducting monthly and quarterly calls, and keeping them updated on HPSA designation and update requirements. State PCOs can leverage this information to secure additional data and request updates or new analyses at any time. HRSA provides the State PCOs with several reminders of HPSA designation update requirements and details what the "proposed for withdrawal" status means in the Shortage Designation Management System. HRSA

informs and supports State PCOs to work with stakeholders in submitting new or updated HPSA data at any time to minimize the impact of lapsing designations. Additionally, HRSA conducts technical assistance calls with the State PCOs to discuss and review potential HPSA designation updates and score changes, and contacts all State PCOs to alert them of potential HPSA withdrawals and deadlines to update designations.

HPSA withdrawals occur when areas no longer meet criteria due to improved population-to-provider ratios, reduced poverty levels, or increased access to nearby health care services, for example. Maintaining outdated designations risks diverting limited resources from areas in greater need. HRSA is statutorily required to publish an annual Federal Register Notice announcing the availability of the list of all designated HPSAs. During the COVID-19 pandemic, HRSA paused these withdrawals to accommodate challenges faced by the health workforce. Recognizing the pandemic's impact, HRSA provided jurisdictions and facilities additional time to adjust to potential HPSA designation changes.

HRSA instituted an additional step in the annually required Federal Register Notice process in 2023. HRSA first published a Federal Register Notice in July 2023 that informed State PCOs of designations at risk of losing their HPSA status, giving State PCOs at least six months to update designations with new data. The second Federal Register Notice published in January 2024 officially withdrew designations if no action was taken.

HRSA urges jurisdictions with withdrawn HPSAs, or HPSAs with non-competitive scores, to contact their State PCO to review their options. HPSA scores can change due to factors like provider availability, population shifts, and poverty rates. Under HRSA's cooperative agreement, State PCOs assess needs, determine eligible areas, and then submit designation applications to HRSA. HRSA reviews these applications and designates HPSAs if they meet eligibility criteria. This process applies to all jurisdictions, including those that lose HPSAs or have HPSAs with low scores.

Although each maintains statutorily directed eligibility criteria, most of HRSA's approximately 70 programs that work to connect health care providers to communities in need do not depend on HPSA scores. More information about HRSA's health workforce programs, including an overview of eligibility criteria, is available on HRSA's health workforce program profile page: https://bhw.hrsa.gov/programs. HRSA remains committed to collaborating with all parties to ensure underserved communities are accurately identified through HPSA designations.

Rep. Rick Allen (R-GA)

Question #59

Back in February, the National Association of Attorneys General sent a letter to Congressional leaders on behalf of a bipartisan group of 39 attorneys general, including Georgia AG Chris Carr, urging action on pharmacy benefit manager (PBM) practices. Their letter outlined several PBM business practices, such as spread pricing and tying their own compensation to the list price of medicine, that are increasing costs for millions of patients, employers, and community pharmacies not only in my state but across the country.

a. Secretary Becerra, since you've mentioned on record that HHS is currently enforcing the Drug Price Transparency rule, I am assuming you also agree something needs to be done to protect patients and stakeholders from such practices. YES, or NO?

b. Even though you've previously stated that HHS is actively enforcing the Drug Price Transparency rules, we have been waiting years for any enforcement. What is your department doing to directly help community pharmacists and patients, especially those who are in rural and underserved communities, who are being squeezed by PBMs and their bad practices?

Response:
On August 20, 2021, the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) released FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (FAQs Part 49) announcing the deferral of enforcement regarding certain requirements, including the requirement that plans and issuers publish machine-readable files related to prescription drugs, pending further consideration by the Departments. In deferring enforcement of this requirement, the Departments noted the enactment of the prescription drug requirements under section 204 of division BB of the Consolidated Appropriations Act, 2021 (CAA), and stakeholder concern about potentially duplicative and overlapping reporting requirements for prescription drugs.

On September 27, 2023, the Departments released FAQs About Affordable Care Act Implementation Part 61 (FAQs Part 61) rescinding Q1 of FAQs Part 49, which had expressed the Departments' general policy of deferring enforcement of the TiC Final Rules' prescription drug machine-readable file requirement pending further consideration in a future rulemaking by the Departments. The Departments will address enforcement decisions under the relevant requirements of the TiC Final Rules on a case-by-case basis, as the facts and circumstances warrant.

Question #60

I recently sent a letter to the Department of Labor regarding so-called alternative funding programs, or AFPs. AFPs intentionally steer beneficiaries toward manufacturer or independent charitable patient assistance programs intended for the uninsured or underinsured. Third-party vendors are increasingly advising employers to turn to AFPs as a solution for high specialty drug costs, while advising plan sponsors to exclude coverage for many of these specialty drugs, forcing enrollees to navigate patient assistance programs to maintain access to their medication. In short, I am concerned that AFPs may mislead employers, make it more challenging for patients to access lifesaving specialty medications, and wrongfully utilize patient assistance funds for their gains. Has HHS taken any actions to address AFPs?

Response:
The Department of Labor is the agency primarily tasked with administration of requirements applicable to private employee benefit health plans under Title I of ERISA.

Question #61
Congress passed the No Surprises Act to create transparency in medical billing. However, according to the GAO, the Department's implementation of the No Surprises Act has led to "over 61 percent of the 490,000 filed claims remaining unresolved as of June of 2023." And thanks to this Administration's failed fiscal policies, clinicians are facing increased costs, and the thousands of claims that are held up in the Federal Independent Dispute Resolution (IDR) Process are further exacerbating their financial problems. What will your department do to ensure payment is processed in a timely manner once a resolution is reached in the IDR process so that they can avoid the added burden of reaching out to HHS?

Response:
The Federal IDR portal first opened for disputing parties on April 15, 2022. After opening, the Departments observed that the volume of disputes was substantially larger than the Departments or certified IDR entities initially expected. Between January 1, 2023, and June 30, 2023, disputing parties initiated 288,810 disputes. The number of disputes initiated through the Federal IDR portal over this six-month period was 13 times greater than the Departments initially estimated the number of disputes initiated would be over the course of a full calendar year and has grown each quarter. In the first quarter of 2023, 136,111 disputes were initiated, which was a 24% increase compared to disputes initiated in the fourth quarter of 2022 (110,034). In the second quarter of 2023, 152,699 disputes were initiated, which was a 12% increase in disputes initiated over the first quarter of 2023.

The backlog and throughput difficulties facing the Federal IDR process can be ascribed to two main issues: higher than expected volume of disputes and the complexity of eligibility determination. When a dispute is submitted through the Federal IDR portal, and before proceeding to a payment determination, certified IDR entities must first make complex determinations about whether the dispute is eligible for the Federal IDR process. Eligibility for the Federal IDR process depends on a number of factors, including federal vs. state jurisdiction, whether the particular items or services are covered by the NSA protections, correct batching or bundling of items and services, compliance with applicable deadlines, and completion of the 30-business-day open negotiation period. In order to make an eligibility determination, certified IDR entities often need to reach out to disputing parties for additional information, lengthening the overall time needed to process a dispute.

Moreover, as a result of opinions and orders issued in several lawsuits that vacated portions of the regulations and guidance on the Federal IDR process, the Departments had to suspend initiation of new disputes multiple times to make changes to the process to align with court orders. While the goal was to keep these suspensions as short as possible, the repeated need to suspend IDR operations due to court orders has been highly disruptive to the process and has contributed to a backlog of IDR cases.

However, to address the high volume of disputes, the Departments worked to improve and automate how the Federal IDR portal operates, as well as provide technical assistance and guidance to certified IDR entities and disputing parties to make the process run more smoothly. For example, the Departments made major updates to the Federal IDR portal, including updating webforms to capture information to aid in eligibility determinations, expanding data validations to ensure disputing parties are inputting accurate information, updating system functionality to accommodate changing requirements as a result of court rulings (including temporarily suspending the Federal IDR portal functionality to ensure that guidance and IT systems were consistent with court orders), automating email communications to reduce delays between disputing parties and certified IDR entities, and improving how the Departments respond to inquiries from certified IDR entities and disputing parties.

The Departments' work to respond to initial IDR process challenges is yielding substantial results. Certified IDR entities have scaled up their operations to address the high volume of disputes. Certified IDR entities rendered 83,868 payment determinations in the first six months of 2023, more than five times the number of payment determinations made in all of 2022 (16,238). Certified IDR entities have increased their payment determination output each quarter compared to the prior quarters. Certified IDR entities made 26,741 payment determinations in the first quarter of 2023, 64% more than the prior quarter, and made 57,127 payment determinations in the second quarter of 2023, which was more than twice the number from the prior quarter. Certified IDR entities closed 134,036 disputes in the first six months of 2023. Disputes were closed for several reasons, including: a payment determination was made, the dispute was determined ineligible for the Federal IDR process, the dispute was withdrawn, parties reached a settlement, or the dispute was closed for administrative reasons, such as unpaid fees. Despite the increase in the number of payment determinations, due to the high volume of disputes initiated,

some disputing parties are still awaiting eligibility and payment determinations. The Departments' objective is to help certified IDR entities and disputing parties obtain resolution on disputes as expeditiously as possible.

> The Departments understand that the enforcement of the timeline for non-prevailing parties to make outstanding payments following a certified IDR entity's payment determination is an issue and we have received complaints regarding late payments after a payment determination has been made. We are actively working to review and resolve these complaints and we take the issue of late payments after IDR payment determinations very seriously. Additionally, based on our review of the complaints, we have made operational changes to help mitigate issues we have identified. These changes include developing a new payment determination template for certified IDR entities to use which includes claim line-level details and developing a process for sending these templates through the Federal IDR portal. While we believe these operational enhancements should help mitigate some of the identified issues related to missing information, we continue to investigate complaints as they are received. In 2022, we provided guidance for certified IDR entities and, additionally, in November 2023, the Departments issued the Federal IDR Operations notice of proposed rulemaking which, if finalized, is intended to help ensure a more efficient Federal IDR process. In general, the Departments are seeing progress in payers making timely payments following a payment determination when we reach out to payers in response to complaints. As we continue to work with all parties to improve this process, we encourage parties who use the Federal IDR process and who are not receiving timely payments on closed determinations to submit complaints.

Rep. Aaron Bean (R-FL)

Question #62
Mr. Secretary, I am a co-sponsor of the bipartisan HELP Copays Act (H.R. 830), which would ban copay accumulator adjustment programs and mitigate copay maximizer programs. You recently testified before our colleagues on the House Energy & Commerce Subcommittee on Health on April 17, and in response to a question about the 2023 District Court ruling over copay accumulators from Rep. Buddy Carter, you said, "We will comply with the law; that's our obligation," and "We are going to follow the court ruling wherever we can." However, I was troubled to learn that you went on to confuse the issue, saying that this was an issue in the Medicare program, where you should know that copay coupons are prohibited.

a. Will your department issue guidance stating that the 2020 Notice of Benefit and Payment Parameters regulation regarding copay accumulators is in effect and that CMS will enforce a ban on copay accumulator adjustment programs except in cases where a generic is available?

b. If you plan to issue guidance, when can we expect this guidance?

Response:
HHS intends to address, through rulemaking, the issues left open by the Court's opinion, including whether financial assistance provided to patients by drug manufacturers qualifies as "cost sharing" under the Affordable Care Act. Pending the issuance of a new final rule, HHS does not intend to take any enforcement action against issuers or plans based on their treatment of such manufacturer assistance.

Ranking Member Robert C. "Bobby" Scott (D-VA)

Question #63
On Tuesday, May 21, 2024, the Office of Community Services and the Administration for Children and Families within the Department of Health and Human Services (HHS)
issued a final report related to the state of Florida's administration of the Low Income Home Energy Assistance Program (LIHEAP), the Low Income Household Water Assistance Program (LIHWAP), and the Community Services Block Grant (CSBG) following reports of significant service disruptions in spring of 2023.[2] These programs collectively serve some of our most vulnerable individuals and families. Now that HHS has issued its final report, it is important that the Committee understand the full scope of what occurred in Florida and what will be done to ensure that program participants do not face further disruption.

a. Can you tell the Committee how long LIHEAP and LIHWAP service disruptions in the state lasted? What is the estimated amount of energy and water assistance benefits that were not distributed during that time period? How many people in the state were impacted by Florida's shutdown of LIHEAP and LIHWAP, including those who were unable to apply for or receive LIHEAP and LIHWAP assistance?
b. Media reports and accounts from stakeholders indicate that Community Action Agencies (CAAs) in Florida, which administer the CSBG program as well as other safety net programs, faced a lapse in funding for several weeks, causing service disruptions and staff furloughs. How many CAAs had to shutter their operations due to the state of Florida's funding lapses? How many CAA staff were furloughed? For how long were CAAs shut down? How many CAAs took out credit to cover expenses?

Response:
Program partners notified the Office of Community Services (OCS) on February 17, 2023, that funds were not available to local administering agencies. On that same day, Florida's Department of Commerce (Florida Commerce), responded to OCS that they had reached their budget authority spending limit in mid-to late December 2022. Florida Commerce notified OCS that additional spending authority was approved on February 28, 2023. Florida Commerce subsequently indicated they began reimbursing local administering agencies by approximately March 10, 2023.

OCS interviewed four local administering agencies during its August 2023 monitoring review. These agencies included local governments and community action agencies. The agencies interviewed indicated reimbursements from Florida Commerce to the administering agencies were paused for approximately three months in the spring of 2023.

Additionally, Broward County Community Action stated that they laid off 14 temporary workers during the time-period when Florida Department of Commerce sought additional spending authority. For both Community Services Block Grant and Low Income Home Energy Assistance Program grantees, Capital Area and Northeast Florida Community Action Agencies stated they paused applications for at least one-week during this time-period and were not reimbursed for approximately three months on expenditures. Capital Area Community Action Agency stated that they needed to draw on a personal line-of-credit to make ends meet. These agencies did not identify the number of individuals that could not receive benefits; however, these agencies were located in highly populated areas in the State of Florida, including Tallahassee, Jacksonville, Fort Lauderdale, and Miami.

Question #64

The *No Surprises Act* greatly expanded the responsibilities of both the Department of Health and Human Services and the Department of Labor to protect consumers from surprise medical billing. In addition, the law

includes several consumer protections on issues, such as health care price transparency, health plans' obligation to maintain accurate provider directories, and continuity of care requirements.

How would this year's proposed budget support on-going implementation and enforcement of the *No Surprises Act*?

What would the impact be if Congress does not extend the implementation funding provided by the *Consolidated Appropriations Act, 2021*?

Response:
To implement the No Surprises Act, the Departments scaled up expertise and resources for rulemaking, technical builds, enforcement, and staffing. While the original appropriation expires at the end of 2024, most of the statutory requirements added by the No Surprises Act and Title II Transparency provisions are permanent and the Departments will have ongoing responsibilities. Some of these responsibilities, including enforcement of critical consumer protections against surprise billing, cannot be funded with IDR administrative fees. Without additional dedicated funding, the Departments may need to phase-down or phase-out certain enforcement efforts, including investigation and resolution of some health plan and provider complaints. For example, HHS may have to significantly adjust its staffing of the No Surprises Help Desk, curtailing consumers' and providers' access to a crucial resource for information about NSA requirements and protections, and leaving them without a central point of contact to submit complaints. HHS further may limit its provider enforcement activities, leaving consumer complaints of illegal balance bills and other violations of the NSA unanswered. Other impacts include:

- Plan enforcement activities, including market conduct exams related to late payments by non-prevailing parties following a payment determination;
- Policy development and program implementation related to the NSA's advanced explanations of benefits (AEOBs);
- Prescription drug data collection, preventing HHS from collecting, analyzing, and publishing findings about prescription drug pricing and the impact of prescription drug rebates on patient out-of-pocket costs; and
- Air ambulance data collection.

The impact of the loss of funding to the Departments of Labor and the Treasury should be directed to those agencies.

Rep. Suzanne Bonamici (D-OR)

Question #65
Community Action Agencies (CAAs) provide essential services and programs that meet the unique needs of their local communities and empower low-income individuals and families to achieve economic stability. Unfortunately, the slow distribution of federal Community Service Block Grant (CSBG) allotments from state agencies limits CAAs' reach. In 2015, the Department of Health and Human Services (HHS) adopted guidance for state and federal accountability measures, which includes a measure on timely payments of grant and subgrant funding. This metric evaluates payments from HHS to the states and from states to the CAAs. Despite these actions by HHS to address this issue, local agencies remain frustrated by the slow distribution of funds from their state.

How can HHS improve delivery of federal CSBG funds to local CAAs in a timely manner?

Response:

HHS works expeditiously to release funding to state agencies on quarterly basis. State agencies under the CSBG are required to comport with specific State Accountability Measures outlined in policy that stipulates funds are to be distributed to local agencies within 30 calendar days of the state agency receiving the funds (ACF-OCS-CSBG-IM-144). When HHS monitors grant recipients in accordance with regulations, we assess the timeliness of funding releases to local agencies.

Question #66
HHS recently requested comments on a proposed revision of the CSBG annual report in an effort to reduce the administrative burden of reporting; however, the annual report is a component and not the entirety of federal CSBG reporting requirements.
How is HHS working to reduce excess paperwork across the board, especially for smaller CAAs, and streamline reporting systems for local agencies that administer
multiple programs, such as Head Start and Low-Income Home Energy Assistance, in addition to CSBG?
Many local CAAs work with state agencies that administer CSBG and related programs, how will HHS prevent duplicative state reporting requirements on CAAs?

Response:
In an effort to reduce the reporting burden of individuals, families, local, and state agencies, HHS examined the CSBG Annual Report (OMB #0970-0492) and identified any data points that were not essential for federal reporting that could be removed. On April 22, 2024, the Administration for Children and Families (ACF) published a notice in the *Federal Register* inviting comments on a version of the annual report that significantly reduces reporting burden and removes 160 data points. This effort considered where there is duplication in the data reported across several federally funded programs. ACF received many comments on the updated version and after ensuring time to consider all comments received, is currently finalizing the streamlined report for submission to the Office of Management and Budget.

HHS has examined where there is duplication in the reporting to eliminate several data points that are collected in multiple federal reports and has removed certain data points that are collected in other federal datasets (including those collected by the Low Income Home Energy Assistance Program).