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OVERSIGHT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

THURSDAY, FEBRUARY 15, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 12:30 p.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Upton, Shimkus, Latta, Lance, Griffith, Bilirakis, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden(ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Eshoo, DeGette, and Pallone (ex

officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight & Investigations; Mike Bloomquist, Deputy Staff Director; Adam Buckalew, Professional Staff Member, Health; Kelly Collins, Staff Assistant; Zachary Dareshori, Staff Assistant; Paul Eddatel, Chief Counsel, Health; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Clerk, Health; Ed Kim, Policy Coordinator, Health; James Paluskiewicz, Professional Staff, Health; Mark Ratner, Policy Coordinator; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Danielle Steele, Counsel, Health; Austin Stonebraker, Press Assistant; Josh Trent, Deputy Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Jacquelyn Bolen, Minority Professional Staff; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Health Counsel; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; Miles Lichtman, Minority Policy Analyst; Rachel Pryor, Minority Senior Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Kimberlee Trzeciak, Minority Senior Health Policy

Advisor; C.J. Young, Minority Press Secretary.

Mr. Burgess. The Subcommittee on Health will now come to order. I ask everyone to please take their seats.

And before we get started, I do want to take a moment to recognize yesterday=s devastating events in Florida. We will continue to learn more about how things occurred and I know my colleagues and I will keep the victims, the injured, and their loved ones foremost in our minds.

Representative Bilirakis and Representative Castor, we will also be thinking of you, the entire Florida delegation, the people of Florida during this difficult time.

I would like to recognize myself five minutes for the purpose of an opening statement. This afternoon, we are honored to have Secretary Alex Azar before the Health Subcommittee to discuss the Department of Health and Human Services= budget for the fiscal year 2019.

First, Secretary Azar, congratulations on your recent confirmation and we appreciate your willingness to participate today and I believe this is your third congressional hearing in 24 hours. So we also appreciate your endurance.

Earlier this week, President Trump and his administration released their budget, which provides a blueprint on where federal investments could be made as well as areas of additional funding

and resources and areas of efficiency.

We appreciate the administration sharing its vision for the upcoming fiscal year as all of us on the committee work to solve many of the health care issues impacting our respective communities across the country.

Mr. Secretary, you see before you on this dais men and women with a multitude of backgrounds and experience and different political approaches to solving these problems -- different political philosophies.

But I can tell you for a fact everyone seated on this dais on either side is committed to seeking solutions and doing the work necessary, and I pledge that we will work with you as we accomplish these goals for the American people.

The Energy and Commerce Committee, specifically this subcommittee, has the broadest jurisdiction in Congress over our nation=s health care matters, major policy operations under the Department of Health and Human Services.

These issues include both private and public health insurance markets, Medicare, Medicaid, Children=s Health Insurance, and the Affordable Care Act; biomedical research and developments, particularly those emanating out of the National Institutes of Health; the regulation of food, drugs, and medical

devices, as well as cosmetics through the Food and Drug Administration.

We also oversee federal policies affecting substance abuse and mental health, which demand interagency collaboration, especially with the Substance Abuse and Mental Health Administration; and oversight of not only the nation=s public health but also global health, including the Centers for Disease Control and Prevention.

Again, members on both sides of this dais on this committee, we do have our differences but I believe we have the mutual goal of delivering for the American people and working together on issues that demand our full attention.

We have got an opiate crisis that demands our attention. We have got to improve the quality and access to health care products and services. We have to harness the scientific and medical technologies of today to advance the health care policies of tomorrow.

What this committee has already accomplished under previous administration and the current administration is indicative of what is certainly possible: passage of the Medicare and CHIP Reauthorization Act to repeal the sustainable growth rate formula; the enactment of the 21st Century Cures Act; the

reauthorization of several key user fees at the Food and Drug Administration last year; the reauthorization of Children=s Health Insurance and community health centers and other important public health and Medicare extenders just last week.

On this committee, we were able to include 19 member-led initiatives -- health care initiatives in the recent Bipartisan Budget Act that included both Republican and Democrat priorities. The Health Subcommittee still has an extensive list of items to finish before the end of this year.

These include holding hearings on legislative policies and developing the proposals to blunt the opioid epidemic, to reauthorize the Pandemic and All-Hazards Preparedness Act and Animal Drug User Fee, and examining the cost drivers of the nation=s health care infrastructure and offering solutions and improvements to programs like 340B drug discount under the Health Resources and Services Administration.

We are also interested in Consumer eHealth in the Office of the National Coordinator for Health Information Technology.

I would like to build upon the work that our subcommittee initiated last year and continue assessing the ways that our current health care infrastructure can more positively impact Americans in urban and rural areas where illnesses like

Alzheimer=s disease and mental health disorders pose challenges for our loved ones and their families.

As a physician who understands the demands and challenges of treating patients while maneuvering through the reporting and other compliance requirements, which can often be barriers to providing better patient care, I want you to know I am committed to relieving the burdens that have been placed on doctors through commonsense market-driven solutions.

Many of the actions the current administration has taken thus far are very encouraging and it is my hope we can continue to work together on this effort.

Mr. Secretary, I want you to regard this subcommittee as a resource and a partner to you and your agency to fulfill your mission and deliver for America.

Again, I want to welcome you, Secretary Azar, and I want to thank you for being here. I look forward to hearing your vision for the Department of Health and Human Services and exploring opportunities to work together on the many critical health issues on behalf of the American people.

At this time, I would like to recognize the ranking member of the Health Subcommittee, Mr. Gene Green of Texas, for five minutes, please.

Mr. Green. Thank you, Mr. Secretary and Mr. Chairman. Thank you, Mr. Secretary, for being here today, and it is unusual to have two Texans who are ranking and chair of the Health Subcommittee. We wondered about that for most of this session. But somehow it works out.

This week, President Trump released his 2019 budget request. Budgets are more than just numbers on a page. They are statements of priorities.

Unfortunately, I believe the priorities of the administration are out of whack. This budget doubles down policies that would hurt working Americans and jeopardize their health.

It proposes devastating cuts to Medicaid, Medicare, public health programs, and yet again, calls for repeal and replace of the Affordable Care Act.

This dangerous budget imperils access to care for millions of Americans and puts our nation=s health care system at risk.

Three million Americans lost their health insurance this year because of the administration. This budget proposes to take away from millions more.

Proposing to cut Medicaid by $1.4 trillion is an assault

on the working families and could even -- would be even crueler than the permanent caps on funds that Trumpcare passed by the House would have imposed.

It was -- it would implement harsh barriers to coverage for low-income families altogether. The budget would gut the single largest insurer of children, enact an unprecedented cut on the largest payer for behavioral health, and threaten care for seniors in nursing homes, individuals with disabilities, and working families.

Repealing the ACA and cutting $675 billion in health care dollars over a decade would take health care away from millions of Americans, raise costs, and destroy Obamacare=s protections for people with preexisting conditions.

This budget cut of almost $500 billion from Medicare shifts costs to seniors and cutting our health care safety net. It cuts $1 billion from the Centers of Disease Control and Prevention at a time when a robust public health infrastructure couldn=t be more important.

It is clear they have very different aspirations for this country and what our health care system should look like.

The picture of the administration=s budget paints a harsh one where more and more Americans join the ranks of the uninsured

every day, where seniors face declining quality of care and Medicare due to deep and irrational cuts to pay for the tax cuts for the wealthy, and where working families and people with disabilities can no longer rely on the safety net that is Medicaid.

I appreciate the opportunity to hear from our witness. I am looking forward to answering questions and I=d like to yield one minute to my California colleague, Ms. Matsui.

Ms. Matsui. Thank you very much, Mr. Green.

I am extremely concerned by the priorities reflected in this president=s budget. This proposal directly and negatively impacts hardworking families who depend on crucial services.

It guts Medicaid by $1.4 trillion. These cuts mean working single mothers in between jobs, families with a family member who suffers from addiction, and grandparents in long-term care facilities will have less access to care.

And the HHS budget once again declares war on the Affordable Care Act, restricting access to coverage. These are cruel inflictions from an administration who claims to be addressing the opioid crisis.

I am disappointed that HHS, which has a mission to enhance and protect the health and well-being of all Americans, has presented a budget that targets the most vulnerable in our

communities -- women, children, people with disabilities and mental illness, and the LGBT community.

I sincerely hope that in our conversation today we can address the failings in HHS= budget vision and how the agency should in fact be working to protect all Americans.

Thank you. I yield back to the ranking member.

Mr. Green. Mr. Chairman, I yield one minute to my colleague from Vermont, Congressman Welch.

Mr. Welch. Thank you very much.

Mr. Secretary, in March of 2017, President Trump invited Congressman Cummings and me to the White House to discuss drug prices.

This committee has got a big concern about that. Mr. Burgess has been very active. And his concern was that the prices are beyond affordability for individuals, for the businesses that are trying to cover their employees and for taxpayers. He believes they are too high. He doesn=t -- he=s explicit that it=s inexcusable and unsustainable. The causes are many. You=ve got incredible experience in the industry so you understand it.

In the hope, I think, that the entire committee has is that when you come back in a year, let=s say, we are going to show that the price has stabilized or started to go down.

The status quo is just killing us. And if you have these medications that have great promise but people can=t afford them, they are not going to be sustainable.

Mr. Green. Mr. Chairman --

Mr. Welch. And I yield back.

Mr. Green. Okay. In my last six seconds, I want to also take personal privilege. My staff member, Kristen O'Neill, this is her last day with us. She=s going to bigger and better things.

She=s been in our office doing health care for six years and, as you know, that=s been pretty traumatic for both sides of the aisle. But I=ll miss Kirsten because she=s been a great staff member and made sure I didn=t make too much of a fool of myself.

[Applause.]

And I yield back my time.

Mr. Burgess. Gentleman yields back. The chair thanks the gentleman.

Chair recognizes the gentleman from Oregon, Mr. Walden, chairman of the full committee, five minutes for an opening statement.

The Chairman. Well, thank you, Mr. Chairman, and I would

also join in I guess congratulating Kirsten on her departure. I don=t know if that=s a good thing or a bad thing.

But you=ve certainly played a key role on health care issues here and done a great job for Gene, and our team has enjoyed working with you as well. So we wish you every success in going forward.

Mr. Secretary, we are delighted to have you here as well. Welcome to the Energy and Commerce Committee.

On behalf of all of us, I=d like to again congratulate you again on your confirmation as the secretary of the Department of Health and Human Services.

Your previous leadership experience at the department and in the private sector I think gives you a tremendous springboard to do great work for the American people and we like to work as much as we can around here in a bipartisan way and we know we share a lot of common objectives. We appreciate your appearing before the subcommittee so shortly after your confirmation.

Energy and Commerce has always led the way in delivering meaningful health care reforms and policies for the American people and last year we completed our work to spur new innovation and competition in the life sciences sector through the FDA Reauthorization Act.

Ensuring and strengthening America=s leadership role in

biotechnology to help consumers will continue to be a priority for our committee.

We also just enacted the longest extension of the Children=s Health Insurance Program -- as you know, CHIP. We did critical extensions of Medicare extenders that seniors rely upon.

We strengthened public health by providing funding for community health centers -- really, really important, especially in -- I know in my part of the world, 240,000 Oregonians get their care through our very important network of community health centers and we have done a lot of other public health priorities.

We also rolled back the Affordable Care Act=s Independent Payment Advisory Board, which threatened to undermine care for our nation=s seniors who rely upon the Medicare program.

We did this all in a fiscally responsible way by doing the hard work of ensuring that new spending was fully paid for with targeted and smart reductions in other spending.

These priorities and others were part of the 19 Energy and Commerce Committee bills that were signed into law by President Trump as part of the Bipartisan Budget Act of 2018. So we got a lot of work teed up through here and then we are able to put it in that package and the president signed it.

So, Mr. Secretary, we had a chance to talk earlier this week

about our shared priorities and we look forward to partnering with you and the entire Department of Health and Human Services.

This committee has a rich tradition of bipartisan oversight and legislative work and I see a lot of opportunity for us to continue down that path in the coming weeks and months.

Particularly, I=d like to focus on the issue of opioids and the crisis that is afflicting our country and our citizens. It=s a top priority for me.

It=s a top priority for members on every side in this committed. We need to build upon our previous legislative efforts, known as the Comprehensive Addiction Recovery Act, or CARA, and the funding provided in the 21st Century Cures Act.

I would point out that=s the most funding the United States government has ever put directly toward the opioid epidemic and we intend to do more and we are set up in the budget agreement to do even more, going forward.

But we want to make sure it goes to the right places for effective purposes and helps in this effort. While these laws resulted in record amounts of money being devoted to this fight, more is needed to address this growing crisis and in last week=s

budget bill we were able to deliver headroom to provide new resources for both 2018 and 2019. So we look forward to working with our friends in the Appropriations Committee as we work on how that money should be spent.

Last year, we held a Member Day. We solicited solutions to help combat the opioid epidemic. We had, I think, something like 50 members of Congress come before this committee -- an unprecedented show of support -- with their ideas and their suggestions about what we could do.

We also have had tremendous work being done by Oversight and Investigations Subcommittee, now led by Chairman Harper, looking at how these drugs got into our communities and the trip wires that didn=t trip, or if they did we want to know why somebody didn=t take notice.

Given that addressing the opioid epidemic has bipartisan support and President Trump=s leadership and commitment to this issue, it is my hope and belief this committee will deliver additional legislation this spring and that we can get into law soon.

The Health Subcommittee also plans to build upon the work of our Oversight and Investigations Committee=s report on 340B. This program is important as it serves our low-income

individuals. But it=s essentially not been modernized in two decades. So it=s our belief that reforms are necessary to both strengthen and secure the program so it can best serve low-income populations and make sure they have access to affordable medications. So we look forward to working with you on that.

Along with finding opportunities to lower costs for consumers across the board and addressing reauthorizations later this year, 2018 will be busy for this subcommittee and, Secretary Azar, we look forward to partnering with you on these initiatives and many more, going forward.

And with that, Mr. Chairman, I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from New Jersey, Mr. Pallone, ranking member of the full committee, five minutes, please.

Mr. Pallone. Thank you, Mr. Chairman.

To my dismay but not my surprise, President Trump=s 2019 budget proposal continues the cruel and complacent perspective of ripping health care away from millions of Americans to help pay for the Republicans= tax scam that overwhelmingly benefits the wealthy and corporations.

This budget is an attack on working families, seniors, and lifesaving programs. I want to just highlight some of the more egregious issues with the budget.

It doubles down on gutting and capping the Medicaid program, the nation=s largest health insurer, and cuts our nation=s safety net by $1.4 trillion.

Meanwhile, it builds on the administration=s ongoing illegal efforts to kick vulnerable Americans off Medicaid through work requirements, lockouts, and proposed lifetime limits.

Simply put, the Trump administration=s vision for our country through this budget is to take coverage away from families living on the brink that depend on Medicaid to make ends meet.

The Trump budget also includes over $500 billion in cuts to Medicare, jeopardizing health care for seniors, deep cuts to safety net providers, nursing homes, home health agencies, and other providers appear to be based not on any real policy rationale but cutting for the sake of cutting. Essentially, cut health care for seniors to pay for that Republican tax cut.

Sadly, the Trump budget continues the same Republican efforts to repeal the Affordable Care Act. As proposed, ACA repeal would leave millions more uninsured, gut protections for premising conditions, and result in a $675 billion cut to our

health care system.

In addition, ongoing efforts to sabotage the ACA such as cutting off cost-sharing reductions and rolling back consumer protections have already resulted in skyrocketing costs for middle class families and 3 million more Americans uninsured in 2017.

And now, HHS is sitting by the sidelines while Idaho clearly circumvents the law, and this is simply unacceptable.

Today, we will hear from our newly-confirmed Secretary Azar and Mr. Azar moves into the top leadership position at a very trying time.

The department has been embroiled in scandal since day one. From former Secretary Tom Price=s exorbitant travel expenses to the use of official resources to lobby in favor of ACA repeal and replace to Brenda Fitzgerald=s purchases of tobacco stock while she was the head of CDC. These issues deserve immediate attention.

This morning I sent a letter to you, Mr. Secretary, asking you to conduct a topdown review of the department and all of its operating divisions to assess the extent to which HHS personnel are abiding by all applicable federal ethical regulations and policies and whether appropriate safeguards are in place to

protect against abuse and conflicts of interest.

I hope we hear today about your plans to faithfully uphold the laws set by Congress, improve transparency, and eliminate conflicts of interest and protect the health of working families.

The American people deserve a commitment to restore the integrity of the department.

I=d like I -- I don=t have exactly two minutes but half my time initially to Mr. Lujan and then to Mr. Kennedy. I yield to Mr. Lujan at this time.

Mr. Lujan. Thank you, Mr. Pallone, and Mr. Secretary, thank you for being here today.

In previous hearings, you told some of my Democratic colleagues that we all shared values on health care. I am interested to hear more about how the Trump administration=s budget reflects these shared values or perhaps explore where in fact we are not aligned.

I believe health care is a right, not a luxury. I believe health care should be affordable no matter your income, accessible no matter where you live, high quality no matter how you=re insured.

The president=s budget proposal continues the Republican obsession with repealing the Affordable Care Act, which would

strip health care away from tens of millions of Americans.

Let me be clear. Those are not my values. I believe it=s a tragedy that seniors all across this country have to choose between rent and prescription drugs.

I believe it=s a tragedy that before the Affordable Care Act more Americans filed bankruptcy for medical debt than anything else. I believe it=s a tragedy that before Medicaid expansion, paying for inpatient opioid treatment was out of reach for so many middle class Americans.

This Trump budget dismantles Medicaid and the Affordable Care Act. It represents an attack on working families and lifesaving programs. The Trump budget cuts care for children, families, women, and people with disabilities while once again favoring the wealthy over corporations. Those are certainly not my values.

I yield back.

Mr. Pallone. Mr. Kennedy, you got, like, 10 minutes left.

Mr. Burgess. Ten minutes?

Mr. Pallone. Ten seconds.

Mr. Kennedy. I got six, seven seconds. So I=ll yield, Mr. -- I=ll yield back.

Mr. Pallone. I am sorry. Thank you, Mr. Chairman.

Mr. Burgess. Gentleman yields back. Chair thanks the gentleman.

This concludes member opening statements. The chair would remind members that pursuant to committee rules, all members= opening statements will be made part of the record.

Testifying before our subcommittee today is the Honorable Alex Azar, secretary of the United States Department of Health and Human Services.

Secretary Azar, you will have an opportunity to give an opening statement followed by questions from members. We do want to thank you for being here today.

You are now recognized for five minutes to summarize your opening statement, please.

STATEMENT OF THE HONORABLE ALEX AZAR, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF SECRETARY AZAR

Secretary Azar. Chairman Burgess, Ranking Member Green, Chairman Walden, and Ranking Member Pallone and members of the committee, thank you for inviting me here today to discuss the president=s budget for the Department of Health and Human Services for fiscal year 2019.

I would like to begin by expressing, of course, my sympathies and prayers for the victims and families of the tragedy in Florida. I want to echo the president=s comments this morning that this administration is committed to working with states and localities to tackle the issues of serious mental illness.

It=s a great honor to be here. It=s an honor to serve as secretary of the Department of Health and Human Services. Our mission is to enhance and protect the health and well-being of all Americans.

It is a vital mission, and the president=s budget clearly recognizes that. The budget makes significant strategic investments in HHS= work, boosting discretionary spending at the department by 11 percent in 2019 to $95.4 billion.

Among other targeted investments, that is an increase of $747 million for the National Institutes of Health, a $473 million increase for the Food and Drug Administration, and a $157 million increase over 2018 funding for emergency preparedness across the department.

The president=s budget especially supports four particular priorities that we have laid out for the department, issues that the men and women of HHS are already working hard on: fighting the opioid crisis, increasing the affordability and accessibility of health insurance, tackling the high price of prescription drugs, and using Medicare to move our health care system in a value-based direction.

First, the president=s budget brings a new level of commitment to fighting the crisis of opioid addiction and overdose that is stealing more than a hundred American lives every single day.

Under President Trump, HHS has already disbursed unprecedented resources to support access to addiction treatment. This committee in particular took a major step in addressing the crisis through creating the 21st Century Cures Act=s state-targeted response to the opioid crisis grants.

The budget would take total investment to $10 billion in

a joint allocation to address the opioid epidemic and related mental health challenges.

Second, we are committed to bringing down the skyrocketing cost of health insurance, especially in the individual and small group markets so more Americans can access quality affordable health care.

This budget recognizes that this will not be accomplished by one-size-fits-all solutions from Washington. It will require giving states room to experiment with models that work for them and allowing companies to purchase individualized plans that meet their needs.

That=s why the budget proposes a historic transfer of resources and authority from the federal government back to the states, empowering those who are closest to the people and can best determine their needs.

The budget would also restore balance to the Medicaid program, fixing a structure that has driven runaway costs without a commensurate increase in quality.

Third, prescription drugs cost too much in our country. President Trump recognizes this, I recognize this, and we are doing something about it.

This budget has a raft of proposals to bring down drug prices,

especially for America=s seniors. We propose a five-part reform plan to further improve the already successful Medicare Part D prescription drug program.

These major changes will straighten out incentives that too often serve program middlemen more than they do our seniors. These changes will save tens of billions of dollars for seniors over the next 10 years, adding to savings we are already generating with reforms the Medicare Part B payments under the 340B drug discount program.

The budget also proposes further reforms in Medicaid and Medicare Part B to save patients money on drugs and provide strong support for FDA=s efforts to spur innovation and competition in generic drug markets.

We want programs like Medicare and Medicaid to work for the people they serve. That means empowering patients and providers with the right incentives to pay for health and outcomes rather than procedures and sickness.

Our fourth departmental priority is to use the tremendous powers we have through Medicare as the largest purchaser of medical services in the U.S. to move our whole health care system in this direction.

This budget takes steps toward that by, for instance,

eliminating price variation based on where post-acute care is delivered, rationalizing payments to physicians and hospital-owned outpatient facilities, supporting investments in telehealth, and advancing the work of accountable care organizations.

The future of Medicare must be driven by value, quality, and outcomes, not the current thicket of opaque unproductive incentives.

Making our programs work for today=s Americans, sustaining them for future generations, and keeping our country safe is a sound vision for the Department of Health and Human Services and I am proud to support it.

Thank you, Mr. Chairman.

[The prepared statement of Secretary Azar follows:]

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Mr. Burgess. Mr. Secretary, thank you for your testimony. Thank you for being here today. We will move on to the member questions portion.

I would like to first recognize the vice chairman of the subcommittee, Mr. Guthrie from Kentucky, five minutes, please.

Mr. Guthrie. Thank you, Mr. Chairman. I appreciate it.

Mr. Secretary, thank you for being here. I had a meeting earlier today with Ed Workforce on Opioids and that=s something that we are all concerned about, particularly my home state.

And one tool that could be improved to combat the opioid crisis is prescription drug monitoring programs. As you know, PDMPs can help spot potential drug misuse or diversion.

I=ve heard from stakeholders that integration PDMP data into the clinical workflow in a timely manner is needed to improve provider and dispenser resources.

Can you please describe how HHS is thinking about leveraging its authorities to encourage best practices within PDMPs?

Secretary Azar. So thank you, Congressman, for that question.

I look forward to any ideas that you and others may have about ways that we can support states in this critical effort.

One of the proposals in our budget is to require states to

monitor high-risk billing activity to identify and remediate abnormal prescribing and utilization patterns that may indicate abuse in the Medicaid system. That may include states with prescription drug monitoring programs as a vehicle to do that.

We also are asking for authority to make sure that whenever we exclude a provider it will automatically lead to transmission of that information to DEA to pull their ability -- the physician=s ability to write controlled substances through the DEA.

Mr. Guthrie. Thank you.

Second question on Medicaid rebates -- strengthening and improving the oversight of the Medicaid drug rebate program is something this committee has been working on for several years.

In fact, recently the HHS Office of Inspector General just issued a report on CMS= oversight of the program. In their report, the OIG found that from 2012 to 2016 Medicaid may have lost $1.3 billion in base and inflation-adjusted rebates for 10 potentially misclassified drugs with the highest total reimbursement in 2016. The budget -- this budget includes a proposal to clarify Medicaid definition of brand and over-the-counter drugs under the Medicaid drug rebate program to prevent inadequately -- inappropriately lower manufacturer rebates.

We are interested in your legislative proposal in this budget

and could you describe it and then have your office provide us with details?

Secretary Azar. Yes, thank you.

So this is an issue that came up in the last year through -- or last year and a half regarding making sure that manufacturers are clearly understanding and that the rules of the road are very clear -- what=s a branded drug, what=s a generic drug, what=s an over-the-counter drug so that we are getting our proper rebate payments in the Medicaid -- the Medicaid program, and as you mentioned, that can be an error to the point of -- to the tune of $1.3 billion of misreporting. So we are asking for language that would clarify that.

In addition, you know, we have got in our budget proposal a plan that we would like authority to grant up to five states the ability to negotiate their own formulary for drugs with drug companies to see if they can do an even better job than we do through our statutory Medicaid drug rebate program to bring down drug costs.

Mr. Guthrie. Thank you. I look forward to looking at the details of that.

And one more -- I=ll go back to my first question on the prescription drug monitoring programs. It=s my understanding

that prescription drug monitoring programs are not allowed to have data on patients receiving methadone.

On the other hand, buprenorphine prescribed in an office-based setting is typically filled at the pharmacy and pharmacies can submit dispensing information on -- to the PDMPs.

So methadone dispensing and buprenorphine dispensing are treated unequally when it comes to this prescription drug monitoring. What can the department and Congress do to improve safety and health outcomes for patients while still protecting patient privacy?

Secretary Azar. I am glad you mentioned that.

I am -- I had not been aware of that issue with methadone reporting into the prescription drug monitoring databases. I=ll be happy to look into that. I don=t understand why that would be the case. These can be very important vehicles to prevent physician shopping as people try to abuse legal opioids. So I am happy to look into that.

Mr. Guthrie. Well, thank you. I look forward to sharing that with you and looking forward to getting the answers.

And I appreciate you being here. I know you=ve had a couple of long days. Well, I have about 50 seconds left so I just want to say I actually drove to Greenbrier and when I got there

everything that had happened and they were interviewing Dr. Burgess, and the person on the radio kept saying -- on the radio kept trying to, well, wasn=t there fuel -- wasn=t there whatever -- essentially, did you run into a dangerous situation. Dr. Burgess kept saying -- like all the others there, he kept saying, AWell, I didn=t think about that. I was just trying to help people."

So I=ve always known you to be a man of principle and it=s great to verify also you=re a man of character. So I appreciate that very much, and I yield back.

Mr. Burgess. And Dr. Bucshon as well, of course, that day.

Mr. Guthrie. Yes. I have 14 seconds. Yes, everybody. But I heard you specifically say that. So I appreciate it.

Mr. Burgess. All right. If you=re through praising me, I was going to yield you another 15 minutes.

[Laughter.]

Chair recognizes the gentleman from Texas five minutes for questions.

Mr. Green. Mr. Chairman, I=ll reserve my time.

Mr. Burgess. And reserves -- the chair recognizes the gentleman from New Jersey five minutes for questions, please.

Mr. Pallone. Thank you, Mr. Chairman.

Secretary, the state of Idaho recently released guidelines that would eviscerate critical protections that are enshrined in federal law and would potentially destabilize the health insurance market.

Idaho would allow insurers to deny people with preexisting conditions, not cover pediatric dental or vision care, charge older Americans more, and exclude maternity and newborn coverage.

I sent you and Administrator Verma a letter on this issue a few weeks ago and I asked questions about whether these guidelines are in compliance with federal law and, if not, what the agency planned to do to enforce the law and I received what I consider an unacceptable response.

And I quote, it says, AAt this time, the Centers for Medicare and Medicaid Services does not have any additional information to share regarding this bulletin. We are committed to fulfilling our obligations under the law while continuing to work with states to provide flexibility where possible and we are happy to keep you informed of any developments."

So Mr. Chairman, I=d like to ask unanimous consent to enter my letter and the response into the record, and I=ll give them to you now.

Mr. Burgess. Without objection, so ordered.

Mr. Pallone. And, again, this response is inadequate and nonresponsive so I=d like to use my time today to follow up on some of the questions set forth in my letter and where possible I=d ask you to respond yes or no because we only got three and a half minutes.

Secretary, are you aware that the Affordable Care Act imposes certain requirements on health insurance covered offered in the individual market including, for example, community ratings, coverage of preexisting conditions, and the inclusion of essential health benefits? That, I think, would be a yes or no.

Secretary Azar. That would be a yes, I am aware.

Mr. Pallone. All right. Thank you.

Is it your impression that these requirements are optional for states or able to be waived?

Secretary Azar. I would need to check under 1332 our waiver authority against each of those. I still haven=t sat with the attorneys learned all the parameters of what can be waived or what can=t be waived through our waiver --

Mr. Pallone. All right. Well, I=d ask you, if you could, to get back to me in writing within, like, a week or so about that because I don=t think it would be that difficult to respond.

Secretary, are you aware that under Section 2761 of the Public Health Service Act as secretary of the department you have a legal obligation to enforce the law and take action against any insurers offering noncompliant plans in the state of Idaho?

Secretary Azar. So we have only -- at this point, I=ve seen what=s in the press reports and I=ve seen what Idaho has purported to pass and then just the recent news about the Blues= plan coming in with a plan.

Once that gets -- if that gets to the point where it=s actually both finalized as well as certified by the state or not certified, where there is final action we would certainly review that and -- a searching review for compliance with the legal obligations that we have in our statutes.

Mr. Pallone. I mean, I appreciate that. But, you know, in my opinion -- and I know you don=t agree with me -- I think that, you know, these news reports are pretty clear what they are proposing and I would think that, you know, if you felt -- and I do -- that they were in violation of the law you could initiate and start some kind of investigation now. You wouldn=t have to wait until, you know, you see whether they are finalized or not because what my concern would be that if we wait until then, you know, they might already have a negative impact on the

public.

But explain to the committee -- I know you haven=t taken any action against the state, you said, or any action against insurers who are clearly in violation.

But how long would this take? You said, I have to wait until it=s final. I mean, I am concerned that this -- you know, that this happens and people are negatively impacted. You want to give me some kind of time line, if you could?

Secretary Azar. Well, we are certainly not going to let anyone be negatively impacted by noncompliance with the law. What we are going to do, though, is not reach out -- I just -- I can=t reach out to every press report and --

Mr. Pallone. No, I know. But --

Secretary Azar. -- take enforcement action based on information in press reports.

Mr. Pallone. You see, my concern though --

Secretary Azar. We are tracking it very closely, though.

Mr. Pallone. All right. But I just would like to make sure that you complete an evaluation before the plans are approved by Idaho and sold to consumers, which I am told by the news report could happen as soon as April.

So can you at least assure me that your evaluation and decision whether to go after them or not allow it would be made before they approve it and sell it to consumers?

Secretary Azar. I cannot imagine a circumstance where we would not evaluate it for compliance against the law before offered to consumers.

I do think it=s appropriate to wait to see even if the state finds it in compliance with whatever their state laws are. I don=t see why we would be reaching in and picking -- and picking up matters out of press reports.

Mr. Pallone. All right.

Secretary Azar. We don=t make it a habit of reviewing applications of states.

Mr. Pallone. Would you at least assure me that you -- would you at least assure me that you wouldn=t allow them to go ahead and sell these things without doing that evaluation and determining?

Secretary Azar. I fully expect that we would do so.

Mr. Pallone. All right.

Secretary Azar. I fully expect that would be. I can=t imagine why we would not.

Mr. Pallone. All right. I appreciate that.

Thank you, Mr. Chairman.

Mr. Burgess. Gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from Michigan, former chairman of the full committee and the author of the Cures for the 21st Century, Mr. Upton, you=re recognized for five minutes.

Mr. Upton. Thank you, Mr. Chairman, and welcome, Mr. Secretary, to our great committee.

I do have a couple questions. The opioid crisis -- and I know that this committee looks forward to a bipartisan series of bills in the next number of weeks, moving forward -- for me, I have a district that=s sort of a blend between rural and urban and I just want to know what some of your thoughts are providing particularly technical assistance to some of those communities that may not have the resources even though we know that our more populated centers are stressed to the Nth degree as well.

Secretary Azar. Thank you for asking about that.

I am just really very -- I am just gratified -- excited that on a bipartisan basis we are able to tackle this opioid crisis and the $10 billion of funding that is -- appears to be in the budget agreement and we have requested $3 billion of that for 2019 on top of $3 billion in 2018 that we are hoping will come

through the omnibus.

So significant funding on top of the historically high level of funding through 21st Century Cures that we put out in 2017.

We have one program in particular I wanted to call your attention to for more rural areas. So through HRSA in 2019 we would propose $150 million for rural substance abuse to actually help those providers in more rural areas and ensure there is adequate capacity there for treatment for addiction and dependence.

We also would be putting $400 million into quality improvement payments for our community health centers -- just by way of example, some of the steps at the community level.

Mr. Upton. Yes. I visited a couple of our community health centers, one in particular this week, and they do a really amazing job and, again, one of the things that=s certainly been bipartisan as this committee has moved forward.

I don=t know if you=re familiar with this fire retardant PFAS, which has been in the ground water and particularly in a lot of our military installations from years past.

Our delegation -- Michigan delegation met formally earlier this week and I know that we as a -- on a bipartisan basis are looking to do a letter to the appropriators asking that there

may be funding in this omnibus appropriation bill next month for the Centers for Disease -- a CDC study looking at how extensive that is. Are you very familiar with this issue?

Secretary Azar. I am slightly familiar. Obviously, not as much as you are.

I know that CDC is already working on gearing up and preparing for that study work in the event of appropriation.

Mr. Upton. So we=re -- if you could help us on that, that would be appropriate.

As the newly sworn-in secretary of HHS, you are certainly taking a very important role -- oversight role on major federal and state programs.

There have been a couple of pretty high profile state budget battles not only -- in particular, Illinois, which has had a significant disruption in payments to vendors which led to hardships for some Medicaid recipients in that state.

I am working on a proposal that, again, I think will be bipartisan to ensure that Medicaid beneficiaries are not impacted by those budget battles by ensuring that managed care plans can, with late payments from the state to third parties in order to maintain a cash flow and continue paying their front line providers who are, in turn, treating those Medicaid

beneficiaries.

I don=t know if you=re aware of that situation or not.

Secretary Azar. I am not, but I=d be happy to get back to you on that if you could get more detail because that=s not a situation -- I know the Illinois issues on payment in the past, certainly, but I hadn=t heard of this particular third party issue.

Mr. Upton. Yes, they continue to -- we are looking to try and resolve that particularly for the companies that are in essence eating the -- not getting paid for now years because of those Illinois battles.

The last question I have is in =05 Congress changed the Medicaid -- excluding the prompt pay discounts from the AMP calculation.

I=ve introduced legislation to fix the prompt pay loophole in order to treat prompt pay in Medicare the same as in Medicaid, and as most businesses use it as a tool to make markets work more efficiently. It will raise reimbursement for community-based physicians to help improve access in less expensive settings.

Does the administration support applying that same prompt pay policy in Medicare as well as in Medicaid?

Secretary Azar. This would be in the ASP+6 methodology --

Mr. Upton. Correct.

Secretary Azar. -- and excluding it from ASP. I don=t know. That=s a new issue to me. I have not heard about the question of prompt pay within ASP submissions. Again, happy to -- happy to look at that and get back to you on that.

Mr. Upton. Yes. I may submit a formal question and let you respond in the days ahead.

With that, yield back. Thank you. Thank you, Mr. Secretary.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, five minutes for questions, please.

Ms. Schakowsky. Thank you, Mr. Chairman, and thank you, Secretary.

I am very concerned about the skyrocketing costs of and the crushing burden of prescription drug prices. Families around the country are struggling to be able to pay for them and some people are dying.

Tragically, Shane Patrick Boyle and Alec Raeshawn Smith both died because they could not afford the jacked up price of insulin during the time that Eli Lilly was under your watch and this

occurred.

I think it=s completely unacceptable. So you acknowledged in your Senate Health Committee testimony and in your comments today to Sherrod Brown -- Senator Sherrod Brown that the list price is part of the problem.

So what I want to know is what is HHS going to do specifically to deal with the list price? I really don=t want to hear about the other ways that you may be under control of the Medicaid negotiation or more generics. If there is nothing, you can just tell me that there=s nothing. But I really want to know about list price set by pharmaceutical companies.

Secretary Azar. So the list price is a problem and so we have in the budget proposal one of the items is in Part B, the physician-administered drugs, to actually have an inflation penalty in there as we do in Medicaid.

So that if a pharma company increases to price above inflation there would be a reduction in the reimbursement that would be -- that would be offered by Medicare and that then flows through also to the patient who pays a share of that at the point of sale or at the doctor=s office.

We also are looking at -- we proposed five major reforms to the Part D program, several of which we think actually reverse

the incentives for high list prices.

Ms. Schakowsky. Okay. Let me interrupt -- let me interrupt for just a second.

Again, there are sectoral ways that you might be dealing. So we are dealing with Medicare, dealing with Medicaid.

But in terms of doing something for all consumers of drugs, is there not something that can be done about these list prices that -- it=s like in dealing with an avalanche, we are dealing with the middle of the avalanche rather than the top of the avalanche, which is really the issue of the list price.

Secretary Azar. Well, if -- there is only one list price. So if we can use our influence through these government programs and create incentives towards lower or flatter list prices it benefits everybody.

So that actually is what we are trying to do, Congresswoman.

Ms. Schakowsky. So you=re saying if, in Medicare Part D, that you would do that -- that that would affect the list price for everyone including people not in Medicare Part D?

Secretary Azar. It creates a disincentive towards higher list price and that list price is the same across the entire sector. There is one list price. It=s called the wholesale acquisition cost. And so that would impact everybody and benefit

everyone if we can do that. What we are trying to do is look for, and I am open to ideas you would have -- how do we -- every incentive in the system right now is towards higher list prices.

Ms. Schakowsky. Exactly.

Secretary Azar. And we create incentive towards lower or flatter list prices that respect -- that way it respects innovation, it respects marketplaces, but actually make the finances in the market work to push down list prices.

Ms. Schakowsky. I would hope so because otherwise the least insured person is going to be the one that=s going to pay that jacked up price so that the pharmaceutical companies can continue to make their profits if we don=t do it across the board.

Secretary Azar. I agree with you.

Ms. Schakowsky. So okay. I wanted to, in the time remaining -- so last week as the ranking member of the now-defunct select panel that was dealing with the issue of fetal tissue, I wrote to you with the other Democratic members of that panel raising questions about HHS Office of Civil Rights chief, Chief of Staff March Bell, who I -- well, worked with is not quite the right word -- who was the chief counsel to Chairman Blackburn on the panel.

Mr. Bell has acknowledged working with David Delaiden, who

was indicted for his action in creating the highly-edited video that prompted the panel=s beginning even in the first place.

And by the way, I ask unanimous consent, Mr. Chairman, to submit that letter that I wrote into the record.

Mr. Burgess. Without objection, so ordered.

Ms. Schakowsky. So these connections pose a serious -- a serious risk with March Bell=s new position at HHS. So I would like to know, yes or no, given the ethical questions surrounding Mr. Bell=s conduct during the select panel=s investigation can you commit that March Bell will be recused from any case pending before OCR on fetal tissue or abortion services?

Secretary Azar. We just received the letter that you sent and I appreciate your raising these concerns. We will look at them seriously and we will work the career-designated agency ethics official and ensure that he and we follow any applicable government ethics rules on recusal.

Ms. Schakowsky. And I am happy and I think other members of the panel -- that were members of the panel would be happy to work with you as well. We were mistreated and the connections that he had were really unacceptable.

So I thank you and I yield back.

Mr. Burgess. The chair thanks the gentlelady. The

gentlelady yields back.

The chair recognizes the gentleman from Ohio, Mr. Latta, five minutes for questions, please.

Mr. Latta. Thank you, Mr. Chairman, and thank you very much, Mr. Secretary, for being with us today. And before I begin my questions, I=d like to thank your staff at FDA for all their hard work and collaboration on the OTC monograph reform work that we are doing and I look forward to working together to get important legislation across the finish line.

As you mentioned in your testimony, one of the HHS top priorities is and should be tackling the opioid epidemic and you=ve heard from the former full committee chairman about the issues that opioids is having across this country.

The misuse of opioids is taking lives of individuals far too soon and the crisis is particularly horrific in Ohio. A recent report indicates Ohio=s drug overdose deaths rose 39 percent between mid-2016 to 2017.

That=s the third largest increase among states. More importantly, that=s 5,232 lives lost in a 12-month span.

This crisis is devastating families and our communities. In December 2017, HHS held a symposium and code-athon to identify and develop data-driven solutions to the opioid epidemic.

It is my understanding the event went well and helped to develop ideas that could become foundational solutions to the problem. It seems the event also highlighted the continued challenge the federal government has in leveraging data across departments and agencies particularly within HHS, given the sensitivity of health data.

Mr. Secretary, what do you need from Congress to enable data sharing with in HHS across your own agencies and with other departments in a safe and secure manner that both protects patient privacy and facilitates innovative solutions?

Secretary Azar. Congressman, I had -- I have not had raised to me the issues of any data security or data transfer issues within HHS among our agencies.

So I=d love to check back with our folks and see what they came up with and if there are authorities that we would need to enable effective transfer of information and collaboration. I certainly agree that we need to be doing that.

Mr. Latta. Okay. Let me -- let me go on because, again, especially in Ohio, as I said, this is truly an epidemic.

Continuing with the data discussion, I have a bill, the Indexing Narcotics, Fentanyl, and Opioids Info Act, that seeks to improve how communities respond to the epidemic by putting

information on federal funding, efforts on prevention and treatment data on effective programs and data on areas hit hardest by opioid abuse all in one place.

In what ways is HHS currently working to make the data surrounding the epidemic more easily accessible to the public, and if I could just be more specific.

In my district and when I=ve been across the state of Ohio, I=ve heard from departments, agencies. They have a very hard time. They don=t have grant writers and they are trying to get help and they can=t find the help really out there and they also are trying to find where the money is to help facilitate this.

So it=s really -- does HHS have something out there right now that the communities and law enforcement could be looking at to get some help?

Secretary Azar. So if the concern is around sharing best practices, that=s actually something that I=ve spoken with our SAMHSA administrator about -- how we can create better vehicles to ensure that what we learn from one state can be taken by others without reinventing the wheel.

In fact, just this week, the president and I separately have spoken with Governor Kasich about the work going on in Ohio and what best practices from there we might be able to take and

translate out to others states as having been sitting in the epicenter of the opioid crisis.

Mr. Latta. Okay, because also just -- you know, again, to follow up, though, if someone=s out there looking for something right now that HHS might have to help them, could they out online and find it right now?

Secretary Azar. I believe at the SAMHSA.gov website but also certainly just letting -- calling in into SAMHSA we would be very happy to point them to available resources that we have.

Mr. Latta. Okay. And because, again, I think maybe just follow up again because if you could provide the specific steps. So if someone -- you say they=d have to go to the SAMHSA website? And again, I want to thank HHS because they have been in my district at one of our events that we had to get information out to the public from HHS and SAMHSA.

But, again, what I am hearing from the people in my district is that they can=t find the information. So, again, that=s why I=ve introduced the legislation to try to make it more accessible.

You have a one-stop shop, you might say, that you can find this information. So I=d like work with you all on this as we go forward because, again, it=s -- this is what we hear from back

home from our departments or agencies or ADAMHS boards. But it=s critical for them to get the -- get the help -- get the information.

Secretary Azar. Happy to work with you on that.

Mr. Latta. Thank you.

Mr. Chairman, I yield back.

Mr. Burgess. Gentleman yields back. Chair thanks the gentleman.

The chair recognizes the gentlelady from California, Ms. Matsui, five minutes for questions, please.

Ms. Matsui. Thank you, Mr. Chairman, and thank you, Secretary Azar, for being here today with us.

Mr. Azar, you previously stated that one of your top goals as secretary is to address the opioid epidemic. The president=s proposed budget acknowledges the fight that states and local communities are waging against the crisis and proposes increasing some funding for prevention efforts.

I share this goal and appreciate the additional funding, particularly for things like community behavioral health clinics.

However, the massive cuts this budget makes to Medicaid and the repeal of the Affordable Care Act would undo any progress made and, indeed, take a step backwards in our efforts to provide

treatment to those suffering from a substance abuse disorder.

To take it a step further, the proposed budget preserves the CMS OPPS rule that is an attack on the 340B drug discount program. The purpose of this program is to allow hospitals and clinics to stretch scarce federal resources to serve the under served.

So taking a piece of that away takes away critical resources that these providers are using for things like fighting the opioid epidemic on the ground in our communities.

Giving some of those savings back to the hospitals that have high levels of charity care not only does not make sense administratively, it wrongly indicates that 340B providers are not already serving the vulnerable.

That is the point. In fact, the flexibility allowed by the savings in the program allows hospitals to do things like open new clinics in rural or under served areas. Why would we want to take that away?

It seems evident that this budget is taking money from the very communities the Trump administration claims to want to help. The 340B program, a crucial player in our fight against opioids, does not cost a dime of taxpayers= money. It should be a program with strong bipartisan support. I cannot comprehend why it is

under attack.

As I said, this budget proposes to cut Medicaid by over $1.4 trillion through block grants and per capita caps. And yet, shoring up Medicaid and strengthening that program is perhaps the single best thing we can do to battle the opioid crisis.

Medicaid covers four in 10 nonelderly adults with an opioid addiction and a full 80 percent of treatment for infants with neonatal abstinence syndrome. It is the largest insurer for children and a lifeline for their parents.

Often, Medicaid is the only way those with an opioid addiction come into the health care system for treatment.

Your rhetoric on the opioid epidemic is not matched by your actions. Cutting the very insurance coverage that treats these people for ideological reasons -- the coverage that provides opioid abuse treatment -- will not help us address the opioid epidemic.

The president=s budget have made it abundantly clear that he=s not serious about this epidemic. Secretary Azar, do you agree that Medicaid is a critical tool in the fight against the opioid crisis?

Secretary Azar. Our Medicaid program is an important tool in providing health care to many Americans but we also have to

put it on a stable long-term sustainable footing for it to be there for this and future generations.

That=s the challenge that we have and we want to empower the states so that they have the right incentives to actually deliver quality service and for the states the opioid crisis is front and center and so they will design their programs in the best way possible for them to be able --

Ms. Matsui. We understand that. However, Medicaid has been a success and I really truly feel that eliminating the Medicaid -- this is really truly eliminating the Medicaid entitlement for all intents and purposes by cutting by $1.4 trillion.

Now, the Affordable Care Act then only expanded Medicaid to cover those who often had no access to employer-sponsored coverage. It ensured that plans offered actually cover services that people need from preventive care to inpatient hospital care.

Secretary Azar, do you believe in the value of preventive health services?

Secretary Azar. I think we all share the goal of preventive health services.

Ms. Matsui. Okay. Do you believe that people are more likely to seek and receive preventive health services when they

are free of charge?

Secretary Azar. People are going to seek -- if they are insured and they have the ability to seek out preventive services they are going to -- they are going to more likely utilize services.

Ms. Matsui. Right.

Secretary Azar. Sometimes they may over utilize from free of charge as opposed to having cost sharing --

Ms. Matsui. Well, preventive care, though, is really important.

Do you believe people are more likely to seek and receive preventive health and chronic condition management services when they are available locally in the community whether in person or remotely?

Secretary Azar. Well, we want to make sure that services are available and are accessible to people through community health centers, through telehealth, through alternative service providers. That=s part of our agenda is to make sure that health care is affordable and accessible to people.

Ms. Matsui. So do you also believe that a person is more likely to seek medical treatment if they have health insurance than if they were uninsured?

Secretary Azar. Our goal -- we all share the goal of helping to make insurance be affordable and accessible to individuals. The challenge is our current individual system under the Affordable Care Act is not delivering on that promise for 28 million Americans for whom it=s unaffordable.

Ms. Matsui. Many of the provision in this budget claim to provide choice to patients when really they are just allowing patients to once again be offered less substantial coverage and services.

With that, I yield back. Thank you.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from New Jersey, Mr. Lance, five minutes for questions, please.

Mr. Lance. Thank you, Mr. Chairman, and good afternoon to you, Mr. Secretary. Congratulations to you on your appointment and your confirmation and I look forward to working with you.

As you are aware, the administration received additional resources for the FDA. I believe it was $486 million as a result of the two-year budget agreement the president has signed into law.

With these new funds we understand that the FDA will continue

to do everything possible to bring safe new therapies to consumers as quickly as possible such as by investing in continuous manufacturing research and that is research that is being done in part at universities in New Jersey.

The administration worked with this committee on the 21st Century Cures Act two years ago and took a major step toward facilitating the further development of this technology.

Mr. Secretary, could you please explain to the committee how this new funding could advance efforts such as these?

Secretary Azar. Absolutely. Thank you, Congressman.

We appreciate the work of this committee through 21st Century Cures to reinvigorate and strengthen the FDA for the 21st Century and the funding that we got through the budget deal.

This enables us actually to increase year-on-year FDA discretionary funding by $663 million which allows us to put a huge investment to speed approval of new drugs and devices as well as to invest in our core quality and safety programs.

So we are quite excited about this at FDA and think this will really help us with speeding access to safe quality medicines for patients.

Mr. Lance. Thank you, Mr. Secretary.

I am pleased to see that the administration=s budget request

includes changes to Part D that will help lower costs to senior citizens by passing on negotiated discounts and rebates to beneficiaries.

Would you please update the committee on this proposal, Mr. Secretary?

Secretary Azar. Thank you so much, Congressman, for asking about that.

We have a five-part proposal with the Part D drug program with the idea of how do we lower out-of-pocket costs for our senior citizens.

The first thing that we are requesting Congress do is require that the insurers pass at least one-third of the rebates they receive from the drug companies on to the senior citizen when they walk into the pharmacy at the point of sale.

The second is to create for the first time ever a genuine out-of-pocket maximum for seniors so that when they hit catastrophic coverage they will pay nothing for their drugs.

We would also fix an incentive in the system where right now these high list prices keep pushing people to catastrophic coverage where we, the Feds, are on the hook for 80 percent of that.

We want to flip that so that the insurance companies are

on the hook for 80 percent and we are on the hook for 20 so that they will push back to keep those list prices down.

We also want to give free generics to our low-income seniors who are in the drug program. So free generics throughout for them.

And we want to give the plans more flexibility to negotiate against drug companies, loosening up some of the rules that they have against them.

Mr. Lance. And, Mr. Secretary, I hope that these plans might be put in place as quickly as possible.

Secretary Azar. We will need to work with Congress on that. But this collection of efforts including others I didn=t have a chance to mention could save seniors tens of billions of dollars in out-of-pocket savings on top of the $3.2 billion of savings President Trump already delivered through the Part B regulation that=s been discussed here already from saving out-of-pocket expense for seniors.

Mr. Lance. Thank you, Mr. Secretary. I look forward to working with you on that issue as well as others. I have confidence in you based upon your distinguished career in the private sector and in the public sector working with President Bush and also your distinguished tenure with two of the best

jurists in the history of the nation and I congratulate you on your becoming the secretary of HHS.

Thank you, and Mr. Chairman, I yield back the balance of my time.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentlelady from Florida five minutes for questions, please.

Ms. Castor. Thank you, Chairman Burgess, and welcome, Mr. Secretary. I appreciate your comments at the outset of the hearing regarding the school shooting in Parkland, Florida.

That=s now the eighteenth school shooting in America so far this year and we are here in mid-February. In America, about 96 Americans die every day at the hands of a firearm. That includes domestic violence, incident suicides. More Americans have died from gun violence in America since 1970 than all who lost their lives in every war in the history of our country, and it=s -- another completely saddening statistic is that more preschoolers die every year because of gun violence than police officers.

So I appreciate your sentiments that we have to do more when it comes to mental health resources. Would you also commit here

today that you will act in a proactive fashion to support new efforts for gun violence safety research at the agencies under your purview including the Centers for Disease Control?

Secretary Azar. Thank you, Congresswoman. Again, our sympathies to those of you from Florida.

We believe we have got a very important mission with our work with serious mental illness as well as our ability to do research on the causes of violence and causes behind tragedies like this.

So that is a priority for us at especially at the Centers for Disease Control.

Ms. Castor. So specifically on my question -- you know, there was a rider that has been added to various appropriations bills over time that has had a chilling effect and, in essence, has acted as a ban on the Centers for Disease Control conducting gun violence safety prevention research just like we do with automobile accidents that has really ended up saving a lot of lives over time.

Would you commit to that specifically on gun violence prevention safety research?

Secretary Azar. So my understanding is that the rider does not in any way impede our ability to conduct our research mission.

It is simply about advocacy.

Ms. Castor. So will you -- will you proactively speak out now, knowing we have had our eighteenth school shooting here? We are mid-February and 96 Americans on average die a day. Will you be proactive on the research initiative?

Secretary Azar. We certainly will. Our Centers for Disease Control and Prevention -- we are in science business and the evidence-generating business and --

Ms. Castor. Thank you.

Secretary Azar. -- so I will -- I will have our agency certainly be working in this field as they do across the whole broad -- the broad spectrum of disease control intervention.

Ms. Castor. And we are going to hold you to it.

And Mr. -- and Mr. -- Chairman Burgess, this is an important topic for our committee. I wonder, would you commit to holding a hearing on specifically just the topic of gun violence prevention research? That=s the purview of this committee.

Would you commit today to holding a hearing? We had -- the Democrats had a hearing on our own. But we=ve got to work on a bipartisan way on this. Would you commit to holding a hearing here in the next few months?

Mr. Burgess. The committee is open to all suggestions and

I think we have been -- I think we=ve shown that track record over the past year and two months.

Ms. Castor. We haven=t had a hearing on this. But thank you, Mr. Chairman. We will hold you to that.

Speaking of the CDC, we are now living through a worse than expected flu season. Over the past years, we have had zika, ebola, and I am very troubled by the Trump administration=s proposal for a $1 billion cut at the Centers for Disease Control. I mean, this is weakening our public health research, and I heard what you said -- that you support science.

Then why is a $1 billion cut to the CDC a good idea?

Secretary Azar. Well, that=s actually not what=s happening. The $1 billion -- most of that is the transfer of the leadership and supervision and budget for the strategic national stockpile -- simply a transfer of that function to the assistant secretary for preparedness and response.

And then the rest is the transfer again of the National Institute of Occupational Safety and Health to be within the NIH where we believe it more accurately fits the research function. So --

Ms. Castor. But then you also -- you=re cutting $140 million from chronic disease prevention and health promotion programs

that will limit our ability to control these very chronic health conditions -- sixty million from emerging infectious disease programs.

I just don=t think that=s wise in the days of -- when we have had ebola and zika, and the CDC has such an important mission and prevention is so important.

Secretary Azar. Actually, what we have done is invest the $500 million in chronic disease and prevention for the -- through the America=s Health block grant, $263 million through our immunization program, and $137 million in the emerging infectious disease and zoonotic disease --

Ms. Castor. Fortunately --

Secretary Azar. -- and we regularize that now to not be in the prevention fund but actually move it to the discretionary side so it=s part of our organic ongoing operations of the CDC that put us on a sounder footing for the future.

Ms. Castor. Well, I hope that=s the case. We are going to exercise our oversight role aggressively and, fortunately, in a bipartisan way we beat back significant cuts to the CDC proposed by the Trump administration last year and I hope we will do so again.

Thank you very much.

Mr. Burgess. Gentlelady yields back.

The chair recognizes the gentleman from Indiana, Dr. Bucshon, five minutes for questions, please.

Mr. Bucshon. Thank you, Mr. Chairman. Welcome, Mr. Secretary. Thank you for all the work that you will be doing and have done on behalf of the American people.

In June 2015, a GAO report found that, and I quote, AThere is a financial incentive at hospitals participating in the 340B program to prescribe more drugs, prescribe more expensive drugs to Medicare beneficiaries." Again, that=s a quote. That=s not my comment -- GAO report 2015.

A hospital is able to purchase these drugs at a significant discount with on requirement to pass along savings to the patient or Medicare.

Do you believe that additional program requirements including targeted guardrails and reporting on the use of 340B program savings would help us reverse this unintended consequence?

Secretary Azar. Congressman, I think that the Energy and Commerce Committee has done some exceptional work in looking at the 340B program and finding where it=s not maybe meeting all of its purposes and where better oversight is needed.

One of the things that we have proposed through the budget is actually enhanced regulatory authority and oversight authority for HRSA and for this important program.

Mr. Bucshon. Okay. Thank you.

And I am also concerned about the increase in cost of health care for consumers and I am interested in ways to address the problem.

Experts and researchers including some providing testimony in our oversight subcommittee hearing -- just yesterday, actually -- have expressed concern that the 340B program incentivizes hospital consolidation and this consolidation can increase costs for patients.

A recent New England Journal of Medicine study funded by HRSA and the Robert Wood Johnson Foundation found that final hospital -- that the final hospital outpatient rule from CMS that I would -- and I am quoting again, ALower drug reimbursements to hospitals participating in the 340B program could slow hospital-physician consolidation while not adversely affecting care for low-income patients served by general acute hospitals."

How does this finding from a leading medical journal influence your thinking about potential new policies in 340B?

Secretary Azar. I think it=s undeniable that 340B has actually led to consolidations, especially hospital acquisition of independent physicians to be able to take advantage of the acquisition of drug cost or physician-administered drugs to be at a lower cost and have that arbitrage.

We have seen that in the practice of oncology. So I think it=s undeniable that that is going on. And so as we look at reforms in 340B to ensure that it serves its purpose, getting medicine as affordable as possible to low-income and uninsured individuals and to support those who do. We need to -- we certainly want to examine those guardrails.

Mr. Bucshon. Yes. I mean, I just want to say for the record I support the 340B program. I think it=s a very important program.

I have a lot of rural hospitals and other hospitals across the state that really need the 340B program. But I also support more oversight and within the program. Based on the Energy and Commerce Committee=s final report that came out from our O&I Subcommittee oversight hearings on the program.

I am going to make a quick comment, I mean, based on one of my colleagues= comments, and this is not a question to you, Mr. Secretary.

But I want to point out that I was on the Select Committee for Infant Lives and it has been discussed here about trying to deflect from the findings of that subcommittee.

And I just want to say that what our Select Committee found and sent criminal referrals to the Department of Justice against organizations that were selling human body parts for profit.

The good news is they are not doing it anymore because they are completely shut down. So I just wanted to clarify that, deflecting from the subcommittee=s work and our final report.

It doesn=t change the fact that some will go to pretty long -- well, extensive lengths to protect Planned Parenthood with -- in addition to other organizations that are performing abortions in the United States.

And then so the FDA Commissioner Gottlieb has also stated publicly that the Congress should take action to clarify the regulation on LDTs -- laboratory-developed tests -- and Congresswoman Diana DeGette and I have draft legislation and right now we have submitted to the FDA and CMS for technical assistance and we are waiting for those results.

So I hope we can count on the full cooperation of HHS as we work through this process because it=s really a critical piece of legislation and some critical reforms.

Secretary Azar. We will certainly be happy to continue that technical assistance in that very complex area of lab-developed tests.

Mr. Bucshon. It is very, very complex. Again, thank you for your service.

Mr. Chairman, I yield back.

Mr. Burgess. Was the gentleman thanking the chairman for his service?

Mr. Bucshon. Thanking the secretary and the chairman, of course, for his service.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Maryland, Mr. Sarbanes, for five minutes.

Mr. Sarbanes. Thank you, Mr. Chairman. I thank the secretary for being here.

I want to pick up on the first part of my time where Representative Castor left off in terms of research being conducted by your agency and by the CDC into gun violence.

Yesterday, obviously, another community was forced to make sense of what is really a uniquely American tragedy, which are these school shootings we have seen.

This it at least the 273rd school shooting nationwide since

Sandy Hook occurred back in 2012. In those shootings, 439 people have been injured.

A hundred and twenty-one people have died, and we keep sending our thoughts and prayers to the victimized families. But we really should be sending them laws that put in place common sense gun safety measures.

Members of Congress, that=s our job. I mean, we provide thoughts and prayers. There is others who are in a better position to do that. Our job is to actually change the law to try to address these tragedies.

I just assume -- I mean, I know you had testimony yesterday, I think, on the Hill and earlier this morning. So you=ve not been back in the office since then.

But I got to believe that this would -- another tragedy like what we saw yesterday would just be an all hands on deck moment for you and those around you, your team, to look in the agency, figure out how you can assemble some resources and put them behind some serious research into gun violence. Is that something that your team is undertaking now?

Secretary Azar. Well, as you know, I am with you. So I am not back at the department at the moment so I=ll have to check and see what=s going on in terms of -- in terms of that.

But we -- with any kind of public health emergency or response we, of course, will update the secretary=s emergency operation center to ensure, for instance, with the response situation what=s the hospital capacity -- are we able to care for those who are injured -- what is the census of local --

Mr. Sarbanes. So I am going to interrupt you because I am talking about a different kind of response. I get that response. I understand that you want to support the first responders that are on the ground, the hospitals that are taking the victims.

I am talking about a response that says this is a public health crisis and our agency, which is charged with dealing with public health and is the Department of Health and Human Services, is going to have to really ramp up the kind of research -- public health research -- we do into this crisis of gun violence -- an epidemic of gun violence across the country.

So is that a commitment, as Representative Castor asked you? I am asking you again, is that a commitment that the agency and that you, new to the job, are prepared to commit to?

Secretary Azar. So we will continue to look at it across our range. We have many public health issues and priorities that we have to investigate and conduct research on and what programs there are and studies that are available that are being worked

on at the CDC.

So I am happy to look into what is currently going on and get back to you on that. I am just not aware of -- I am 14 days there so I am not aware of every single research program that we have and every study that=s being conducted at the moment.

Mr. Sarbanes. Well, I hope you=ll do that and, Mr. Chairman, I want to echo the request that we have some kind of hearing that addresses this issue of gun violence as a public health crisis.

Real quickly, let me shift gears. I understand that the administration is looking at expanding what are called short-term limited duration plans, coverage plans which, in a sense, are these kind of skinny junk plans where you don=t have the same kind of protections, you can exclude coverage for pregnancy and childbirth if you=re an insurer that offers these kinds of things.

You can exclude coverage for mental illness or nervous disorders, for alcohol or drug dependence, et cetera -- all the kinds of things we were trying to address in the individual market previously.

But now there is this move on the part of the administration, and I assume it=s going to be going through your office, to make these skinny plans that don=t have the kind of coverage protections

in place more widely available.

You cannot believe that that is moving in a positive direction. I wanted to ask you to address that.

Secretary Azar. Well, as you know, the short-term limited duration plans were supported and available during the entirety of the Obama administration as a vehicle available to individuals in transition and for whom the Affordable Care Act --

Mr. Sarbanes. Right, for a short transition period.

Secretary Azar. -- the individual market for 365 days a year up until October of 2016.

Mr. Sarbanes. Right. But going forward, there is a move on the part of the president to expand both the time frame and allow more of these junk coverage provisions to be in place.

I hope that we are not going to start moving in that direction because it undermines the very principles that were fundamental to the Affordable Care Act and providing a higher level coverage.

So I hope you=ll be vigilant and make sure that those plans don=t begin to swallow up the kind of decent coverage that Americans can expect across the country.

Thank you, and I yield back.

Mr. Burgess. Chair thanks the gentleman. The gentleman yields back.

The chair recognizes the chairman of the full committee, Mr. Walden of Oregon, five minutes for questions, please.

The Chairman. I thank the chairman and again, Mr. Secretary, thank you for being here.

Our committee is spending a lot of time on the opioids investigation and trying to deal with this killer in our communities.

I know in my state more people die from opioids overdoses than in traffic accidents and I think that=s pretty close to the case across the country. Every day, every hour people are losing their lives.

And so our focus has been and will be continue to be on the opioid epidemic. Prescription drug monitoring programs, or PDMPs, can be effective in improving the prescribing of controlled substances in addressing the opioid crisis.

More and more PDMPs are being used as public health tools. However, current federal efforts to support PDMPs are not well coordinated.

However, the following programs could support PDMPs, the Harold Rogers PDMP program run out of the Bureau of Justice Assistance, National All-Schedules Prescription Electronic Reporting Act administered by SAMHSA but hasn=t been funded since

2010, state demonstration grants for compressive opioid abuse response, which also has not been funded CDC=s Opioid Prevention in States grants, which provide the most supports to the states are not even authorized in statute.

And finally, the Office of the National Coordinator for Health Information Technology supported PDMP integration with health IT but this effort only lasted from 2011 to 2013.

So what is HHS doing to better coordinate all of these efforts? How can we better assist to address the needs of states to get timely, complete, and accurate information into the hands of providers and dispensers so they are able to make the best clinical decisions for their patients?

What should we do in this space? What can you do in this space?

Secretary Azar. So these can be -- these prescription drug monitoring programs -- these registries -- can be very important vehicles to assist prescribers and pharmacists with knowing if they are dealing with a patient who is basically prescription shopping, physician shopping, pharmacy shopping. They=ve been shut down one place, they go somewhere else to get around the system.

In our budget proposal, we actually are asking Congress to

require that states have effective programs for this type of risk identification and risk mitigation for prescribers, pharmacists, and patients that are overutilizing, overprescribing, overdispensing.

We don=t specifically ask Congress to dictate the vehicle of it through the prescription drug monitoring programs. I am interested in looking more into the issue of interoperability.

States have developed these programs already independently and so there is a resource and burden question about forcing that interoperability to try to be nationwide. But, say, in Ohio, West Virginia, or Kentucky where they are bordering and you could easy abuse, I=d like to look at ways we can certainly encourage them to work towards connecting their systems up for ready interstate checking.

The Chairman. I border Washington, Idaho, Nevada, and California with my district and I know this is an issue I=ve heard about out there and there is some collaboration and coordination.

But it seems to me that part of what happens with people who are addicted they -- the desire is so high they are going to find every avenue that they can to satisfy it. And so it=s something I think is really important.

And, you know, we get a lot of questions about this potential allocation of money available under the CAPs to do work on opioids -- you know, where should it go.

Have you have a chance to give any thought to where you think the money could best be spent and have the most impact?

Secretary Azar. So for the -- for the initial allocation that we have requested, which is the $3 billion in 2019, $1.24 billion of that would go to SAMHSA. One billion of that would go out to states in the state-targeted response grants, and so that=s doubling what the 21st Century Cures funding was over the last two years.

We have got a very interesting $150 million new program for rural substance abuse --

The Chairman. Good.

Secretary Azar. -- to really support providers in rural areas, a program for $150 million on infectious disease transmission to help with HIV/AIDS transmission Hep C, $74 million to help communities buy naloxone for first responders --

The Chairman. Good.

Secretary Azar. -- for overdose, drug court support, pregnant mother support, medically-assisted treatment support, investing in all of those.

Seven hundred and fifty million of it we would be sending to NIH to support next-generation nonopioid pain treatment development and devices as well as the best cutting-edge research on other forms of pain management. CDC, FDA also would receive funding.

So we have got a game plan that we already are articulating there.

The Chairman. Excellent. Excellent.

All right. We will look forward to working with you on that. Mr. Chairman, my time has expired.

Mr. Burgess. Gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, five minutes for questions, please.

Mr. Kennedy. Thank you, Mr. Chairman. Mr. Secretary, thank you for your service. Thank you for appearing before us today.

I=ve got a couple of minutes. I want to try to get through this quickly. My colleagues have, obviously, already touched on the fact that under your responsibilities resides the -- or under your umbrella resides the Centers for Disease Control. They touched on the fact that 17 students went to school yesterday

and did not come back. They=ve touched upon the fact that nearly 100 Americans die every day because of gun violence.

No one needs reminding in this committee or otherwise that this is an epidemic that has infected our schools, our concerts -- 60 dead, 800 wounded just a few months ago -- our churches.

I received an email last night, early this morning from a 17-year-old high school student in my district, Mr. Secretary, that said, AI don=t think proper words can address my concerns. These school shootings scare me. I am scared that my school will be next, that my friends will be next, or that I will be next."

I don=t think it=s selfish to want to be safe in school, is it? Not just for the victims. I imagine losing the people I love in an awful way like that and simply decide not imagine it. There are kids who lose their best friends every day to this increasingly normal tragedy.

Something needs to happen here. Mr. Secretary, please, I ask you, and echoes of my colleagues here, to do everything that you can to make sure that a major public health crisis is going to be addressed under your tenure at HHS. Will you reiterate that pledge?

Secretary Azar. So I will be happy to look, as I mentioned

earlier, to look at what we have invested and if we have the right programs and the right level of research in this field and get back to you on that.

Mr. Kennedy. Thank you, sir.

Shifting gears a bit here onto Medicaid. There has been much written and said over the course of the past couple of months about Medicaid work requirements.

Mr. Secretary, I am under the impression that the mission of your organization is to, quote, Aenhance and protect the health and well-being of all Americans." That=s correct, right?

Secretary Azar. Absolutely.

Mr. Kennedy. And am I to then understand that the policy of this administration is that working -- there is a direct link -- a causal link between working and healthier outcomes for Americans?

Secretary Azar. We actually do believe that there is a causal link between those who are trained, educated, and able to work -- for those who are able -- and better health outcomes. And so we do believe in supporting that.

Mr. Kennedy. Mr. Secretary, that=s not -- that=s not the same question, respectfully. That somebody that is better trained, educated, and able to work is healthier is different

than a work requirement makes people healthier.

In fact, I believe a recent study put out -- might have been today -- indicates that the cost per patient in delivery of Medicaid in Kentucky is actually going to go up, not down, with the imposition of the work requirement. Have you seen that study?

Secretary Azar. I have not seen that study.

Mr. Kennedy. Oh. Well, we can submit it for the record for you.

Shifting gears as well, not only are there pieces put in place around Medicaid work requirements, there is disturbing reports coming out that at least five states and that CMS is entertaining the possibility of putting on lifetime caps on Medicaid.

If I am -- I am just -- I want to try to understand this. Would it be the policy of this administration that it would be recommending that lifetime caps would somehow make a population healthier?

Secretary Azar. There are requests that are coming in along those lines. We do not have a position on this and I do not want to speculate on the ruling on a waiver. But that is not something that we have invited in terms of waiver requests and so we do not have a position on that at this point.

Mr. Kennedy. And I understand that the administration might not and I understand that that=s going through the process at the moment.

But could you, perhaps given -- I know you=ve only been there for a couple weeks but you=ve got a lifetime of service in health care. You are truly -- you=re an expert.

You were confirmed by the Senate in a closely divided Senate to this role. I assume you have some idea as to whether putting a lifetime cap on Medicaid would make a Medicaid population healthier.

Secretary Azar. I understand the importance of this issue. I do not want to speculate without actually looking at it in the context of the request that we received.

But we do not have a view that is supportive of it or against it. We need to look at it. I need to talk to our team as we evaluate any requests that come in on this -- on this one.

Mr. Kennedy. Okay. Perhaps then if I am to understand what a lifetime cap would actually mean, my understanding of the tax code is that there is in fact a taxpayer subsidy that goes to employer-sponsored health care. Is that right?

Secretary Azar. There is, yes.

Mr. Kennedy. And so what we are basically saying is healthy

people can enjoy that taxpayer subsidy for their health care but when it comes to being poor, if you get really sick we could cut you off. Is that right?

Secretary Azar. No. Again, I don=t -- I have not reviewed any of these waivers or requests that some states appear to be making. So I couldn=t even speak to what they are asking for at this point. This is quite fresh.

Mr. Kennedy. Well, there is public reports from The Hill and from the Washington Post indicating that five states are putting that forward. It might be going through your process.

But I am trying to get some guidance as to whether the position of this administration is going to be that if you are healthy you can get taxpayer subsidies but if you are poor and sick you don=t.

Secretary Azar. I don=t make it a practice to rule on very serious matters based on what=s in The Hill.

Mr. Kennedy. Fair enough. Yield back.

Mr. Burgess. Chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Oklahoma, Mr. Mullin, five minutes for questions, please.

Mr. Mullin. I appreciate, Mr. Secretary, you not making decisions based on The Hill information, although some of it is quite entertaining.

Mr. Secretary, thank you so much for being here. Mr. Chairman, thank you for allowing me to ask some questions. I am going to get right into it.

Mr. Secretary, I was happy to see that HHS is setting aside $10 billion for the opioid and serious mental health issues. But I was surprised to see there was no mention about amending the CFR 42 Part 2.

The president=s opioid commissioner and former CDC administrator both believe that we need to amend Part 2. I was kind of getting your position. Have you looked at Part 2 to see if -- what your thoughts are on --

Secretary Azar. I apologize. Could you help educate me what Part 2 is? That=s not a provision I am familiar with.

Mr. Mullin. Well, so --

Secretary Azar. The substance of it -- I don=t know the substance.

Mr. Mullin. Well, we have a bill right now, H.R. 3545 that I=ll be happy to work with you on this if you want to. We=d love to educate your office on it. We have literally four minutes

here and I don=t think I could go through Part 2 enough to get to it.

But we -- this is something that I have taken on that has been extremely important to me so I appreciate your honest answer on that. If you would like to have your office contact us -- you guys are shaking your head. Right on. I appreciate that.

Because we have -- we feel like we have a fix for this in our office. So if you=ll just meet with us. The bill is H.R. 3545.

Secretary Azar. Okay.

Mr. Mullin. And we have had a hearing on it before in here. But I understand you=ve only been there two or three weeks. So and by the way, I really do appreciate the time. You get confirmed and then all of a sudden it goes -- wow, what did I get myself into, right?

One more thing I want to get into, I also chair the Indian Health Service Task Force, which is very important to me, being Cherokee. The opioid epidemic has unproportionately hit Native Americans.

I had the privilege of representing District 2 of Oklahoma, which has the highest Native American population in the country, and opioid is wrecking our state and many people=s states. And

we are working extremely hard to try to figure out how we can put, as I say, the genie back in the bottle.

You know, why we keep sending controlled substance and that are highly addictive home is beyond me. That=s beside the point. But I really do want to work with you on it.

But yesterday, I think my colleague and a member of the task force, Kristi Noem, asked you about your plan to deal with the agencies and with IHS.

You said that you had prioritized it and provided more money than the president=s budget and this was good to hear. But I wanted to know if you had any specifics that you could lead me down the road on that.

Secretary Azar. So as I mentioned yesterday, in the president=s budget with regard to there is certain facilities that are having trouble with quality and certification from CMS and being able to perform.

Most are Great Plains. We have gone one Navajo. I don=t know if there is one -- I don=t remember if there is one in Oklahoma that=s been decertified also. I don=t think so.

Mr. Mullin. No.

Secretary Azar. And so we have got $58 million that we are proposing to invest in assisting those facilities and achieving

their certification, retaining it, and maintaining quality service for the people that we serve.

I am actually -- like I say, we put $413 million additional dollars in increase for IHS in the budget as well as another $100 million for IHS around the opioid crisis as part of that $10 billion funding in 2019.

Mr. Mullin. Our task force is a very bipartisan task force and we have left politics completely out of it. One thing we have noticed is there is very little standing operating procedures and there is very little communication between one clinic to the next.

There is a drastic difference between the Great Plains and, say, in Oklahoma where we have maybe a little bit more funding to be able to put into our Indian clinics. I personally am a product of that.

I grew up in Hastings Hospital and went there many, many, many, many times and I found their service being very adequate -- very adequate. My kids still use it.

But we do understand there is a difference and what I would like to do is work with your team. We would love to be able to maybe set something where we meet you in South Dakota and see what=s happening there and the lack of service that is given,

and then also show you what=s happening in Oklahoma when the tribes invest in their own back yards and be able to work with you on coming up with standard operating procedures where we can draw the line and have the same quality of care no matter where you go inside the IHS system and where they can access records and quality doctors and quality health care.

This is something our task force has taken on as very important to us and if you would -- if you would have your office reach out to us. We want to work with you on this. We want to get this solved.

Secretary Azar. As do we. So we are open for any suggestions how we can improve the performance of IHS in delivering quality safe services for our beneficiaries.

Mr. Mullin. We=d love to meet you up there too and show you first hand what=s happening.

Mr. Chairman, I am sorry. I went over. I=ll yield back. Thank you.

Mr. Burgess. The chair forgives the gentleman. The gentleman yields back.

The chair recognizes the gentlelady from Colorado five minutes for questions, please.

Ms. DeGette. Thank you so much, Mr. Chairman. Welcome,

Mr. Secretary.

The Washington Post is reporting today that HHS employees threatened to cut federal funding from the Vera Institute of Justice if the organization=s lawyers communicated with their clients about their abortion rights.

Now, as a lawyer myself, this seems like an unacceptable intrusion into the attorney-client relationship to me. I am wondering, Mr. Secretary, did your staff instruct lawyers at the Vera Institute or any other organization not to discuss abortion rights with their clients?

Secretary Azar. Congresswoman, I actually -- I did not see that story. It=s the first I am hearing it.

Ms. DeGette. Well, okay. I am not asking you about the story. I am asking you did your staff instruct the lawyers --

Secretary Azar. It=s the first I am even hearing of the issue. I have not heard anything about this.

Ms. DeGette. So you don=t even -- you don=t know. Would you think that would be appropriate if they did instruct lawyers not to advise their clients of those rights?

Secretary Azar. I would -- so I would like to go back and look into this and see. That=s a serious claim --

Ms. DeGette. So you=re not going to answer my -- you don=t

know if it would be appropriate or not?

Secretary Azar. Again, I -- again, I don=t want to answer hypothetical questions without looking into the facts of the situation.

Ms. DeGette. Okay. Well, let me ask you this.

There is something that=s been around quite a while at HHS and that is that there is been a pattern of conduct about the Office of Refugee Resettlement under Director Scott Lloyd=s leadership in particular to disregard the rules in federal law when it comes to women=s reproductive rights and health.

Let me talk to you about a couple things. As well as this report today, we also found out that Mr. Lloyd has attempted to deny access to abortion to at least four immigrant teens in detention including one who was a victim of rape.

Now, in that -- in each of these four cases, the federal courts declared Director Lloyd=s actions unlawful and allowed the girls to access their reproductive health care.

Are you aware of those four cases, sir? Yes or no will work.

Secretary Azar. I am aware of media reports about them.

Ms. DeGette. Well, you=re --

Secretary Azar. I=ve just been at HHS for 14 days so I haven=t --

Ms. DeGette. Yes. Yes, you have. But so you=re not aware within the agency?

Okay. Well, I sent a letter to the agency -- and you were not there then, in fairness to you -- it was dated December 1st -- with some other folks asking that Mr. Lloyd end these unlawful ORR policies denying reproductive health care to immigrant women and girls in detention.

We have not yet received a response to this letter. Can you commit to me that we will get a response to this letter?

Secretary Azar. Yes, we will certainly respond to your letter.

Ms. DeGette. Okay. And Mr. Chairman, I=d ask unanimous consent to put the letter into the record.

Mr. Burgess. Without objection, so ordered.

Ms. DeGette. Now, Mr. Lloyd, as secretary of HHS, you have the authority to stop Mr. Lloyd and his staff from advising people they can=t tell people about their constitutional rights.

Will you commit to me today that you will ask him to please stop doing that?

Secretary Azar. So we have with regard to these children who come into our custody a very important statutory obligation, which is to look out for the health and welfare of them as well

as their unborn children and it is a solemn obligation. It is a difficult obligation --

Ms. DeGette. Well, excuse me.

Secretary Azar. -- and it is now a matter of pending litigation and I really can=t -- I do not know the facts of the situation nor could I comment because it is -- these are pending matters in litigation.

Ms. DeGette. Okay. Well, good news. Four courts have already said that your department can=t stop them from getting abortions. Are you contesting those court decisions?

Secretary Azar. I am not aware of the status on the litigation. I=ve been at the department for 14 days.

Ms. DeGette. Okay. Is it the -- let me --

Secretary Azar. I will not -- I will not comment on potentially pending litigation.

Ms. DeGette. Okay.

Secretary Azar. It would be irresponsible for me as secretary. I am the named party in the litigation.

Ms. DeGette. Well, let me -- then -- excuse me, sir. Perhaps you can comment on HHS policy for me then. Is it the policy of HHS to not tell -- to tell your contractors that they are not allowed to discuss abortion rights with their clients?

Yes or no.

Secretary Azar. As I told you, I am not aware of any policy either way --

Ms. DeGette. No, no. Okay.

Secretary Azar. -- or the facts of that situation.

Ms. DeGette. Well, you=re the head guy. Would you support that kind of a policy?

Secretary Azar. I am not aware of the facts of that situation nor can I sit here and off of the cuff state a policy position for the department.

Ms. DeGette. If a -- if a employee of HHS told the Vera Institute that their federal grant would be withdrawn if they advised their clients of their rights, would you support withdrawing it?

Secretary Azar. I am going to repeat that I -- it was irresponsible of me to sit here and on the basis of a supposition of facts articulate a policy position --

Ms. DeGette. Okay. But --

Secretary Azar. -- without investigating and looking into it.

Ms. DeGette. Okay. Great.

Secretary Azar. You would not expect me to do otherwise.

Ms. DeGette. Okay. Great. So will you commit --

Secretary Azar. I need to be a responsible officer.

Ms. DeGette. Excuse me. Will you commit to me that you will investigate and look into it?

Secretary Azar. I will. I already mentioned --

Ms. DeGette. And will you also commit to me that you will get me an answer back in writing within 30 days of this hearing?

Secretary Azar. I will -- I will not be able to commit on the time line there because I do not know the nature of the investigation, the facts, or whether it connects to matters of litigation.

Ms. DeGette. When do you think it would be appropriate to get back to me?

Secretary Azar. I will not be able to commit on a date until I know the circumstances here and know whether it connects to a matter of litigation because this may be a matter that the Justice Department would decide. I don=t want to make a false commitment to you on getting back to you by a date certain on something that might be --

Ms. DeGette. Will you get back to me?

Secretary Azar. We certainly will, yes.

Ms. DeGette. Great. Thank you.

Mr. Burgess. Gentlelady=s time has expired. The chair thanks the gentlelady.

The chair recognizes the gentleman from Virginia, Mr. Griffith, five minutes for questions.

Mr. Griffith. Thank you very much, Mr. Chair, and I appreciate your responses to the previous questions, particularly that you=ll get back with some information but not a specific answer based on the legalities of everything.

That being said, I also appreciate your answers previously in relationship to the opioid crisis, which is important to so many of us, and I think that my colleagues have covered that extensively so I am going to move on to some other things. But appreciate working with you on that in the future.

I=ve got a number of things that I am passionate about and that affect my district. One is I have a very rural district in the southwest corner of Virginia and I want to ask you about telehealth because it seems me that we have some issues there with reimbursement.

And if the doctor is willing to conduct a telehealth consult I believe they should not be prevented or discouraged from providing the service because of outdated reimbursement policies and I would like to work with you and HHS to help find ways to alleviate reimbursement challenges that are in the way of telehealth exploding and bringing medicine to the nooks and crannies of every part to America.

So what policies are you all working on to facilitate the delivery of telehealth and what policies do we need to change -- and I know you may not have an answer after only two weeks -- but please let us know what do we need to change to help you all allow reimbursement for telehealth services so the people can get services all over the country and all -- predominantly rural areas but I can see applications in other areas as well.

Secretary Azar. Thank you for raising that issue. I am a big supporter of telehealth and how we can harness that, especially for under served areas like our rural communities.

I do suspect there are significant statutory barriers around reimbursement there given that most of our constructs were set up in the 1960s for our payment regimes.

So we=d love to work with you on that as I go back and we plow through and identify those barriers to see where we might be able to make changes.

I believe in the budget we have one provision that we are recommending regarding Medicare Advantage plans, I think, and supporting greater payment flexibility around telehealth. But I am sure there are many, many more. But I am a big believer in the opportunities that we have there.

Mr. Griffith. I don=t think it=s a partisan issue. I think you=d find support on both sides of the aisle to change the laws that are keeping you all from doing things that we all want you to do -- so I appreciate that -- in relationship to telehealth.

Let=s talk about neonatal abstinence syndrome. I am encouraged to see that CMS used state plan authority as it did in the case of West Virginia this week with respect to the state=s request to allow its Medicaid program to reimburse certain treatment centers that take care of infants with neonatal abstinence syndrome.

This move suggests that CMS and the states can work together to address the distinct needs of each state. If my home state of Virginia or my neighboring state of Tennessee or other states should choose to follow suit and request coverage of similar services through a state plan amendment or waiver, may I get your commitment that your staff at HHS and CMS will work swiftly to allow such a waiver so that we can ensure infants with NAS in Medicaid get the care that they need?

Secretary Azar. I don=t know the particulars on that approval but we certainly will work with any state that is going to be delivering care in that area within the confines of our waiver and demonstration authority and we will do that as swiftly as we possibly can. That seems quite noble.

Mr. Griffith. All right. Now here=s one more I am going to push you on. Durable medical equipment -- I know that there have been some issues. But for rural areas the competitive bid reimbursement adjustment has been deadly for durable medical equipment suppliers.

Folks are having -- I=ve got one fellow in particular. He=s

driving through, you know, up and down mountains to deliver oxygen, et cetera, to people that he considers friends and clients.

He keeps having to lay people off just to make ends meet. So I ask you, there is an interim final rule that=s pending at OMB. I=ve spoken with OMB and Mr. Mulvaney about that.

Will you commit to working with Director Mulvaney to ensure this IFR is released expeditiously? It=s currently sitting in your hands.

Secretary Azar. So I can=t speak to that particular IFR or that issue because I do believe that=s a matter pending in litigation.

But I will tell you our budget -- I am very concerned about the issue of DME -- the competitive DME and rural access, and our budget proposal actually has some I think very important reforms and suggestions for rural access there.

Mr. Griffith. And I appreciate that because I will tell you that it won=t be a whole lot of months before he just has to completely shut down has operation and then I will have constituents who are no longer being served because, you know, when you=re a long way from the nearest town it=s hard to drive down there and get your own equipment and drive it back up the mountain.

The Chairman. Would the gentleman -- would the gentleman yield a second?

Mr. Griffith. I yield.

The Chairman. Yes, I just want to double down on that because I am finding the same thing in rural parts of my district where all of a sudden in Burns, Oregon, a long way away, getting access to DME. Durable medical equipment is a real problem.

Oxygen is becoming a real problem and this is something that I hope the administration will act on expeditiously as well. So I am glad you raised that.

Mr. Griffith. Thank you very much, Mr. Chairman.

Mr. Chairman, I yield back.

Mr. Burgess. Chair thanks the gentleman. Gentleman yields back.

The chair recognizes the gentleman from Oregon, Dr. Schrader, five minutes for questions, please.

Mr. Schrader. Thank you very much, Mr. Chairman, and thank you, Mr. Secretary, for being here.

You talked in your testimony about the need to improve the individual and small group markets and I think, frankly, I am one of the folks, along with many others, both sides of the aisle that believes that=s true.

But very concerned that in the president=s budget it proposes actually repealing more of the Affordable Care Act, which would cause millions to lose coverage, and this is despite the fact that we had this big debate last year and Congress, who is the lawmaking body, decided not to move forward along those lines.

I don=t think Americans want to see their health coverage go away. I think they want to see us come together and strengthen and improve that individual marketplace which is bleeding over to the small group.

I am with a group of bipartisan members, several of which serve on this committee, called the Problem Solvers, that has a bipartisan proposal -- about 25 of us -- that have supported this.

We have legislation that=s introduced. It includes the CSRs that were included in both the Republican and Democratic budgets. Talks about a stability fund that was in Republican as well as Democratic proposals.

It gives the flexibility you alluded to to states, both in the 1332 and 1333 waivers. Rolls back some of the employer mandate and gets rid of the medical device tax.

Would your administration and you personally be interested in promoting that type of proposal to solve the problem?

Secretary Azar. So, obviously, we have our budget proposal which is the broader -- the broader Graham-Cassidy package but I am also very happy to work with you and learn more about these ideas that you=ve got.

Our commitment is we want to make insurance affordable for people in the individual markets.

Mr. Schrader. Thank you. Thank you. Well, I appreciate that because we would like to work with you or the administration,

come up with just a common sense proposal to fix what needs to be fixed at this point in time so Americans have health care.

Under the current budget there are huge cuts to Medicaid and the marketplace. Could you give us some idea of the numbers of folks that are going to lose coverage as a result of the proposals you=ve put forward?

Secretary Azar. So we don=t -- we don=t -- I don=t have a score that does any estimating on that. What we would do is --

Mr. Schrader. If I may interrupt. I am sorry. I have only limited time. I apologize.

The CBO does have a score and they=ve indicated repeatedly that 23 million Americans would lose coverage if the Affordable Care Act is repealed in its entirety.

Unfortunately, we have already gone through a measure of that with the current tax cut bill that came out. Very, very concerned that if we double down on that that would be not good for Americans and hope that as health secretary the goal would be to get people more health care, not less health care.

Last piece, if I may -- getting back to the proposals coming out of the great state of Idaho. I respect everyone=s sovereignty, but I think the goal of the Affordable Care Act isn=t just to treat conditions and people as they walk in the door but to make a better health care system, to make people healthier so that they don=t have to walk through that hospital door quite

as often.

And I guess my question to you is would you and this administration enforce all the essential health benefits that are currently a requirement of the Affordable Care Act, given that that is the law of the land at this point in time including prescription health benefits, mental health benefits, maternity, emergency care, ambulatory care, laboratory services, prevention and wellness, pediatric care, hospitalization, and rehabilitation?

Secretary Azar. So we certainly have a duty to enforce the laws Congress has written and passed and within any flexibilities, of course, that we have under waiver and other authorities. But we -- obviously, we have to be committed to enforcing the laws that Congress have given us.

Mr. Schrader. All right. I appreciate that very much, Mr. Secretary, and look forward to working with you.

Secretary Azar. Thank you. Same here.

Mr. Schrader. Thank you, and I yield back, Mr. Chairman.

Mr. Burgess. Chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Florida, Mr. Carter.

Mr. Carter. Well, thank you, Mr. Secretary. Congratulations and thank you for being here today. We appreciate your presence.

I want to start by asking you about DIR fees. Are you

familiar with DIR fees?

Secretary Azar. You know, I am somewhat. Is that the -- are we talking in the context of the specialty pharmacy issues?

Mr. Carter. Not -- no, not necessarily in a specialty pharmacy. This would be in any pharmacy. These are -- these are generally just the fees that are price concessions or maybe even just fees that are imposed by the pharmacy by the PBMs and that are recouped sometimes years later, years after the prescription has been -- has been dispensed.

And, obviously, the patients are not getting the benefit of this and therefore it is costing taxpayers more money because in Plan D, as you well know, the higher the drug and the higher the cost to the patient it=s going to push them into the donut hole and then ultimately into the catastrophic part where the taxpayers will be taking up more of those costs.

I=ve led several letters to your department, to CMS, regarding this. I hope that you will look at this closely. One of my colleagues, Congressman Griffith, on this committee has a bill right now making it to where DIR fees would have to be recouped at the point of sale and could not be recouped years later.

So I hope you=ll look at that very closely. I want to ask you next about abuse deterrent formulations. Are you familiar with that and how it could be used in the way of opioids?

Secretary Azar. I am somewhat. I am sure not as deep --

as deeply as you are with your clinical background.

Mr. Carter. Okay. Okay.

Well, I hope that you will look at that. I think that is something that could benefit us and certainly in our fight against the opioid, something I know you=re committed to and certainly that we are committed to.

If I may, if you could just hang with me for a second. You were -- you were the CEO of Lilly Manufacturing and Lilly Pharmaceuticals.

Secretary Azar. Just the -- I was just the president of the --

Mr. Carter. Just the president.

Secretary Azar. -- commercial business in the United States.

Mr. Carter. But you understand how PBMs work and you understand that whole scenario. As a practicing pharmacist for over 30 years, I too understand that. And I am just -- I am just curious.

Let=s just take a product that Lilly may have had. Let=s take Prozac or Zyprexa, and both of those are available now in generic formulations. But if you wanted to -- let=s take Prozac, for instance -- if you wanted to get Prozac onto a formulary, as the pharmaceutical manufacturer did you have to offer the company, the pharmacy benefit manager who was -- who was compiling that -- compiling that formulary -- did you have to offer them

a rebate in order to get it back?

Secretary Azar. So if I could address this generally.

Mr. Carter. Please do.

Secretary Azar. I would not want to speak in the context of my former employer.

Mr. Carter. I understand.

Secretary Azar. But yes, generally most -- I mean, almost all brand of products will have to offer rebates to pharmacy benefit managers in order to secure equal or preferred status on a formulary.

Otherwise, they will be disadvantaged or ever not covered by that PBM in terms of the benefit package. So that=s quite standard.

Mr. Carter. Yes, and I just want to --

Secretary Azar. It would be the more unusual case where there isn=t a rebate that=s being paid.

Mr. Carter. I just -- I=ve always wondered where does that rebate go? Do you know?

Secretary Azar. Where does the rebate go?

Mr. Carter. Yes, sir.

Secretary Azar. So I am certain --

Mr. Carter. I do know one place it does not go. It does not go to the pharmacist. I can assure you of that.

Secretary Azar. I believe some of it, obviously, goes into the premium and buying that down. For depending on the PBM=s

business model, some may be retained by the pharmacy benefit manager as their profit or to cover their expenses. Some may be passed on in lower premiums. I think it would depend on each individual PBM how that works.

Mr. Carter. But you would agree that that rebate is significant?

Secretary Azar. It can be quite significant. Average commercial rebates approximate about 35 percent.

Mr. Carter. Just out of curiosity, you know, if that rebate -- it=s not going to the patient and it=s not going to the pharmacy, the pharmaceutical manufacturer is paying it to the PBM.

You know, I am not opposed to anybody making money. But the mission of a PBM is to control drug prices. If they are controlling drug prices why is the president -- one of the president=s initiatives to bring drug prices down?

Secretary Azar. Why is it? The president wants --

Mr. Carter. If the PBMs are doing their job, if they are indeed controlling drug prices, why did the president identify a drug price? Why have all these people on this committee here today asked you about prescription drug prices? Why is that one of the primary issues that we discuss up here?

Secretary Azar. It=s actually -- so, first, there are pockets of our programs where we don=t get as good of a deal as we ought to and can do and that=s what we are working on.

Mr. Carter. But I am speaking specifically to the -- I don=t

meant to interrupt.

Secretary Azar. No, no. And for list -- I think it really has to do with list prices. Every incentive in our system is towards higher list prices.

Mr. Carter. I would just -- if I may, I just remind you that there are three PBMs that control 80 percent of the market and that one of the PBMs, Caremark, had gross revenues in 2016 that exceeded that of Pfizer Pharmaceuticals, of Ford Motor Company, and of McDonald=s, combined.

Mr. Secretary, we got to do something about this. We need transparency. Sunlight is the best disinfectant out there. We have to have transparency.

I can=t see this in the Plan B. You won=t let me see it. We need transparency.

Thank you, Mr. Secretary.

Secretary Azar. And we -- and we do support efforts towards greater transparency.

Mr. Carter. I know you do and I look forward to working with you. Thank you very much.

Mr. Burgess. Gentleman=s time has expired.

The chair recognizes the gentleman from New Mexico, Mr. Lujan, five minutes for questions.

Mr. Lujan. Mr. Chairman, thank you very much.

Mr. Secretary, thank you for being here today as well.

Mr. Secretary, I am going to ask you a yes or no question

off the top here. There is a $1.4 trillion -- there is $1.4 trillion less in the budget for the Medicaid program -- yes or no?

Secretary Azar. There is a $1.2 trillion new fund that would replace the Medicaid expansion and the individual subsidy program under the Affordable Care Act.

Mr. Lujan. You=re talking about Graham-Cassidy?

Secretary Azar. Yes. Exactly.

Mr. Lujan. So would you agree with the CBO=s score -- that the CBO said at the very least that Graham-Cassidy reduces Medicaid by $1 trillion? Are you unaware of that?

Secretary Azar. I don=t know the -- I don=t know the net score on this. You=ve got the $1.4 billion that would come down but the $1.2 that would actually replace it through the grant program there.

So I don=t know -- I don=t know the ups and downs on the complete CBO scoring with regard to which part is expansion and where the subsidy -- the advance able refundable tax credits fit into there.

Mr. Lujan. So, Mr. Secretary, I mean, there can be a lot of spin around this, in the same way that during the repeal and replace effort my Republican colleagues said that they were not cutting Medicaid -- that they were giving more flexibility to the states. Is that how you would describe the $1.2 trillion that you=re describing here?

Secretary Azar. Well, no. The core Medicaid program -- the old -- the traditional Medicaid will grow under our budget from about $400 billion over 10 years to $453 billion.

The Medicaid expansion does get rescinded as part of the Graham-Cassidy plan and is replaced along with the individual subsidy program with that $1.2 trillion grant program.

Mr. Lujan. Let me ask the question a different way. President Trump, on several occasions, said that he would not cut Social Security, not cut Medicare, not cut Medicaid.

May 7th, 2015, 10:40 a.m. he tweets, AI was the first and only potential GOP candidate to state there will be no cuts to Social Security, Medicare, Medicaid."

July 11th, 2015, 3:23 a.m., ARepublicans who want to cut Social Security and Medicaid are wrong."

A quote to Daily Signal: AI am not going to cut Social Security like every other Republican. I am not going to cut Medicare or Medicaid."

Did the president keep his word in his budget?

Secretary Azar. You know, with regard to --

Mr. Lujan. Yes or no, Mr. Secretary. Did he keep his word?

Secretary Azar. Well, with regard -- with regard to Medicare --

Mr. Lujan. Mr. Secretary --

Secretary Azar. -- what we are proposing there is to actually reduce by $250 billion over 10. The rate of growth goes

from 9.1 percent annual increases to 8.5 percent. It doesn=t take from beneficiaries. It actually continues to grow.

Mr. Lujan. Mr. Secretary, did the president keep his word that he would not cut Medicare, Medicaid, and Social Security in his budget?

Secretary Azar. I can=t speak to Social Security and then as to the core fundamental --

Mr. Lujan. Mr. Secretary, let me ask you the question differently then. Did the president keep his word that he would not cut Medicaid and Medicare?

Secretary Azar. The president kept his word that we are not taking from beneficiaries in Medicare and for Medicaid the president --

Mr. Lujan. Will the president -- Mr. --

Secretary Azar. -- has repeatedly been supportive of repealing and replacing Obamacare and Medicaid expansion is part of that. He was clear from day one in his campaign about that.

Mr. Lujan. Mr. Secretary -- Mr. Secretary, his -- he didn=t mention beneficiaries here. He said he would not cut Medicare and Medicaid and Social Security. He would not cut Social Security and Medicare and Medicaid like every other Republican.

Did the president keep his word that he did not cut Medicare and Medicaid?

Secretary Azar. The president is keeping his word that we are supporting Medicare. We are making Medicaid sustainable for

the long term for beneficiaries and we are -- and we are proposing the repeal and replace of Obamacare, which is not delivering for our people.

Mr. Lujan. Mr. Secretary, did you have a hand in developing this budget?

Secretary Azar. I arrived 14 days ago. So no, I did not.

Mr. Lujan. You didn=t approve what was submitted?

Secretary Azar. The budget was already at the printer. I was -- if the Senate would have confirmed me sooner I would have been able to be involved but --

Mr. Lujan. Let me ask a question.

Secretary Azar. -- I arrived 14 days ago after --

Mr. Lujan. Let me ask you a different --

Secretary Azar. I can only do what I can do.

Mr. Lujan. Let me ask you a different question. Do you support the president=s budget?

Secretary Azar. I do support the president=s budget. That=s why I am here today.

Mr. Lujan. Did you keep your word that you would enforce not cutting Medicaid and Medicare as you answered to Senator Ben Nelson on the January 24th, 2018 Senate Finance Committee --

Secretary Azar. I never -- I never said that I would enforce not cutting. I said the president --

Mr. Lujan. Oh.

Secretary Azar. -- the president does not support --

Mr. Lujan. Mr. Secretary --

Secretary Azar. -- cutting Medicare and Medicaid.

Mr. Lujan. -- let me read you a quote.

Secretary Azar. I support the president=s -- and I support the president=s position. I will go along with where the president is on these programs.

Mr. Lujan. Mr. Secretary, if I may, there is a great video that=s posted. I think CSPAN has it. CNN has it. And here=s what you said when Senator Nelson asked if cutting Medicaid, Medicare, and Social Security should be used to fill this huge budget deficit hole. You believe the president kept his word and your job as secretary would be to enforce, not to cut those programs. So I=ll stand by that.

Secretary Azar. As long as -- as long as that is the president=s --

Mr. Lujan. Mr. Secretary --

Secretary Azar. -- I am here to implement Medicare and Medicaid --

Mr. Lujan. Mr. -- last question, if I may, because I am out of time here. Have you collected a check from Dr. Price for his travel on private planes?

Secretary Azar. I do not know.

Mr. Lujan. Have you investigated abuses at HHS with travel?

Secretary Azar. I=ve just arrived 14 days ago so I=ve been busy getting ready to come here to meet with you today.

Mr. Lujan. Mr. Chairman, as my time is expired here, I know that we have talked about oversight hearings in this subcommittee on this issue. They still have not been scheduled.

I look forward to seeing those scheduled so we could get to the bottom of this and I=ll be submitting more questions to the record to find out what=s been investigated.

This is a serious issue. Millions of dollars have been squandered and the American taxpayers deserve --

Mr. Burgess. The gentleman=s time has expired.

Mr. Lujan. Thank you, Mr. Chairman.

Mr. Burgess. I am certain that Mr. Guthrie will -- I mean, Mr. Harper from Mississippi will await your letter.

The chair now recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. Bilirakis. Thank you. Thank you, Mr. Chairman. I appreciate it, and thank you, Mr. Secretary, for being here. I appreciate it very much. Thanks for your service.

I am on also -- in addition to being on this great committee and this subcommittee, I am also vice chairman of the Veterans Affairs Committee.

This gives me a unique opportunity to serve the health needs of various populations. Community health centers -- and I was the author of the reauthorization of the community health centers. They do great work.

In fact, the administrator of HRSA, Dr. Sigounas, was down

in my district recently. We discussed expanding substance abuse services but also mental health services and dental services as well and treating even more veterans.

Community health centers already provide quality care to more than 300,000 veterans -- as a matter of fact, he told me exactly 330,000 veterans across the country -- and are an important source of care for veterans in rural areas who may not be able to easily access VA facilities.

Can you share with the committee some of the ways in which health centers are working with the VA to address the health care needs of our nation=s veterans?

What more can we do to improve veterans= access to community health centers and are you a proponent of community health centers?

Secretary Azar. So I and we are absolutely proponents of our community health centers and one of the things that I am very happy about through the budget deal that was reached is that we put the community health centers on secure footing financially and that we also, through our opioid program, we are going to be making significant investments into HRSA and the community health centers. I think $400 million will go through quality incentive programs to community health centers to assist them on the opioid crisis.

I am not as familiar about veterans issues in connection with HRSA and community health centers and would be very happy

to learn more about ways in which we can be supportive and helpful to our veterans through our community health centers.

Mr. Bilirakis. Yes, I=d like to work with you on that. So, in other words, the VA people that are in the VA system we want to make sure that they have an option, a choice, to go to a local community health center, particularly in some of the rural areas where the clinic or the hospital is far away. And I discussed that with Dr. Sigounas and I have a bill that I=d like to talk to you about.

Again, Mr. Secretary, in the budget submission you mentioned changing -- and again, this is probably -- you said that you=ve only been on the job for two weeks so it=s really not your budget even though you approved the budget -- you mentioned changing the Part D pharmacy lock-in program.

Is your budget proposal trying to reform and centralize the lock-in program inside CMS rather than the Part D plans? Or are you trying to require all plans to initiate a pharmacy lock-in program?

Secretary Azar. I believe it=s just to require the Part D plans to initiate a lock-in program rather than a centralized one. I believe that=s the case.

Mr. Bilirakis. Okay. Very good. Let me get into another issue because we don=t have a lot of time.

Currently, ASPR=s disaster medical assistance team is experiencing a staffing shortage. I am sure you=re aware of that.

As hurricane season is less than four months away, what is being done at HHS to address this serious public health and safety issue?

Secretary Azar. So we are -- we are working -- I=ve actually met with our assistant secretary for preparedness and response and we are prioritizing the hiring to ensure that we get our full complement of medical disaster medical services individuals for those disaster teams.

You know, one of the important lessons coming out of this unprecedented hurricane season was our need to continue our learning processes for how we can deal with multiple either manmade or naturally occurring disasters and public health threats at one time. That was a really unprecedented episode and it=s a good learning for us.

Mr. Bilirakis. Very good. I=ve got time for one more question, I believe, Mr. Chairman, and thank you for your service, by the way, Mr. Chairman.

Currently, there isn=t a clear standard for medication-assisted treatment prescribing and we have heard reports of an increasing number of rogue actors offering MAT.

In many cases, the pop-up clinics actively recruit vulnerable client population and provide standardized -- substandard, in my opinion, services with minimal oversight.

While we support consumer choice, of course, and market competition, we also want to balance this with the consumer

safeguards to ensure that this program -- the problem improves, not worsens, and that bad actors are not rewarded via federal dollars.

Additionally, questions have been raised as to whether states are requiring evidence-based practices to be used in the STR grant program.

What is HHS doing to ensure rogue actors are not the recipient of federal dollars and evidence-based practices are being used so that the funds expended go to providing the best possible treatment in recovery services?

Mr. Burgess. If the gentleman will suspend. The chair is going to ask if he would submit that in writing. We do have members who are --

Mr. Bilirakis. Yes, can you please do that? I would appreciate it if you addressed that.

Thank you very much, and I yield back, Mr. Chairman.

Mr. Burgess. And I thank you for your -- I thank you for your accommodations.

The chair recognizes Mr. Cardenas from California for five minutes, please.

Mr. Cardenas. Thank you, Mr. Chairman. Secretary Azar, I am glad you were able to join us today and I look forward to your answering some of my questions.

I=d like to begin by talking about Scott Lloyd, the head of the Health and Human Services Office of Refugees Resettlement.

Tremendous responsibility. This is a man who has shown complete disregard for the U.S. Constitution.

He abuses his authority and tries to enforce his personal beliefs on immigrant women in custody over and over again. He has tried to control women=s bodies and violate their constitutional rights to have an abortion.

Mr. Chairman, at this time, I=d like to ask unanimous consent to submit for the record a Washington Post article published today that describes an email reporters obtained from an official federal contractor. The contractor is Vera.

The email claims that after a conversation with a federal employee at the Office of Refugee Resettlement at Health and Human Services they were directed to prevent their lawyers from discussing abortion access even if minors in custody asked for help to understand their legal rights or else their multimillion-dollar contract with the Department of Health and Human Services would be jeopardized. For the record, please, Mr. Chairman.

Mr. Burgess. Without objection, so ordered.

Mr. Cardenas. Thank you so much, Mr. Chairman.

Wow, that sounds like a complete violation of the law to me. Scott Lloyd, the Office of Refugee Resettlement, chief -- his actions have put young women=s lives in danger, even considering subjecting the women to unproven medical experiments and he personally tried to block a rape victim from getting an

abortion.

This is in a memo and I=ll quote from that memo. Quote, AHere there is no medical reason for abortion. It will not undo or erase the memory of the violence committed against her and it may further traumatize her. I conclude it is not her interest," end quote.

To me, it=s just ironic that a man would mention the violence committed on this young girl while at the same time violating her rights.

Why does Scott Lloyd still have a job at Health and Human Services?

Secretary Azar. Well, first, we don=t draw conclusions from media reports, but also this is a matter -- these are matters in pending litigation. I am not -- I am not going to be able to speak to them nor do I know the facts and circumstances. I have not been able to look into them yet at my time at the department.

Mr. Cardenas. How committed are you to make it a priority to look into the details of this which you just mentioned that is now there is litigation going on over this matter?

Secretary Azar. So the mission that ORR has for these young children is a very solemn one to look out for their health and well-being as well as the health and well-being of their unborn children.

That is a very difficult task. It=s an unenviable one and

I think they tried -- they are trying to do the best they can under the circumstances here to protect both the women=s -- the young girls= health as well as the unborn child=s health and to make sure they are standing in here under their statutory obligations to do this, and we will certainly be looking to ensure that our programs are consistent with the law, that the way we administer them is consistent with court cases as they eventually come out.

Beyond that, I am not able to really comment. I don=t have the facts.

Mr. Cardenas. Well, I am glad you answered that way. So maybe you can double down on that answer by expressing before this committee, members of Congress, about the policies that the Department of Health and Human Services, of which you are now the head, when it comes to following the law and also the U.S. Constitution it appears to me that that consistency would be incumbent upon any department, any public servant.

Secretary Azar. I would agree. We will always attempt to follow the law and the court constructions of the law and what our obligations are against -- up against that.

Mr. Cardenas. So are you committed to making sure that not only Scott Lloyd but anybody under your department would actually make sure that their actions and their interactions with the people that they=ve been charged in their care that they be consistent with following the Constitution of the United States

and the laws passed by this Congress and by presidents past and present?

Secretary Azar. We all take an oath. You did. I did. Everyone at the department takes an oath to support and defend the Constitution and laws of the United States.

Mr. Cardenas. Okay. So, again, I asked you earlier how committed are you to make sure that you look into the specific situation that Scott Lloyd has been involved with that he=s now under your purview?

Secretary Azar. So this is a matter in litigation. I am not going to be able to comment about my personal activity connected to that or the nature of any investigations that we would conduct.

This is -- these are matters that are being litigated in the courts right now and we will -- we will follow where the courts end up here and we will look -- as I am able to we will look and determine whether our actions are consistent with the law and with -- and with case law as it evolves.

Mr. Cardenas. So you mean to tell -- you mean to tell this committee, members of Congress, that you cannot give your own personal opinion about your personal commitment to how much you=re going to look into this and how quickly -- or whether or not you make it a priority?

Secretary Azar. I am -- I am the head of the agency. My name is on the litigation. I am not able to comment on pending

litigation matters or actions that=ll be taken pursuant to that.

Mr. Cardenas. I am not asking about actions. I am talking about --

Mr. Burgess. Gentleman=s -- gentleman=s -- gentleman=s time has expired.

Mr. Cardenas. I yield back.

Mr. Burgess. The chair thanks the gentleman and the chair recognizes the gentlelady from Indiana, Mrs. Brooks, five minutes for questions, please.

Mrs. Brooks. Thank you, Mr. Chairman, and thank you -- welcome, Secretary Azar, and congratulations on your confirmation.

I am curious -- how many hearings have you had this week?

Secretary Azar. Three in 24 hours.

Mrs. Brooks. Yes, that=s what -- that=s what I thought. I haven=t followed them all but I know that you have been in the hot seat. And so congratulations. I hope we are your last for the week, I hope.

Secretary Azar. I believe so.

Mrs. Brooks. Good. I want to thank you. In your bio, what I am really thrilled about is the fact that you mentioned part of your work when you were deputy secretary focused on advancing emergency preparedness and response capabilities.

It=s some -- it=s an issue that I think we don=t talk enough about in Congress and I want to -- and because at that time you

testified actually as assistant secretary of health in =06 that, and I quote, Awill work to streamline and make more effective the current BioShield interagency governance process. We will make this process more transparent and work to educate the public and industry about our priorities and opportunities."

A decade has passed since that happened. I don=t think we are there yet and as you know the president=s budget proposes to transfer the national -- the strategic national stockpile to the assistant secretary for preparedness -- ASPR, as you=ve just talked about meeting with -- from CDC and I think you talked about that transfer in funding.

And this move, as I understand it, will consolidate strategic decision making around the development and procurement of medical countermeasures.

First, I want to state my support for it and I=ve included this same proposal in the discussion draft of the PAHPA reauthorization that I am working with my colleague and good friend, Representative Eshoo, that we look forward to working with you and your staff on the reauthorization of PAHPA.

But I want to just ensure that you are familiar with the specific proposal and ensure that you are supporting that proposal as it stands.

Secretary Azar. Absolutely. In fact, when I was general counsel and deputy secretary, where we ran strategic national stockpile out of was something that we thought eventually needed

to be with the ASPR but we didn=t have yet the developed procurement capabilities there and management. We now have a very sophisticated program there and so I think the time is now.

It integrates the capability on procurement, on threat assessment, as well as deployment in an operational setting. So I think it=s absolutely the right thing to do.

Mrs. Brooks. Outstanding, and we look forward to working with your staff to make sure that we get it right in the PAHPA reauthorization and also learn whether or not there are any other authorities or things that need to be changed.

When you talk about -- you talked about implementation and delivery. That=s something I actually want to ask about because we often focus on vaccine development which can often overshadow vaccine delivery when it comes time and in a pandemic it=s my understanding BARDA said that we could need up to 600 million drug delivery devices over a six-month and our current excess capacity in the marketplace it can take years to produce different devices.

We certainly learned that during the ebola crisis. Across the country we did not, for instance, have enough gloves. We did not have enough masks. We did not have enough things like that but let alone even the devices that would be needed to execute vaccines.

How do we ensure we have enough drug delivery devices to be prepared when we can=t rely alone on the excess manufacturing

capacity?

Secretary Azar. I think that=s an excellent question and that=s one of the reasons why it=s helpful, I believe, to have the strategic national stockpile connected in -- directly into the assistant secretary of preparedness and response so that we line up that holistic sense of genuine care delivery in an emergency, thinking of -- you know, was for want of a nail a kingdom was lost -- that we don=t lack a vial and have a vaccine or lack a needle but have plenty of vaccines. So I think that holistic sense is absolutely part of our mission and our assessment for procurement purposes.

Mrs. Brooks. I want to just wrap up with my minute that I have left.

Our fellow Hoosier, Director of National Intelligence Dan Coats, said just this week when talking about North Korea=s nuclear warheads, he also mentioned they are continuing their longstanding chemical and biological warfare programs.

As you know, over a decade Project BioShield=s special reserve fund has created the only market for medical countermeasure development and in 2013 while Congress authorized the $2.8 billion in funding for the SRF, so far only $1.5 billion has been authorized.

But I understand that in your budget you=ve requested SRF be advanced funded at $5 billion over the next 10 years. Can you talk to us about the consequences if we don=t do that to

national security and if we don=t provide that advanced funding?

Secretary Azar. It is absolutely vital in BARDA, which is about developing and then eventually for us in BioShield procuring countermeasures that only the U.S. government is likely the purchaser for, that we be a predictable purchaser.

So for us to get entities to develop therapies or countermeasures, we need to be able to show that we have the money and have the backing of the Congress. And so that=s where that type of advance appropriations is absolutely vital for us to be able to secure the commitment from our development partners.

Thank you. I am very pleased with your background and expertise in this area and raising these issues to the forefront.

Thank you. Look forward to working with you. I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from New York, Mr. Engel, five minutes for questions, please.

Mr. Engel. Thank you, Mr. Chairman. Welcome, Mr. Secretary. Congratulations on your appointment.

The president, when he was running for office, said that he would never cut Medicaid and we are, of course, very, very unhappy with potential cuts to Medicaid.

A few months ago we passed -- Republicans passed a tax bill that gave massive breaks to big corporations in the top 1 percent and when that bill passed there wasn=t a doubt in my mind that

the administration would use the hole that their tax bill blew in the deficit to justify gutting programs that support working families.

And lo and behold, the president=s budget cuts are $1.4 trillion to Medicaid, just shy of the tax bill=s $1.5 trillion price tag.

It isn=t subtle. It could not be easier to see that the administration has ways to pay for their legislation. Some of us would say handouts to the wealthiest on the backs of Americans who rely on Medicaid for health use and even if we set aside the cuts themselves, the policies in this budget give us an idea of the kind of Medicaid experiments that this administration might allow states to try.

If you ask me, those policies are just as distressing as the cuts because the administration to Congress have made very clear that whatever they cannot cut they will so-called reform in ways that will kick people off coverage, and as far as I am concerned, those kinds of reforms are simply cuts by another name.

The administration has already chosen to go against the Medicaid statute by encouraging states to enact work requirements that we know will take health coverage away from Americans who desperately need it and now the administration is contemplating letting states put in place lifetime limits on Medicaid coverage and that is something that we have fought against for many, many years and it sends an alarming message, one that I=d like to address

right now.

I=d like to quote a parent from my district whose daughter was born with a rare condition because I think she put it best. This is a quote from what she sent me.

She said, AI never thought our family would be in a position to need a safety net -- a program like Medicaid. We might not be who you think of when you think of Medicaid. The safety net is there for all Americans."

So let me say, again, Medicaid is not a handout. It=s a health insurance program and it covers nearly one in five adults in my district.

Medicaid is the single largest insurer for America=s children and it is a promise to every American that our country will not forsake them even when the going gets tough.

So I am glad that I welcomed you because I know you=re going to do -- it=s a hard job you have but I=d like you to commit to us now that your department will not approve requests to place lifetime caps on Medicaid health insurance coverage.

I know Congressman Kennedy a little before was trying to get you to say that. But I=d feel much better if you can give us that commitment.

Secretary Azar. So, Congressman, I appreciate your concern there and I think they are difficult issues and it=s so -- these are so complex difficult issues I really cannot here give you an answer on resolving a waiver I have not seen.

We will take that very seriously. We have not stated an invitation or a state Medicaid director approach around that type of issue. And so I really need to work with our teams to see what the -- what the issues are, what the legal constraints even are.

I don=t even know the legal frameworks with regard to any issue of lifetime caps and how that would interact with our -- with our waiver or demonstration authorities.

So it would -- it would just be entirely premature for me to sit here and give you an answer on that except to say I would take it very seriously and there has not been a statement of the administration=s positions or views with regard to these -- any requests for lifetime caps in Medicaid.

Mr. Engel. Well, I hope you will visit this committee many times and I hope you will listen to what some of us on this side of the aisle are saying. We have some very -- as you=ve heard all afternoon, we have some very serious questions about it.

We don=t want any situation where our people are being knocked off of Medicaid -- people who really need it and lifetime caps is something that we have talked about for a long time here and when we were doing the Affordable Care Act when we talked about it.

It comes up quite frequently and it=s really scary. It=s scary for people who don=t know what they are going to do if this happens.

So I take you at your word. I hope next time you come back we can have a more thorough discussion on it. But please hear what we are saying today.

Secretary Azar. I absolutely will and I appreciate any dialogue that we can have. These are important programs and very difficult issues and the more minds that we have at bear the better.

Mr. Engel. Okay. Thank you. Thank you, Mr. Chairman.

Mr. Burgess. The gentleman yields back. And the chair would observe that there was a repeal of the therapy caps in the bill that we passed a week ago and I hope the gentleman voted for that.

Does the gentleman from Texas continue to reserve?

Mr. Green. I want -- I want to continue to reserve.

Mr. Burgess. All subcommittee haven=t been recognized. The chair will recognize Mr. Welch for five minutes. Mine really is five minutes, Peter.

Mr. Welch. Well, I appreciate that and, Mr. Chairman, I thank you and I thank you for the work you=ve been doing on prescription drug prices and that=s what I wanted to talk to you about, Mr. Secretary.

You=ve got incredible experience in the pharmaceutical industry and that may be something that can be useful. And I start by saying that I think all of us acknowledge that the pharmaceutical industry has done some good things with life

extending and pain relieving medication. The problem is they are starting to kill us with the cost.

And if we want to maintain access to health care, we have got to really stabilize the cost. I don=t care whether we have a government aid system, employer-based system, or individual-based system. If the price keeps going up way beyond inflation, we are going to be broke.

President Trump has said a lot of tremendous things about price negotiation and about bringing down the cost. You, in your hearing before the Senate, as I understand it, said the core problem is the list prices of the drugs. Am I correct in that?

Secretary Azar. I=d say actually I think list price is one of the core problems. The other is insuring that in various parts of our program we are getting an adequate deal and, for instance, Part B, the physician-administered drugs, is one where it=s actually about are we even getting a good net price. So I=d say --

Mr. Welch. Right. Okay.

Secretary Azar. -- there is two main parts.

Mr. Welch. Here=s the bottom line. There is a lot of folks on both sides of the aisle who want to bring these costs down because all of us have consumers that are getting hammered.

There is a real dispute about what role the government is going to play in taking action to bring these prices down. But sitting on the sidelines, which has essentially been the approach

we have taken, is not working.

Two things I want to talk to you about. One is price negotiation and the other is bringing down the list prices. I mean, just to quote your boss on price negotiation, we are the largest drug buyer in the world. We don=t negotiate. We don=t negotiate.

You pay practically the same for the country as if you=re going into a drug store and buy the drugs individually. If we negotiated the price of drugs, we=d save $300 billion a year.

Question -- does -- do you, as the secretary, support what appears to be the position of President Trump to begin price negotiation by Medicare, which is the biggest purchaser of drugs in the world?

Secretary Azar. So in fact, in our -- in our budget proposal we have a very novel element there. One of the things that I=ve talked about is how can we take the techniques that we use to negotiate in Part D and use them in Part B where we do not negotiate -- we simply pay a sales price with a markup on it under the statute.

And so we have actually proposed giving me the authority to move drugs from Part B into Part D where the PBMs can negotiate on our behalf to secure -- to secure the kind of great deals -- the best -- we get the best deals of any payer in the commercial marketplace right now in Part D because the PBMs negotiate that for us.

Mr. Welch. Right. But the government is the biggest purchaser.

Secretary Azar. In Part -- yes, in Part B, absolutely, and we are not negotiating at all or getting any kind of discounts or deals and that=s why we think it=s quite important.

Mr. Welch. So I just want to understand this. Are you in favor of the -- your agency, essentially, having the authority to negotiate bulk price discounts just like the VA program does, just like many of the state Medicaid programs do?

Secretary Azar. I think it requires an understanding of how VA is different. VA is actually acquiring medicine as a purchaser where we=re serving as a insurer in Part B and Part D.

Mr. Welch. Right. Let me interrupt you.

Secretary Azar. It=s a different dynamic and power structure --

Mr. Welch. I only have five minutes. I know it=s complicated and I know you know how to do it. You=ve got the experience. But there is something that=s really simple and elemental that actually was captured by the president=s comments.

If you=re buying on behalf of the whole country, you ought to get a better price than if you=re individually walking into the drug store, per unit, right? That=s essentially what he=s saying.

Secretary Azar. And that=s why we say in Part B we=d asked

for permission for us to use those negotiating techniques in Part D.

Mr. Welch. Well, the -- the negotiating techniques are bargaining. I mean, you know, Tommy Thompson, who was one of your predecessors, did it when we had the crisis and he had to buy an immense amount of --

Secretary Azar. Well, that was -- that was a procurement. I was actually involved in that.

Mr. Welch. Well, you guys did a good job.

Secretary Azar. That was -- that was a procurement.

Mr. Welch. Right.

Secretary Azar. We don=t -- the difference with -- the difference in Part D, for instance, if that=s what you=re getting at, is even Peter Orszag, the Democratic head of the Congressional Budget Office and President Obama=s OMB director, has made clear that in Part D if we were to -- the only way one could get better pricing than we do now is if we had a single restrictive exclusionary national formulary where seniors get --

Mr. Welch. Okay. All right. Let me -- this is my last word.

That=s right, but what I heard you say to Mr. Carter is that essentially the PBMs impose their own formulary by the rebate system they set up and if you want in you=ve got to pay that price.

So they, instead of doctors and pharmacists, are setting a formulary. And in Vermont what we do under Medicaid is we have

got this commission that sets the formulary but then there is flexibility so that if a doctor says this particular patient use this particular drug we do it. So I hope you follow through.

Mr. Chairman, thank you.

Mr. Burgess. Gentleman=s time is expired.

The chair recognizes the gentleman from North Carolina, Mr. Butterfield, for five minutes.

Mr. Butterfield. Thank you very much, Chairman Burgess, and apologize for being late for the hearing, and I know you go through this every day. I=ve been multitasking all day long.

But Chairman Burgess, thank you for holding this hearing. Once again, the administration has shown how out of touch it is with most Americans. It is not surprising that this administration is proposing more changes -- yet more changes to health care that will harm the middle class and make it more difficult for our citizens to access quality health care.

I am from North Carolina. My constituents want health are, plain and simple. People across the country want health care.

That is why, despite all the Republican efforts to undermine the ACA, the program is still going. In my opinion, it=s still going strong and more than 1 million Americans signed up for the ACA for the first time after President Trump pulled the rug or attempted to pull the rug from under the program.

This budget ignores the wishes of our constituents who

flooded our offices with calls, asking us to protect the ACA and protect Medicaid from Republican efforts to gut these programs.

It also ignores the bipartisan will of Congress. They just approved a two-year budget with increased funding for important health programs like the National Institutes of Health. This budget would take health care away from my constituents and I strongly oppose it.

I voted for the Budget Deal Act last week. Since the Affordable Care Act was first implemented, the uninsured rates steadily decline year after year. From 2010 to 2016, 20 million Americans gained health insurance. Unfortunately, this administration has done everything it can to reverse that, in my opinion.

Since President Trump took office, the Department of Health and Human Services has done its best -- in my opinion, again -- to sabotage health coverage for individuals, make it harder for people to get covered.

As a result, for the first time since the ACA was implemented, and it was this committee that implemented the ACA -- I was part of it -- the uninsured rate actually increased for the first time.

According to Gallup, 3 million more Americans were uninsured in 2017 compared to the previous year. It was also the largest single year increase that has been observed since Gallup began collecting this data. Quite an accomplishment, after years of seeing the uninsured rate go down.

Now, Mr. Secretary, I understand from my staff you=ve been on the job for 14 days so I won=t be brutal with you, even though I have some very strong feelings. I understand when you=re new to something you have to get acclimated.

But yes or no, please. Do you agree or disagree, sir, that 3 million more uninsured does not reflect -- well, first of all, do you agree with the 3 million number? Is that accurate?

Secretary Azar. I don=t know that that=s accurate. I just -- I don=t know. I don=t have the current up to date uninsured numbers after the enrolment period that came out of the Affordable Care Act enrollments.

We were slightly off this year from previous -- from the previous year. I don=t know the aggregate change on the uninsured.

Mr. Butterfield. I think -- I think all of the stakeholders generally agree there was a tick down.

Secretary Azar. Slightly.

Mr. Butterfield. Now, how sharp it was I don=t know -- I don=t know that answer for sure. But that=s not success. Anytime the uninsured rate goes down that is not a measure of success. Would you agree or disagree?

Secretary Azar. I think I reflects the problems that we have with the Affordable Care Act on that individual market program. That=s why we want to work together to try to change it to create a program that actually will work and deliver for

those 28-plus million Americans for whom this program is not giving them affordable access to insurance.

So we want to work together to try to solve that for those forgotten men and women. We talk so much about the -- about the 10 million who are in the individual market there that we are buying insurance for, subsidized, and we forget the ones who have been priced out of that market place that we really have to come up with solutions for.

Mr. Butterfield. But you certainly agree that it=s -- that it=s a legitimate goal for all of us as leaders to try to make sure that the population has access to health care? That goes without saying.

Secretary Azar. We all share that goal, yes.

Mr. Butterfield. Okay. And do you make a commitment to us that you will work with us to the extent that you can to make that happen?

Secretary Azar. Absolutely.

Mr. Butterfield. According to HHS, minorities are less likely to receive diagnosis and treatment for their mental illness, have less access to it, availability of mental health services, often receive poor quality of mental health care.

To address these disparities, Congress just authorized a minority fellowship in 21st Century Cures. We are very proud of that program. This program has been supported for many years to improve health care outcome for racial and ethnic populations

by growing the number of culturally competent professionals to serve the under served.

Last question -- yes or no, please -- is HHS proposing to eliminate this program fiscal year 2019?

Secretary Azar. I do not recall that program in our budget. I=d be happy to get back to you in writing on that.

Mr. Butterfield. Get back to me. Get back to me, please.

Mr. Burgess. The gentleman=s time has expired.

Mr. Butterfield. That is very important. Thank you for your patience, Mr. Chairman.

Mr. Burgess. Does the gentleman from Texas continue to reserve?

Mr. Butterfield. I am not from Texas. Oh. Oh. Oh. I am sorry.

Mr. Green. We will be glad for you to come to Texas, Judge.

Mr. Burgess. I recognize the gentleman from New York for five minutes.

Mr. Butterfield. He cut me off so sharply I thought he was coming back at me.

Mr. Burgess. Five minutes.

Mr. Butterfield. All right. There is always a little tolerance when members are winding down, Mr. Chairman. But thank you.

Mr. Burgess. Mr. Tonko is recognized for five minutes.

Mr. Tonko. Thank you, Mr. Chair, and Secretary Azar, first,

let me thank you for coming before this committee.

It is my fervent hope that in the days to come we can find ways to work together to make progress on important health care priorities for our nation.

Unfortunately, today you are here to defend what I believe is a mean budget that would take us backwards -- backwards with this budget on opioids, backwards on mental health, and certainly backwards on providing affordable health quality -- high quality health care for all.

It=s often said that a budget is a statement of our values, and after reading this year=s budget, the values of the Trump administration couldn=t be any clearer.

The overreaching, overarching message that I hear is, you=re on your own. If you are an individual who has struggled with opioid addiction and you have put yourself on the path to recovery with the help of treatment provided by Medicaid coverage, too bad. You=re on your own and Medicaid had been cut by $1.4 million -- $1.4 trillion.

If you are a senior who paid into Medicare all your life and believed this president when he promised over and over again that there would be no cuts to Medicare, too bad -- you=re on your own to the tune of $554 billion over the next decade.

If you are a single mom working two jobs to put a roof over your head and using your SNAP benefits to help put nutritious food on the table, you=re on your own. But don=t worry, we will

send you a box of peanut butter and some Wheaties.

I could go on and on. But simply put, this budget is not reflective of who we are and of our needs and of our needs and of our values that I hear about when I am home in New York.

Many of my colleagues have already spoken about the devastating cuts to Medicaid, Medicare, and the Affordable Care Act this budget contains and I would like very much to associate myself with their remarks.

It cannot be said enough but you simply can=t put forward a legitimate proposal for addressing the opioid epidemic at the same time that you are proposing more than trillion dollars in cuts to Medicaid. It just doesn=t pass the smell test.

Medicaid is the largest payer for behavioral health services in our country and remains our single best tool to address the opioid crisis. The continued partisan attacks on this safety net program puts lives in jeopardy and needs to stop now.

Now even after this administration has talked a big game about prioritizing the opioid crisis, I=d like to dig a little deeper into some specific cuts that I have seen in this budget that will send us backwards in this fight.

First, I=d like to ask about SAMHSA=s strategic prevention framework initiative. As the name implies, the flexible funding is used to support state-based strategies to prevent youth substance abuse.

SAMHSA=s own data show that states and communities receiving

funding from this program have made improvements in reducing the impact of substance abuse.

Secretary Azar, your budget request would cut $60 million from the strategic prevention framework initiative, which would reduce funding by more than one half. In your budget rationale, you state that this cut is made to prioritize other high-need programs.

So, Mr. Secretary, when we have 174 individuals a day dying of overdoses, what is more high need than continuing investments in proven substance abuse prevention strategies that are very much critical to the inclusive formula for success?

Secretary Azar. So we actually are investing new money into SAMHSA -- $1.24 billion for opioids. So I believe we have demonstrated a clear and deep --

Mr. Tonko. But your cutting the prevention program and prevention treatment and recovery are all important.

Secretary Azar. I=d want to -- I=d want to investigate more about that particular program but we actually are adding many new programs. I do not know the particulars on that program. I apologize. But the --

Mr. Tonko. But it=s the point I am making. You=re adding new programs and at the same time drastically reducing standard programs that have really been proven to be successful, and I am trying to figure out the rationale and then the outcome -- the final line in terms of the statistics that I shared -- 174

individuals dying per day.

Secretary Azar. I=d be happy to get back to you on that particular program. I can just tell you our commitment around the opioid crisis and the SAMHSA=s role in it is deep and broad as evidence by the $1.24 billion commitment there just in the one year.

Mr. Tonko. Okay. I appreciate that and look forward to your response.

Another program that is targeted for cuts is SAMHSA=s Screening, Brief Intervention, and Referral to Treatment program, also known as SBIRT, an evidence-based practice that helps screen for potential substance use problems in individuals.

Funding provided by this program helps medical professionals implement SBIRT in their practices and has resulted in at least 2.7 million individuals being screened as of 2016.

The fiscal year 2019 budget eliminates all funding for the SBIRT program, claiming that this successful demonstration that has been taken up across the country and can be paid for by public and third party insurance.

I found this rationale extremely odd because one of the things I hear from advocates all the time is the need for better screening and early intervention.

Mr. Burgess. The gentleman=s time has expired. The chair would ask if he will submit that question in writing. I am certain the secretary will be happy to respond to it.

Mr. Tonko. I thank the chair.

Mr. Burgess. The chair recognizes the gentleman from Texas for five minutes.

Mr. Green. Thank you, Mr. Chairman, and Mr. Secretary, thank you for your patience today and being here, and you=ve heard from the folks on our side of the aisle and I share the values.

And I think I=ve never met a doctor who didn=t just want to treat their patients and to make them well. It=s hard for us, though, to have that goal of making someone well when you start talking about lifetime caps, for example.

In an earlier career here, I remember we had death panels, and if you have a lifetime cap and someone runs out of their Medicaid -- so those are issues that need to be worked out on the elected level.

I have the concern about the president=s budget because, again, we all heard there=s not going to be any cuts in Medicare or Medicaid during the campaign.

But today, we see substantial cuts in Medicaid and Medicare. Cutting $500 billion Medicare and more than $1.4 trillion in Medicaid is just not what I think a health and human services ought to be doing.

We need to figure out how -- ways we can do it, and my goal is not to have rationed care and I think that=s probably the goal all of us ought to share as Americans because my goal has been to expand access.

I represent a very urban district in Houston, and until the Affordable Care Act, 44 percent of the people who worked in my district did not get insurance through their employer. And now they have that option -- in fact, that requirement. We took away the requirement but their employers still need it, so there have been some good things.

Mr. Secretary, particularly in light of the ongoing opioid epidemic, does the administration not comprehend the danger of cutting these health insurance programs and do you agree that people have accessed needed health care services though that service covered by their insurance?

Secretary Azar. So we absolutely -- absolutely share the commitment about -- around substance abuse treatment for individuals who are suffering in the opioid crisis and, again, we share the goal. We just have different tactics to get there. We actually believe that our approaches will lead to more people having access to affordable insurance. Reasonable minds can differ about this. But it=s -- the goal is the same.

We just differ on what we think would get there and we do believe that it=s better for more people to have insurance. We think right now the system is locking so many people out of that in terms of affordability. But we want them to have that access.

Mr. Green. Well, the affordability -- I would hope that the administration would not cut the subsidies that some of my working poor who make -- you know, make too much money to get

Medicaid but they also don=t make enough money to pay for an insurance without the subsidies.

But let me go back to the Medicaid program. Medicaid is the largest single payer of behavioral health in the United States and financing more than 25 percent of all treatment. But the administration=s budget cuts Medicaid by more than 25 percent.

So with cuts like these, it seems like if you cut Medicaid and we still say we want to deal with people with behavioral or opioid addictions, you can=t do it. It=s like me going to Aetna or Blue Cross and say, I want insurance but I am not going to pay for it. That just doesn=t work.

The administration continues to pursue repeal and replacement of the Affordable Care Act. But that=s a congressional decision, both the House and the Senate, and I would hope the agency would not make decisions on it before it gets guidance from Congress because that=s what the law is.

Can you commit to stopping undermining or sabotaging our health insurance markets and take urgent action to reverse the increase of the uninsured rate?

Secretary Azar. So we believe in ensuring that our programs help deliver affordable insurance and choice to individuals and the steps that we take are about trying to create stable markets, stable risk pools.

The challenge that we are having on declining enrollment is that our offering is not good. People are being shut out by

these radically increasing premiums from the way the market was designed. So we want to make these -- we want to make insurance to work for folks.

Mr. Green. Let me -- I only have 45 seconds left and I am next to the last for you, so you=ll be out of here soon.

But we did that bill in this committee and we didn=t get everything we wanted on the House version. We ended up with the Senate version. But I think we share that. I don=t want people paying huge premiums or either subsidizing but there is ways we can do it. There needs to be a partnership between the administration and the members of Congress.

And I appreciate that you believe we share the goals. With all due respect, it=s clear that the budget proposal we fundamentally do not share the same goals. The picture the administration budget paints is a harsh one where more and more Americans join the ranks of the uninsured every day and, again, in an urban area like I have -- not a wealthy area -- this would be devastating to folks who are barely on the edge.

And Mr. Chairman, I know I am out of time and I yield back what I don=t have.

Mr. Burgess. Chair thanks the gentleman. The gentleman yields back and I=ll recognize myself for the balance of the time, however much time I may consume, right?

Mr. Green. Well, then I=ll ask for more time.

Mr. Burgess. And you have been very generous with us today

and we appreciate it and historically you=ve been generous with our time and I appreciate that as well.

We did hear a lot today about -- and of course all of us have been here on the dais all afternoon so we haven=t kept up with any of the news.

But as we kept up with it yesterday and this morning it did seem, as you listen to those stories, that there perhaps were some significant cues or clues that were missed somewhere along the way.

While some of that will involve other agencies and municipal agencies and not the Department of Health and Human Services, I hope to the extent that there were -- there were cues missed to the mental health space that you will -- you will work with us in this committee.

We did pass a pretty big mental health title in the Cures bill and if there is something where -- if there is something that you can tighten up administratively or something where you need legislative direction, I just want you to know the committee is prepared to stand by you with that.

I=d also make the observation, and this is information that is readily available on open source, many of the individuals who are involved in this type of crime actually do have some type of psychotropic drug in their system and that is not to impugn or disparage the use of these medications.

But it means that these individuals have intersected with

a mental health professional at some point because these are not compounds that are available over the counter, not frequently something that=s bought on the street.

So it does seem that there has been an opportunity at least to intersect with a mental health professional and anything we can do from the agency perspective or legislatively to tighten that up I=d certainly commit to you that I am -- I am willing to work with you on that.

Your predecessor was a colleague of mine, someone who I felt -- thought very highly of and I will tell you from a doctor=s perspective across the country there was a lot of anticipation when Dr. Price was selected as the -- as the secretary of Health and Human Services.

To the extent, going forward, that we can be cognizant -- you at the agency and us legislatively -- cognizant of things we can do to reduce the burden on physicians and people who actually provide the care.

Insurance, yes, that=s one thing. But if you haven=t got someone there to provide the care the darn insurance card doesn=t do you a bit of good. And I do worry that we have put a lot of burdens on our men and women who practice medicine in this country.

The electronic health records have been a significant burden. I know there is some concern as we go through some of the Medicare structural reforms. Just for the record, it was

important to get rid of the sustainable growth rate formula.

We did that. I did think it was going to take longer than five years for whatever came next. I lost that argument and it is to be done under a five-year time interval.

However, I think you can see from last Friday=s vote that the Congress -- the legislature is willing to provide, if there is legislative relief that is needed as far as the time line or as far as the flexibility, we are prepared to provide that for you.

Remember that this bill, the Medicare Access and CHIP Reauthorization Act, passed with 393 House votes, 93 Senate votes -- big bipartisan majority. A lot of us have a lot of equity and ownership of this and we want it to be done correctly. That=s probably the most important thing.

We have had a number of hearings already. We are going to have another one as MACRA affects small practices and certainly work closely with Secretary or Administrator Seema Verma over at CMS.

And, again, I just commit to you that we want to do what we can to alleviate that burden. You had mentioned the interplay between prescription drug monitoring programs and electronic health records.

That, I guess, would be one of those opportunities to reduce the burden on practicing physicians if there is a way to seamlessly integrate. I don=t know if you can do it as far as the privacy

concerns. But that is -- I think it=s something worthwhile to look at.

What I would also say, and I think you=ve touched on this, there is a lot of data that the Center for Medicare and Medicaid Services has and to the extent that you can identify a practitioner who is writing an inordinate number of prescriptions, a pharmacy that=s filling an inordinate number of prescriptions, a pharmacy that=s taking delivery of an inordinate amount of product, these are things that are actually knowable within the data that=s locked up in the Center for Medicare and Medicaid Services.

So, again, I hope you will -- you will work with us as far as trying -- I think too often we will point to our physician community and say, you guys have got to tighten this up because we have got an opiate crisis in this country.

And yet, there are places where, from the agency perspective, we could tighten things up and perhaps drill down on where some of those problems actually occur.

You=ve been very generous with us today. There are going to be questions coming to you in writing. I have several that I will send you.

With that, the subcommittee stands adjourned and, again, thank you, Mr. Secretary.

[Whereupon, at 3:25 p.m., the committee was adjourned.]