The subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123 Rayburn House Office Building, Hon. Diana DeGette [chairwoman of the subcommittee] presiding.

Members present: Representatives DeGette, Schakowsky, Kennedy, Ruiz, Kuster, Castor, Tonko, Clarke, Pallone (ex officio), Guthrie, Burgess, McKinley, Griffith, Brooks, Duncan, and Walden (ex officio).

Also present: Representatives Blunt Rochester, McMorris Rodgers, Bucshon, Carter, Gianforte, Cardenas, and Rush.
Staff present: Kevin Barstow, Chief Oversight Counsel; Jesseca Boyer, Professional Staff Member; Jeff Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Saha Khaterzai, Professional Staff Member; Chris Knauer, Oversight Staff Director; Kevin McAloon, Professional Staff Member; Meghan Mullon, Staff Assistant; Joe Orlando, Staff Assistant; Alivia Roberts, Press Assistant; Tim Robinson, Chief Counsel; Benjamin Tabor, Policy Analyst; Sydney Terry, Policy Coordinator; Rick Van Buren, Health Counsel; C.J. Young, Press Secretary; Nolan Ahern, Minority Professional Staff, Health; Jennifer Barblan, Minority Chief Counsel, O&I; Margaret Tucker Fogarty, Minority Legislative Clerk/Press Assistant; Caleb Graff, Minority Professional Staff Member, Health; Brittany Havens, Minority Professional Staff, O&I; Peter Kielty, Minority General Counsel; James Paluskiewicz, Minority Chief Counsel, Health; and Natalie Sohn, Minority Counsel, O&I.
Ms. DeGette. The Subcommittee on Oversight and Investigations hearing will now come to order. Today, the subcommittee is holding a hearing entitled "Sabotage: The Trump Administration's Attack on Health Care." The purpose of the hearing is to examine the efforts of the Centers for Medicare & Medicaid Services to ensure quality and affordable health care for all Americans. The chair now recognizes herself for 5 minutes for an opening statement.

It is no secret that Trump administration has worked to sabotage health care in this country. On his very first day in office, President Trump issued an executive order directing all federal agencies to dismantle the Affordable Care Act, "to the maximum extent by law." And ever since then, the Trump administration has worked tirelessly to undermine the ACA and other critical health programs at every turn.

In her role as the administrator of the Centers for Medicare & Medicaid Services, Seema Verma has been behind many of this administration's efforts to undermine the nation's health care.

Despite her role in this effort, today is the first time Administrator Verma has appeared to testify in an oversight hearing in the House, and we have many questions regarding the administration's actions.

Since the Affordable Care Act was signed into law, more than 20 million people gained affordable, high quality health care
coverage. But now, under President Trump and Administrator Verma, this administration is determined to take us in the wrong direction. Last year, we saw the number of uninsured people in this country increase for the first time since the ACA was passed. About 1.9 million more people were uninsured last year compared to the year before, including nearly half a million more children. Further, the Kaiser Family Foundation estimates that health insurance premiums are 16 percent higher this year than they would have been if the Trump administration had not worked to undermine the ACA.

We know the Trump administration has taken numerous steps to sabotage the ACA. They are chipping away at critical protections guaranteed by the law. They are allowing states to increase consumers' costs, reduce their coverage, and undermine protections for those with preexisting conditions. They are promoting junk insurance plans that do not provide essential health benefits and leave patients on the hook when they need coverage the most. They are making it more difficult and more expensive for individuals to find quality coverage on the health insurance marketplace, and, to top it all off, they are rooting for the ACA's collapse by declining to defend the law in the Texas v. United States lawsuit.

We will likely hear today that Obamacare is the source of all our problems. But while the nation's healthcare law may not
be perfect, it is important to understand what would happen if the Trump administration succeeded in dismantling the ACA entirely. Twenty-one million people could lose their health insurance.

Up to 133 million Americans with preexisting conditions could be denied coverage or charged higher premiums. Those lucky enough to keep their coverage if the ACA is dismantled could once again face lifetime caps on coverage and could lose coverage for things like prescription drugs and maternity care. Women could once again be charged more than men for their health coverage, and 60 million seniors and disabled Americans on Medicare will have to pay more for preventive care and prescription drugs.

Yesterday, CMS announced that ACA premiums will drop by about four percent this year. That is good news. However, let's just think about how many more people would be covered now and how much lower premiums could be if not for the repeated acts of sabotage at the hands of this administration.

The ACA is succeeding despite the Trump administration's efforts to tear it down. Time and time again, this administration's actions on health care have gone squarely against their duty to promote high-quality health care and the well-being of children and families in need. Under this administration, thousands of children and families have lost coverage of basic health services and this administration's
actions have disproportionately hurt those with disabilities, rural Americans, veterans, women, and young people of color.

The Trump administration and Administrator Verma, in particular, have tried to make philosophical arguments for why they are doing these things, but the numbers just don't lie. At a time when we as a nation are facing a series of critical health challenges like the opioid epidemic and unacceptably high rates of maternal and infant mortality, it is unconscionable that this administration is working to reverse the progress that we have made.

Today, the administration will have to answer for its unending sabotage of Americans' health care and Administrator Verma will have to explain to the American public why she and this administration are actively trying to take their health care away.

And with that, the chair will recognize the ranking member of the subcommittee, Mr. Guthrie, for 5 minutes for an opening statement.

Mr. Guthrie. Thank you, Chair DeGette, for holding this hearing with the Centers for Medicaid, and Medicare & Medicaid Services today, and I would like to welcome Administrator Verma to her first appearance before the Energy and Commerce Committee.

CMS oversees the two largest federal healthcare programs, Medicare and Medicaid, as well as numerous other federal programs.
CMS programs will impact over 145 million Americans in fiscal year 2020, and a CMS budget of over one trillion represents more than 25 percent of the entire federal budget. I share this information about CMS not only to emphasize the critical role that the agency plays in the nation's healthcare system, but how to illustrate how we cannot possibly cover all of CMS's work in a single hearing. And thank you, Administrator Verma, for your commitment to promoting competition and innovation for Americans' health care and for that work you have accomplished in your role thus far. Just yesterday, I was pleased to see CMS announce that premiums for mid-level Silver plans will decrease four percent for 2020, a far cry from the double-digit premium increases we have seen in past years.

I have also heard from my constituents on how CMS's Patients over Paperwork initiative will help providers spend more time focusing on the quality of care provided to patients rather than the overly burdensome administrative tasks. I am also glad that CMS is strengthening the agency's oversight of nursing homes in recent months. Last Congress's subcommittee examined CMS's oversight of the quality and safety of care in nursing homes after numerous reports described instances of abuse, neglect in standard care occurring in nursing homes across the country.

Another critical issue facing Americans that CMS has made a top priority is the opioid epidemic. This committee has long
has been at the forefront of the fight to combat the opioid crisis. Last Congress, our investigation and legislative work led to the SUPPORT for Patients and Communities Act which was signed into law 1 year ago tomorrow. While there is much to be done both legislative and through investigations, the SUPPORT Act included important provisions relating to CMS's role and responsibility in helping to address the opioid epidemic.

Many of the initiatives I have just described share bipartisan support, which is why the title for this hearing, "Sabotage: The Trump Administration's Attack on Health Care," is over the top. I don't think anyone can reasonably categorize CMS's effort to protect vulnerable populations in nursing homes and assist states in fighting the opioid epidemic as sabotage. Moreover, the Democrats are likely going to spend a lot of time today criticizing CMS's recent actions relating to Medicaid demonstration projects and Section 1332, State Innovation Waivers. I find it disingenuous, however, to lay CMS's commitment to strengthen its partnership with states and promote innovation as sabotage.

I do, however, want to take some time to discuss areas where I hope CMS will take additional action in the future. We are at the beginning of flu season and it will potentially be one of the worst flu seasons that we have experienced in recent years. This subcommittee held a hearing in 2018 examining HHS's efforts...
to respond to seasonal influenza and while CMS was not a witness at the hearing, we did learn that FDA was working with CMS to use Medicare data to compare the effectiveness of different types of flu vaccines. I have some questions for CMS today about the status of this work and I hope that we can hold another hearing on seasonal flu preparedness as soon as possible.

I also have questions for CMS about the agency's efforts to improve the interoperability of healthcare records while also taking into consideration the sensitive nature of healthcare data. We appreciate the work CMS has done to implement the 21st Century Cures Act, but as I said in my letter to CMS with Congressman Schrader this summer, I am concerned that a recent proposed rule issued by CMS does not adequately protect consumers' sensitive healthcare data. Thank you again for being here today. I look forward to your testimony and I would like to yield my time to the Congresswoman from Indiana, Mrs. Brooks.

Mrs. Brooks. Thank you, Ranking Member Guthrie. And welcome, Administrator Verma.

Seema and her family are constituents of mine back home in Indiana and we actually have been friends for a couple of decades. We worked together in Mayor Stephen Goldsmith's office where she was focused on health policy in the late '90s. That innovation was recognized also by former Indiana Governor Mitch Daniels who asked Seema to work with him in ensuring that health
care was working better for patients throughout Indiana.

She is the architect of the Healthy Indiana Plan which was Indiana's popular bipartisan -- again, I repeat, it was a bipartisan Medicaid program. Healthy Indiana Plan requires individual responsibility through small member contributions utilizing what are called POWER Accounts that function like traditional HSAs, and the Healthy Indiana Plan incentivizes preventive care to drive down costs and keep patients healthier.

We are very, very proud that Seema Verma stepped up at the invitation of the President to take the innovation and her incredible dedication to the health of Americans here in Washington, D.C. We look forward to continuing working with you to continue to improve health care for all Americans.

Thank you, I yield back. Mr. Guthrie. Thank you. And I yield back.

Ms. DeGette. The gentleman yields back. The chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes for purposes of an opening statement.

The Chairman. I want to thank the chairwoman. Today's hearing continues this committee's ongoing work to bring oversight and accountability to the Trump administration's relentless attack on people's health care, whether it be attacks on the Affordable Care Act, Medicare, or Medicaid. Since day one, the Trump administration has engaged in a concerted effort
to undermine, weaken, and outright eliminate health insurance coverage for tens of millions of Americans. I heard what my colleague, the ranking member Guthrie said, that I guess he doesn't think that this administration is sabotaging anything. But, you know, the problem I have here is if someone is on the right, ideologically, and says, look, the government shouldn't be involved in health care, shouldn't get involved in health insurance, people are on their own, if you said that then I would say, okay, I understand. You know, you want to get rid of all the health insurance, you want to get rid of all this, this is not the government's role.

But the problem is I hear my colleagues on the other side, including the President, suggest otherwise. That they want to cover everyone. That they want to help people get health insurance. Well, I don't see that at all. I think, if you look at this practically and not ideologically, it is clear that fewer people have health insurance, that their essential benefits are being cut back, they are not being covered, so to suggest that somehow they are not responsible for that I think is not true. They are responsible. It is a concerted effort to cut back on people's health insurance, their benefits, what kind of coverage they have.

And our witness today is the Administrator for the Centers for Medicare & Medicaid Services, CMS, Seema Verma, who is the
administration's point person on these actions. I think she has a difficult record to defend. During her time as the administrator, healthcare costs have gone up and health insurance coverage has gone down. And thanks to the administration's policies, the number of uninsured Americans increased by nearly two million people from 2017 to 2018, rising to 27.5 million uninsured.

And between December 2017 and this June, more than one million children lost health coverage through either Medicaid or the Children's Health Insurance Program, and these are, you know, bipartisan programs. Why is this administration making it more difficult for people to get coverage, and particularly kids?

These are very disturbing trends and, unfortunately, they could get even worse if CMS and the Trump administration are successful in pushing their harmful policies. The Trump administration is actively supporting a lawsuit that would overturn the Affordable Care Act. This would strip health insurance away from tens of millions of Americans and would allow insurance companies to once again discriminate against people with preexisting conditions.

The administration has expanded junk insurance plans that are not required to cover essential health benefits like hospitalization, prescription drugs, and emergency care.
services. The Trump administration is also placing extremely burdensome, in some cases illegal, hurdles in front of Medicaid beneficiaries. These unnecessary roadblocks are certainly causing pain for low-income families as more than one million children lost health insurance coverage through either Medicaid or CHIP between December '17 and June of this year.

These disturbing numbers show that the Trump administration's policies to drive people off Medicaid, tie them up in red tape, or scare them into not even applying for insurance in the first place are working. And I am deeply concerned by the Trump administration's ongoing attempts to impose illegal work requirements waivers on Medicaid beneficiaries. These requirements are not only cruel and costly, but they are a clear violation of both Medicaid statute and longstanding congressional intent.

And, fortunately, these illegal actions have been rightfully defeated in the courts, but the Trump administration refuses to give up. And the Trump administration is also not giving up in its ongoing attempts to sabotage the health care of millions of Americans through the ACA. In some instances, the proposals have been so extreme that even Administrator Verma has raised the red flag. In an internal memo dated August 2018, she wrote that several administration proposals at the time would, and I am quoting, "cause coverage losses, further premium increases, and
market disruption." And the memo concluded that 1.1 million Americans could lose their coverage.

And I have repeatedly requested Ms. Verma provide the underlying analysis discussed in that memo. If the Trump administration is pursuing a policy that would have harmful impacts on millions of Americans, Congress and the American people have a right to know what exactly that analysis shows. To date, I have received a one and one-half page response that answers none of my questions.

So under Ms. Verma's leadership, CMS is following the rest of the Trump administration in stonewalling legitimate congressional oversight requests and I am appalled by the flimsy, nonresponsive letters this committee has received back from CMS, many times well past the deadline. As I wrote in a letter to both Secretary Azar and Administrator Verma last week, obstruction of the committee's legitimate exercise of its oversight responsibilities is unacceptable and if continued may necessitate the use of additional measures including compulsory process.

So, Administrator, you cannot flout this committee's constitutional duty to conduct oversight. I appreciate you being here today. That certainly says a lot that you are here and I don't want to take away from that, but the stonewalling of our oversight requests have to end.
And with that, Madam Chair, I will yield back. Ms. DeGette. The chair now recognizes the ranking member of the full committee, Mr. Walden, for 5 minutes for purposes of an opening statement.

Mr. Walden. Well, good morning. Good morning, Madam Chair and Chairman of the full committee.

Ms. Verma, thank you for being here. We really appreciate it and we have enjoyed working with you over the years on many of these issues and I am glad you are here. CMS as we have talked about is the largest administrator of health benefit programs in the United States. It is estimated in fiscal year 2020 over 145 million Americans will receive their benefits from programs administered by CMS. So you have got a big job and we appreciate the work you are doing. That includes Medicare, Medicaid, and Children's Health Insurance Program, also known as CHIP. And under Republican leadership and with the support of this administration and, frankly, in opposition to votes on the floor by Democrats, we not only extended CHIP for 5 years and then 6 years, we did it for 10. We did it for 10 years, fully locked in, Children's Health Insurance, and a lot of Democrats have not -- all voted against this almost every step of the way and especially on the House floor. And I don't want to get into this partisan back-and-forth, I hadn't planned to today, but it is just unfortunate because there are issues here that we need
to focus on together.

And I think about the meetings I have had with the President, with you and others. I have not seen a President who has leaned in more to get drug prices down. Now we may have agreements and disagreements to policy, but I wish you could have been here during our markup when nearly every Democrat was holding up posters of what President Trump had said about bringing down drug prices. And while we may have some disagreements about the policy, they were certainly the President's advocates last week when we were dealing with drug costs.

In surprise medical billing, the Chairman and I are working shoulder-to-shoulder with this administration, I believe, on a way to protect consumers from surprise medical billing. Because I tell you, what I run into out in my part of the world is people are so concerned about the high cost of health care and in the Affordable Care Act, and we have had our debates about what the best policies are there, it did not deliver as promised to bring down premiums 2,500 bucks. In fact, I can't find anybody in my district that has seen that level of reduction in their premiums. But what they have seen is an increase in deductibles and copays, and insurance by name is not insurance in function if the deductible and copays are so high you really can't afford to access the care. And so, there are issues there in terms of the Affordable Care Act and all, and there are things we, frankly,
as Republicans supported that became part of the Affordable Care Act. Not the overall bill, but a lot of things contained in there, including protecting people with preexisting conditions, letting your kids stay on until they are 26, there is a whole host of things.

And then we have done a lot of work together and it was referenced earlier today about the SUPPORT Act. As chairman of the committee, I helped steer that through the legislative process here. We had an open session where Members of Congress could come and make their case. Tomorrow marks the one-year anniversary. I just left a meeting, bipartisan, in the Senate with the First Lady and Secretary Azar. Well, we were celebrating what we accomplished together as a Congress, and almost unanimously as I recall, to address this horrible scourge of opioids.

Now when it comes to first times, we are glad you are here, the first time for the committee. The other first time would be to have a hearing in this committee on Medicare for All. We were talking about, my colleagues were talking about how the Trump administration, their allegations, chipping away at ACA. I would argue that their presidential candidates are taking a chainsaw massacre approach to it, because they want to throw out the whole thing and go with a government-run system that wipes out Medicare and Medicaid, VA, all private health insurance, and they are
having a fight over how to pay for it or whether to even talk about how to pay for it. And so, working Americans are going to lose their insurance under their plan, and I have asked for a hearing before this committee since the first of this Congress and we have yet to have one on their Medicare for All proposal.

So there is a lot of debate to be had here. There is also areas we should be working together on and so we are glad you are here. I am going to yield now to the ranking member of the Health Subcommittee, Dr. Burgess. Mr. Burgess. I thank the gentleman for yielding. I would like to do something I don't normally do which is quote from the Washington Post. In the Health 202 article yesterday by Paige Cunningham, it states, "Obamacare premiums will become more affordable next year, despite the dire predictions by Democrats that the Trump administration would destroy the insurance marketplaces." She goes on to say the improvements are striking, considering that Democrats have spent the last few years blasting the Trump administration for peeling away Obamacare regulations.

Quoting Alex Azar, "President Trump, the President who was supposedly trying to sabotage the law has been running it better than the guy who wrote it." Quoting President Trump himself, "Once we got rid of the individual mandate and made it better but Obamacare doesn't work -- but it works at least adequately now and we had that choice to make. And politically it is probably
not a good thing that I did, but it was the right thing to do for a lot of people," he said in July. So I will just submit this entire article for the record. I ask unanimous consent to do so.

Ms. DeGette. Without objection.

[The information follows:]

**********COMMITTEE INSERT**********
Mr. Burgess. And we will carry on. I yield back. Thank you. Ms. DeGette. The gentlemen yields back. The gentlemen yields back. The chair now asks unanimous consent that members' written opening statements will be made part of the record. Without objection, they will be entered.

I would now like to introduce our witness for today's hearing, honorable Seema Verma, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services.

Administrator Verma, thank you so much for coming today. You are aware I know that the committee is holding an investigative hearing and when doing so we have the practice of taking testimony under oath. Do you have any objections to testifying under oath?

Ms. Verma. I do not.

Ms. DeGette. Let the record reflect the witness responded no. The chair then advises you under the rules of the House and the rules of the committee you are entitled to be accompanied by counsel. Do you desire be accompanied by counsel today?

Ms. Verma. I do not.

Ms. DeGette. Let the record reflect the witness has responded no. If you would then, please rise and raise your right hand so that you may be sworn in.

[Witness sworn.]
Ms. DeGette. You may be seated. Let the record reflect
the witness responded affirmatively. And you are now under oath
and subject to the penalties set forth in Title 18, Section 1001
of the U.S. Code.

The chair now recognizes the witness for a 5-minute summary
of her written statement. In front of you is a microphone and
a series of lights. The light turns yellow when you have a minute
left and it turns red to indicate your time has come to an end.

You are now recognized.
Ms. Verma. Thank you. Chair DeGette, Ranking Member Guthrie, and members of the subcommittee, thank you for the invitation to discuss efforts by the Centers for Medicare & Medicaid Services to transform and improve the United States healthcare system. When I came to CMS, our goal was to improve quality, lower costs, and improve the healthcare experience not only for the beneficiaries of our programs but for all Americans.

In 2017, this administration inherited a chaotic and declining individual health insurance market. The relief promised by proponents of the Affordable Care Act never materialized. Quite the opposite. Premiums in states using the federal exchange more than doubled from 2013 to 2017, the final year the previous administration oversaw the program. Issuers were fleeing the market and we were scrambling to prevent bare counties.

But after just over 2-1/2 years as administrator, I am happy to report that our market-based reforms have delivered lower premiums on the exchanges for the first time since the law started. Yesterday, we announced that for 2020 the average premium for a benchmark Silver plan will drop by four percent in states using
the federal exchange platform. This is on top of the decreases we saw last year.

In some cases, the decline in premiums is substantially higher, with six states experiencing double-digit percent, percentage decreases including a 20 percent drop in Delaware, a 15 percent drop in North Dakota, and a 14 percent drop in Oklahoma. On top of this, more issuers are entering the market and the number of states with just a single monopoly issuer is declining. Only two states will have a single issuer in 2020, compared to five this year and ten last year. This is success.

Despite this progress, it was inevitable that Obamacare's affordability crisis would eventually increase the number of uninsured and that is exactly what the latest census data show. The fact is, 85 percent of the 1.9 million newly uninsured in 2018 occurred among people with incomes higher than 300 percent of the federal poverty level. These are people who do not qualify for large ACA subsidies and represent a new class of uninsured, those that can't afford Obamacare's premiums.

Our work to lower premiums hasn't stopped with the exchanges. Under the President's leadership, we have strengthened Medicare, seeing similar success in Medicare Advantage and Part D. Medicare beneficiaries have more choices, with about 1,200 more Medicare Advantage plans available in 2020 than in 2018. Average monthly premiums in Medicare Advantage are the lowest they have
been in 13 years, and in Medicare Part D, the lowest they have been in 7 years. Across the board in Medicare and the exchanges, premiums are lower. All of our work at CMS focuses on making health care more affordable and accessible to the American people. We are using every lever and our large footprint to tackle longstanding issues and problems in the healthcare system. We are executing on our vision to transform care by putting patients first and focusing sixteen strategic initiatives grounded in empowering patients, promoting competition, and unleashing innovation. CMS is committed to moving to a system of competition and value and giving patients the choice and control they want, the affordability they need, and the quality they deserve.

While my written testimony provides more details, I will highlight a few of our efforts on these initiatives. We are empowering patients with the information they need to make decisions about their health care. We have efforts underway around price transparency, quality transparency, and ensuring that beneficiaries' medical records can travel with them while keeping the data private and secure.

We're addressing issues that drive up healthcare costs, especially administrative costs. After becoming administrator of CMS, one of my first actions was to launch the Patients over Paperwork initiative. Across our programs we have made
common-sense changes to our regulations and guidance. Just last
week, for example, we released a proposed rule to modernize and
clarify the regulations that interpret the Stark Law. Our new
policies will save providers an estimated 4.4 million hours a
year previously spent on paperwork, with savings projected to
be approximately eight billion dollars over the next 10 years.

We're also working to bring our programs into the 21st
century. Last year, the administration launched the eMedicare
and the MyHealthEData initiatives to modernize Medicare and meet
the growing needs of a number of tech-savvy beneficiaries. This
includes releasing two new cost calculator tools and the first
redesign of Medicare Plan Finder in a decade. And as part of
MyHealthEData Blue Button 2.0 is already giving Medicare
beneficiaries the ability to securely connect their claims data
to apps and other tools developed by innovators.

We have launched several historic efforts to improve quality
and safety in nursing homes and across the healthcare system to
improve rural health, to transform our program integrity efforts
and to foster innovation throughout the American healthcare
system, bringing new technology and breakthrough treatments to
our beneficiaries. And we're also focused on transforming the
Medicaid program around three pillars: flexibility, integrity,
and accountability. Our goal is to restore the federal-state
partnership in Medicaid and allow states to resume their role
as laboratories of innovation.

We are approving groundbreaking waivers and doing it at a faster pace and we are holding states accountable for results including through our new Medicaid scorecard. At CMS, we are putting patients first --

Ms. DeGette. The gentlelady's time has expired, if you can wrap up, please, Administrator.

Ms. Verma. At CMS, we are putting patients first as we move forward with transforming the healthcare system and providing all Americans with an access to a variety of affordable coverage options.

Ms. DeGette. Thank you.

Ms. Verma. I greatly appreciate the opportunity today.

[The prepared statement of Ms. Verma follows:]

**********INSERT 1**********
Ms. DeGette. It is now time for members to ask you questions and I will recognize myself for 5 minutes.

Administrator Verma, as I stated in my opening and as you mentioned in your statement, we saw the number of uninsured people in this country increase last year for the first time since the ACA was passed to about 1.9 million people; is that correct?

Ms. Verma. That is correct.

Ms. DeGette. And about half of those people were children; is that right?

Ms. Verma. I don't think that number is correct, no.

Ms. DeGette. Okay. What is the correct number then?

Ms. Verma. I think the number's around 400,000.

Ms. DeGette. Four hundred thousand, thank you. Now, in the Texas v. United States case, that is the case that the administration has requested that the ACA be struck down; is that correct?

Ms. Verma. That is correct.

Ms. DeGette. And so, any day now the court will rule and if the court rules the way the administration has asked, then the entire ACA will be invalidated; is that correct?

Ms. Verma. That is correct.

Ms. DeGette. Okay. So now, if the ACA was invalidated, about 21 million people would lose their health insurance; is that correct?
Ms. Verma. I think what's clear --

Ms. DeGette. Yes or no will work.

Ms. Verma. No.

Ms. DeGette. No, okay. How many people would lose their health insurance if the ACA was struck down, do you know?

Ms. Verma. The President has made clear that we will have a plan in action to ensure that Americans have access.

Ms. DeGette. Okay. I am going to get to that in a minute. But if the ACA was struck down, isn't it true 12 million people would lose their insurance?

Ms. Verma. The President has made clear --

Ms. DeGette. No. Yes or no will work. Do you know how many people would lose their insurance?

Ms. Verma. The President has made clear --

Ms. DeGette. Okay, you are not going to answer that. Now let me ask you this. Let me ask you this. If the ACA was struck down, then also the provision of the preexisting conditions would be struck down since it is part of the ACA; is that right?

Ms. Verma. The President has made clear that we will do everything we can to ensure that Americans with preexisting conditions maintain the protection that they have today.

Ms. DeGette. Well, let me just say then, since you are not answering my question, the ACA if it was struck down this is what would happen. Twenty-one million people who are insured under
the ACA would lose their insurance. That includes twelve million people on Medicaid and nine million who have ACA protection. There are currently 133 million people with preexisting conditions who under the ACA get protections.

Now there is about -- I will ask you this. Maybe -- I am sure you will give the same answer, but there is 2.3 million adult children under the age of 26 who because of the ACA are able to stay on their parents' insurance. Now I will ask you this. If the ACA was struck down, would those 2.3 million adult children still have their insurance?

Ms. Verma. The President has made clear --

Ms. DeGette. Okay.

Ms. Verma. -- that we will maintain what works and we will try to address the problems that we're having with the ACA.

Ms. DeGette. So did the administration file some kind of a motion in the Texas case to say that the preexisting conditions should be maintained? Yes or no will work.

Ms. Verma. Individuals that have preexisting conditions today --

Ms. DeGette. Yeah.

Ms. Verma. -- that do not receive a subsidy, I would argue that they don't have the protections today. I mean if we give you an example of the 55 --

Ms. DeGette. So you don't think the ACA is protecting people
with preexisting conditions?

Ms. Verma. If you can't afford your health insurance, if you can't afford health insurance and you have a preexisting condition, then you don't have protections.

Ms. DeGette. Okay. What about the adult children? Did the Trump administration file a motion with the court to say they should still be able to stay on their parents' insurance until age 26? Yes or no.

Ms. Verma. The President has made clear that we will have a plan in action to make sure that Americans have access to affordable coverage. We do not have that today. There are many Americans today if they are not getting a subsidy can't afford health insurance today.

Ms. DeGette. I totally understand your position, Administrator Verma. You are not answering my questions because, frankly, if the ACA was struck down the preexisting, people with preexisting conditions, the adult children, all of those provisions of the ACA would be reversed. So you are telling me, Administrator, that the Trump administration has told people they will be protected. Can you produce for me right now the Trump administration's plan to protect the people? Can you produce that plan right now?

Ms. Verma. So today, a 55-year-old couple making $60,000 a year --
Ms. DeGette. No, no. That is not my question.

Ms. Verma. -- in Nebraska --

Ms. DeGette. My question -- excuse me. My question is do you have a copy of the plan that will replace the ACA? Yes or no.

Ms. Verma. I'm not going to get into any specifics of a plan, but the --

Ms. DeGette. Okay, you are not going to answer the questions. In that case, the chair will yield back and she will recognize the ranking member for 5 minutes.

Mr. Guthrie. Thank you, Administrator. Do you want to finish your comments you were just making?

Ms. Verma. Thank you. So a 55-year-old couple making $66,000 a year in Grand Island, Nebraska could face an annual premium of over $31,000 and that's on top of a $12,000 deductible.

In that same situation in Colorado, that premium would be $32,800. In New Jersey, the premium would be almost 16,000. So we're talking about people having to spend a third to a half of their income on premiums and that doesn't even include the deductibles.

And so, if those individuals or that couple have a preexisting condition, they don't have any protections today.

Mr. Guthrie. So I was going to talk about the lowering premiums, but you are lowering for minority very high premiums
that increased since the ACA was passed. So the lower -- but
you have made efforts and put into place the lowering. What
challenges remain to further lowering premiums?

Ms. Verma. Well, I think one of the things that we need
to do is focus on lowering the cost of care. There's been so
much discussion about throwing more money, having, you know, at
the problem, having more government control, but what we're
focused on is lowering the cost of health care. Many of the
initiatives that we have at CMS whether it's around drug pricing,
whether it's getting rid of administrative burdens that are
getting in the way of doctors spending time with their patients
and actually increasing costs, whether it's focusing on
efficiencies in the system like interoperability and making sure
that patients have access to their healthcare records, we are
trying to focus on actions that are going to lower the cost of
care for Americans. If we do that more people will be able to
afford health care.

Mr. Guthrie. Thanks. And I want to switch a little bit.

I have some Kentucky hospitals that have contacted me about the
star rating system before and their question is they understand
the purpose, but it doesn't adequately or reflect the quality
that they produce at their hospitals. So I know CMS decided to
change the hospital star rating methodology and so my question
is that some stakeholders requested CMS remove or suspend star
ratings from hospital compare website until the hospital star rating methodology is updated, but what does CMS plan to use the current methodology to update star ratings in early -- can you, an estimate for the fix of this?

Ms. Verma. Sure, and I appreciate the question. So, first of all, let's start with as we are focusing on lowering healthcare costs. We think that price transparency is very important and along with price transparency quality transparency is important and that's what the hospital star ratings are all about.

I appreciate the comments and the concerns that hospitals have raised about their methodology and we've made it clear that we want to work with them so we can make sure that Americans have access to quality information that's going to give them the best understanding of what type of hospital and what kind of issues that hospital may have, so we are dedicated to working with them.

In the meantime, though, we want to be able to use what we have because we think it's important for patients to have that information.

Mr. Guthrie. Thank you very much.

Ms. Verma. But we will work with them.

Mr. Guthrie. Thank you very much. And last week or the week before last, I think last week we had a markup on a drug pricing bill here. And then the big concern that I have had and one of the great things that has been bipartisan was the Cures
Act, the things that we moved here. And being in D.C., when I talk to people back home that things are working and things are moving forward, it is the blockbuster drugs that are coming out, the blockbuster procedures. In the bill that was -- the CBO estimated that ten to fifteen remedies or cures would not come forward because of the impact of the bill.

And there were a couple of members on the other side, one that said ten to fifteen would be something to, you would just have to sacrifice for the fact of being able to negotiate lower drug prices. One said that well, if we have these blockbuster cures, we can't afford them, then what good are they, so essentially they are not -- the bill is better than those cures. And I just, my comment was, well, let's come up with the blockbuster cures and figure out how to pay for them and not lose them, because what if that one is Alzheimer's, diabetes, I mean all the things that are out there.

So my question is I get to is one of the ways is value-based arrangements and I know there are certain things such as Stark Law and other things that kind of get in the way of trying to do the value-based arrangements. Could you talk about value-based arrangements and pay, value-based arrangements for dealing with expensive cures?

Ms. Verma. Sure. Well, I appreciate the question and I think we are seeing the advent of new high-cost drugs. We've
seen drugs priced at a half a million dollars, a million dollars, two million dollars. I mean those are providing hope for so many patients because these new medications can actually cure diseases and can actually prevent some downstream costs for the healthcare system over the long term, so they can actually reduce costs.

That being said, I don't think that our system is set up to handle this. In the Part B program, we pay the average sales price plus an add-on of right now it's about 4-1/2 percent with a sequester. But it's an add-on payment, so if you think about paying an average sales price of a million to two million dollars, plus an add-on, I don't think the system can handle it. That being said, we do need to think about value-based.

Ms. DeGette. The gentleman's time has expired. The chair now recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes.

Ms. Schakowsky. Thank you.

Administrator Verma, your testimony before us, you said that "the individual market was in a state of crisis because of the ACA." But in reality, it is you and the Trump administration who have done everything you can to sabotage the ACA and reverse the law's historic gains in health coverage. So let's go over some of the record of the past 3 years, your record.

On his -- and the President's. On his first day in office, the President signed an executive order directing federal
agencies to undermine the ACA "to the maximum extent permitted
by law." Days later, CMS pulled the funding for outreach and
advertising for the final days of 2017 enrollment, and an action
estimated to have reduced enrollment by a half a million people.

You cut the number of days people could sign up for coverage
by half. You spent funds meant for promoting the enrollment on
a public relations campaign to undermine the law. HHS changed
its website, HealthCare.gov, making it more difficult for
consumers to obtain appropriate health coverage. For 2018 open
enrollment, you cut the outreach advertising budget by 90 percent
which resulted in as many as one million fewer people gaining
access to coverage.

You ordered the regional directors to stop participating
in open enrollment events. In 18 cities, including my hometown
of Chicago, you terminated contracts for in-person assistance
who guide applicants through the ACA enrollment process and was
designed to help them sign up for insurance, and those are now
gone. You slashed funding for nonprofit navigator groups that
help people shop for better coverage and you stopped making cost
sharing reduction payments to insurers even though CBO warned
that failure to make these payments would increase -- that would
increase premiums by 20 percent and add nearly $200 billion to
the national debt. And time and time again this

administration, including you and President Trump, himself, have
used inflammatory rhetoric to spread falsehoods and misinformation about the ACA. And though you have slashed funding for ACA enrollment outreach, you have certainly pushed taxpayer funds elsewhere. According to a press report, you personally approved the awarding of millions of dollars of federal contracts to Republican communications consultants who write your speeches, polish your brand, and travel with you across the country. This calls into question your stewardship of critical CMA resources that could be put to good use to give people coverage.

Administrator Verma, it is simply your tenure that has focused on undermining the ACA. We received a report yesterday that premiums will go down by four percent in 2020, but imagine how much more money Americans could have saved if you were uplifting the ACA and helping them to get coverage. President Trump has said that his only plan is to "let Obamacare fail." But you have gone further than that. You are actually sabotaging the law. You have led the effort, Administrator Verma. And, you know, you say -- we have heard for 10 years now, well, actually since the passage of the ACA that Republicans wanted to repeal and replace the law. Now you are telling us if there is a court decision very soon that overturns the Affordable Care Act that you have a plan. Where is the plan? Do you have a plan that you can present to us or is this another pie in the sky promise
Ms. DeGette. The gentlelady's time has expired.

Ms. Schakowsky. -- that we have heard for many years.

Ms. DeGette. The chair now recognizes the gentleman from Texas, Mr. Burgess, for 5 minutes.

Mr. Burgess. I thank the chair for the recognition. Just a point, here. For plan year 2017, navigators received $62.5 million in grants and enrolled 81,000 individuals. There was a group of 17 navigators who enrolled less than 100 people, costing the taxpayers $5,000 per enrollee. Contrast: agents and brokers are able to enroll people at a much more cost-effective rate.

We have had this discussion many times before in this committee.

Ms. DeGette. Will the gentleman yield?

Mr. Burgess. No, I will not. You know my time is limited. You have a quick gavel.

So, let me just ask you this. Which is the more cost-effective way of enrolling people? Is it navigators or is it agents and brokers?

Ms. Verma. I think the answer to that is agents and brokers. What we have found with the navigator program is that when we looked at the numbers, we found that the navigator programs weren't meeting their goals. And that, in fact, despite the spending they were actually enrolling less than one percent of all the enrollments. And when we did the math, sometimes we were
spending $5,000, $7,000 per person for these navigator programs. And so, we felt like there was a better way. If we looked at the previous administration, they had doubled their advertising budget, and even after they doubled the advertising budget enrollment went down and so we sought for a more cost-effective way. And all of our contracts at the agency are focused on promoting the work of the agency and we focused on finding new and cost-effective ways of enrolling people, like digital ads and those have been proven to be effective.

Under our administration, premiums are lower. There are more choices. We have a 90 percent satisfaction rate at our call center for open enrollment which has not happened before. It has only happened under our tenure. And because of the changes that we've made, because we've had a more efficient program, we're even actually able to use those savings to lower the user fees. We did that last year and I hope to be able to do that again in the future.

Mr. Burgess. That is an incredible figure about the call centers. And when the implementation of the Affordable Care Act came online in October of 2013, I did not take the special deal that Members of Congress afforded themselves, I went through HealthCare.gov and that phone interaction took 4 months to actually accomplish and it was one of the most miserable experiences I had ever been through in my life. So thank you
for improving the customer experience at that end. A lot of times people don't care about the politics. They just need the deliverable and it sounds like you are working hard on that.

Thank you for your commitment to Mr. Guthrie on -- we will be working on the next version of the Cures bill at some point over the coming months and, really, we do want to involve you and your office, members of the agency, in some of these fantastic gene therapies and self-therapies that are coming down the pike where a single shot may cure some significantly costly disease.

And Mr. Guthrie is right. We have to have a way with value-based purchasing or amortizing that cost over a longer period of time and certainly look forward to your help as the committee develops -- no good to develop the cure, if no one can afford to take it.

Let me just ask you a question, if I could, on prior authorization. I get a lot of comments from my physician colleagues about prior auth. What are you doing to make the prior authorization, your Patients over Paperwork, how are you trying to reduce the burden of prior auth?

Ms. Verma. Well, that's -- that is a issue that I hear a lot about from providers on the front line. We did a national listening tour and I will say that was one of the number one issues that physicians are complaining about, with good cause. As part of our Patients over Paperwork initiative, we've put out RFIs and we've heard from both sides on this.
I can tell you right now that I have a group of individuals at the agency that's working on how we can figure out how to ensure that we have the appropriate protections in place for program integrity because that's necessary. We want to make sure that evidence-based treatment is being provided to our beneficiaries, but at the same time the process can be burdensome.

Mr. Burgess. Yeah.

Ms. Verma. And it can get in the way of providing good patient care. It can create delays in care. So we're working on it and you can expect to see some action this year on that.

Mr. Burgess. I appreciate that. Let me just try to get one additional question. We have had a lot of discussion in this subcommittee and Health Subcommittee both last Congress and this Congress on the issue surrounding maternal mortality. Had a very good hearing the other day with Dr. David Nelson, the residency director at Parkland Hospital where I trained, in talking about his experiences at Parkland. Are there any tools that CMS does not currently have that would be helpful in addressing maternal mortality?

Ms. Verma. Well, this is something that I started my career on, working on the area of maternal and child health, so it's a very important issue to me. We've had a conference on this issue. Some of the things that we're working on is streamlining eligibility, so as women are on Medicaid and then moving to the
exchanges that we can make that process work better.

Ms. DeGette. The gentleman's time has expired. The chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes.

The Chairman. Thank you, Madam Chair. And I just want to pick up on the statement, you know, the questions you said about the administration's decision to ask the courts to strike down the ACA and the Republican lawsuit that is seeking to declare the entire ACA invalid. Obviously, if the district court ruling is upheld, Ms. Verma, you will be responsible for the largest coverage loss in U.S. history, or at least the President would be responsible for the largest coverage loss in U.S. history. Over 20 million Americans would lose their coverage, raising consumer costs and making lifesaving health care unaffordable for American families. Now, again, you know, as I said in my opening, if, you know, everybody on the right said, oh, that is fine because we don't want the federal government to do anything about people's health care, but that is not what I hear from the Trump or my Republican colleagues. They say they want to provide health insurance even though they are sabotaging everything.

So I wasn't here, but I want to know, does the President have a plan and what is the plan? I mean it sounds almost like there is some kind of secret plan that he doesn't want to reveal. Could you just tell us? What is the President's plan? Some
information about his plan in the event that he is successful in this awful lawsuit, what is the plan?

Ms. Verma. Well, I am not going to get into any specifics of the plan, but what I will say is that the President's healthcare agenda has been in action from day one. Our commitment to lower the cost of health care --

The Chairman. No, but I am not asking about that. You know, I disagree with you that he has had a plan so far other than to sabotage the ACA. But what I am asking is, if the court strikes down the ACA in this lawsuit, what happens then? What is he going to do next? What is his plan to deal with the reality that all these people wouldn't have health insurance?

Ms. Verma. We have planned for a number of different scenarios, but we need to hear from the courts. The President has made his commitment clear that he wants to make sure that people with preexisting conditions have protections, that Americans have access --

The Chairman. Well, I know. But you are not giving me any details other than saying that he is going to give us something. So, look. I think that the administration --

Ms. DeGette. Will the gentleman yield?

The Chairman. Sure.

Ms. DeGette. In the court, the administration asked for the entire Affordable Care Act including --
The Chairman. Right.

Ms. DeGette. -- the preexisting conditions and the kids to 26 and the gender disparities and everything. They asked for the entire thing to be struck down.

The Chairman. Right, right.

Ms. DeGette. They didn't ask for certain portions of the ACA to be retained.

The Chairman. But you see, this is my problem. And I want to move on to another topic, but my problem is, again, if the administration -- if the President was honest and said, look, I am just going to -- I want to get rid of the ACA. I don't have anything else. I don't think people, you know, the federal government should be involved in health care, you are on your own, then I would say, okay, that is your ideology. I don't agree with it, but I understand that is where you are coming from. I just think it is so deceptive though to suggest that somehow we are going to cover everybody and we are going to do something better, but not give us anything. And you are not giving us anything.

But let me go back to my other issue with, that I mentioned before about not being responsive. In June I sent you and Secretary Azar letters requesting -- oh, I am going back to this memo.

In April, you finalized a marketplace rule that changed the
formula for ACA's subsidies despite your own objections to the policy, and I appreciate your objections. In fact, in an internal memorandum to Secretary Azar dated August 2018, you wrote that, I quote, "I recommend not moving forward with this policy and that such a policy would cause coverage losses, further premium increases, and market disruption." And you cautioned that if the policies under consideration are adopted, and I quote, "exchange enrollment would decline by 1.1 million," and you wrote that these actions could result, I quote, "potentially, in bare counties or states with no subsidized coverage available."

My question is, do you still believe that this policy would likely result in families losing coverage?

Ms. Verma. I think there are several policies in that memo. I am comfortable with the final rule and where we came out and I think that the evidence is clear that premiums are lower.

The Chairman. All right.

Ms. Verma. We have more choices available on the exchanges so the actions that we have taken have resulted in Americans having more choices about their health care --

The Chairman. Well.

Ms. Verma. -- and have lower premiums for the first time since the Affordable Care Act started.

The Chairman. All right, I understand that. That -- in June I sent you and the Secretary letters requesting the
underlying analysis that is discussed in the memo and the analysis of the impact of those policies conducted by CMS Office of the Actuary, and last week I sent you and Secretary Azar a follow-up letter reiterating my request. I requested a complete response to my letter by October 30th, but so far, as I have said, I have received a one-and-a-half-page response that answers none of my questions, not a single document. Your response has been unacceptable and Congress and the American people have a right to know what exactly the analysis shows.

So again, would you commit to providing those documents to my letter by October 30th?

Ms. Verma. CMS is a subagency. We are under HHS and all of the documentation requests are handled by HHS and so I would refer your question to the agency.

The Chairman. Well, I mean that is a really poor excuse.

Ms. DeGette. The gentleman's time is expired.

The Chairman. Thank you.

Ms. DeGette. The chair now recognizes the gentleman from West Virginia, Mr. McKinley, for 5 minutes.

Mr. McKinley. Thank you, Madam Chairman.

Administrator, I think we virtually owe you an apology for the way you have been treated here. I have been -- I go home every weekend and I talk to the people. West Virginia, yes, is a red state. I was in Indiana the weekend before, a red state.
But I was in Boston for a meeting up there and I heard the same thing from people on the street and we talked to the waitresses at how people, what is going on in Washington. And they talked about the tone, the accusatory language that is used, the lack of civility.

And today I think it has hit a new point by this word "sabotage." Probably been, we are 42 times already today it has been used like someone found it in a new dictionary that they want to use to try to stir up things. People are appalled by this and they want us to work together and to accuse you and this administration the way they have, I apologize for that.

Ms. Verma. Thank you.

Mr. McKinley. Now, let me ask you a couple questions, however, and that is in West Virginia and Appalachia we are disseminated with the opioid crisis and we are trying to find ways of can there be something set up. So I am going to go away from what they want to -- their sandbox they want to play in.

I want to -- what are ways that we can provide some additional funding or something for non-opioid rehabilitation treatment? Because we have got -- there are incentives all for using opioids, but what about some of the other non-opioids? Could you come back with -- when you all put together your rule there is nothing in there about that, the non-opioid treatment, and I really hope that we can do that. Can we work together,
Administrator, on that?

Ms. Verma. Sure. CMS has worked with state Medicaid programs. We've actually approved 26 state Medicaid 1115 demonstrations which permit states to expand services for care for substance use disorder in institutions for mental disease and we have actually been working to implement all the sections of the SUPPORT Act that relate to CMS.

In relation to your question, I will have Our Office of Legislation reach out to you and your staff to work on that.

Mr. McKinley. If you could, I would like to follow up with that. And the other is, and it began, again I am not going to trash this administration and I am not going to trash the previous administration. We just have difference of opinions, but we can talk to each other. But what we asked under the Obama administration was where did the, for the rehabilitation, for the Medicaid, Medicare, 28 days, where did that come up with? And no one has ever gotten back to us on that with -- so, I am curious to you, do you have an opinion? Is -- and it is a trick question here, is 28 days enough for rehabilitation for someone deep in drugs?

Ms. Verma. Well, I'd like to consult with our agency experts and I'll have our department of legislation reach back out to you.

Mr. McKinley. Wouldn't you be suspicious? Because we have
had to deal with this pretty severely. We have 52 deaths per hundred thousand in West Virginia. We are leading the country on this. Every rehabilitation center I go to asks me that question, where did the 28 days come up from? And I have asked that back under the previous administration and I am asking it now under the -- can we consider at least maybe a pilot project that maybe goes for 120 days or 180 days to find out? Because the impression I am getting under both administrations is that we are looking for quantity of people getting treatment, not quality, and if we put someone in a treatment facility for 120 days, I think the outcome is going to be far better than 28 days. So I really hope that you can get back to me on another time; is that fair to say?

Ms. Verma. That's fair to say, and we'll have our legislative folks reach out to you. But thank you for your question.

Mr. McKinley. Thank you. And again, I apologize for the way you have been treated in this committee so far, okay. Thank you. I yield back my time.

Ms. DeGette. The gentleman yields back. The chair now recognizes the gentleman from Massachusetts, Mr. Kennedy, for 5 minutes.

Mr. Kennedy. Madam Administrator, thank you for being here.

In Arkansas, more than 18,000 Medicaid recipients lost coverage
after CMS approved a work requirement in that state, and in New Hampshire it was nearly 17,000. Both states, the evidence suggests that a large number of these people were either working or eligible for exemptions, but they lost coverage or would have lost coverage because of red tape. Now you might try to tell us that those people found jobs and employer-sponsored coverage, but a recent study from the New England Journal of Medicine found that Arkansas's work requirement increased uninsured rates without increasing employment. Madam Administrator, are you aware of that study?

Ms. Verma. So, first of all, community engagement --

Mr. Kennedy. Ma'am, yes or no. Are you aware of the study?

I have 5 minutes.

Ms. Verma. I'm sorry. Can you repeat the question?

Mr. Kennedy. Are you aware of the New England Journal of Medicine study that says that people lost health care because of work requirements in Arizona, or excuse me, in Arkansas?

Ms. Verma. I'm aware of the article.

Mr. Kennedy. Okay. So in November of last year, MACPAC, a nonpartisan agency that makes recommendations on issues affecting Medicaid, said that low-level reporting in Arkansas was "a strong warning that the current process may not be structured in a way that provides individuals with an opportunity to succeed with high stakes with beneficiaries who fail." And
they called on you to pause disenrollments in order to make
adjustments to the program.

CMS did not pause disenrollments. Instead, you approved
the work requirements in additional states. Why did you approve
work requirements in additional states and not respond to the
concerns of MACPAC?

Ms. Verma. Community engagement requirements are about
improving the lives of people in the Medicaid program --

Mr. Kennedy. Ma'am, can you point to me to one study that
says that a work requirement makes people healthier? One?

Ms. Verma. So I have worked with the Medicaid program for
over 20 years --

Mr. Kennedy. Ma'am, one. I asked Secretary Azar this
question, first question last year. I am certain you were
prepped.

Ms. Verma. There are many studies that talk about how
employment has a positive impact on health outcomes. There are
numerous studies.

Mr. Kennedy. Ma'am, excuse me. No, excuse me. That is
-- once again, Secretary Azar, I asked this question to him 8
months ago. He gave the exact same answer. You guys run
healthcare programs in this country. I am certain you understand
the difference between correlation and causation. Healthier
people might work. Work doesn't necessarily make people
healthier. You are imposing policies on millions of people across this country. Can you show me one study that says that is a good policy?

Ms. Verma. I've spoken to many people on the Medicaid program --

Mr. Kennedy. I will take that as a no.

Ms. Verma. -- living in poverty and none of those individuals want to --

Mr. Kennedy. Reclaiming my time, ma'am, so.

Ms. Verma. -- stay where they are. They want to find a pathway out of poverty.

Mr. Kennedy. I am sure they do. So let's talk about Adrian McGonigal who lost his Medicaid coverage in Arkansas because of the onerous work requirement that you approved. Without Medicaid his medication was going to cost him $800, so he did what anyone would do, he left it at the pharmacy, did his best to ignore preventable pain and suffering, he failed, the illness caused him to miss a few days of work and he got fired. Your work requirements caused him to lose a job and his health care.

And again, do you consider that a success, yes or no?

Ms. Verma. I think it's premature to draw conclusions about Arkansas. The program --

Mr. Kennedy. Is it premature to draw the conclusion for

Mr. McGonigal?
Ms. Verma. The program was in effect for 10 months. What
I will say about --

Mr. Kennedy. Eighteen thousand people lost their health
care. How many more people have to lose their health care before
you can make a determination?

Ms. Verma. Community engagement is about giving people a
pathway out of poverty. People don't want to live in poverty.

Mr. Kennedy. Show me the data that says that -- no one wants
to live in poverty. Show me the data that this actually lifts
people out of poverty. One study. One.

Ms. Verma. Again, there are studies that show that when
we're looking at the social determinants of health and we look
at --

Mr. Kennedy. Ma'am.

Ms. Verma. -- improving somebody's health status --

Mr. Kennedy. You are not going to spin me --

Ms. Verma. -- just giving them insurance --

Mr. Kennedy. You are not going to spin me for the 5 minutes.

Ms. Verma. -- is not going to solve the problem.

Mr. Kennedy. I'm going to reclaim my time, so.

Ms. Verma. We need to address holistic issues.

Mr. Kennedy. Ma'am, are you aware -- you talked about the
financial aspects of trying to deliver health care in a fiscally
responsible manner. Are you aware of how much Kentucky is
planning on spending to implement its work requirements?

Ms. Verma. I have recused from the Kentucky matter.

Mr. Kennedy. I will answer it for you. It is $190 million over 2 years. Do you know what per capita annual expenditure on CHIP in Kentucky is?

Ms. Verma. So states are making investments --

Mr. Kennedy. Two thousand dollars.

Ms. Verma. -- trying to improve the lives --

Mr. Kennedy. Two thousand dollars.

Ms. Verma. -- of the people they serve and those are one-time implementation costs.

Mr. Kennedy. Ma'am.

Ms. Verma. And that if --

Mr. Kennedy. Reclaiming my time. Are you --

Ms. Verma. -- that are spread over the costs of the --

Mr. Kennedy. A contract that --

Ms. Verma. -- that relate to the program.

Mr. Kennedy. A contract that was made for your PR speechwriting and events services was referenced already earlier in this hearing. Are you aware that one of the line items was for a confidant of yours named Marcus Barlow who is scheduled to receive $425,000 over the life of that contract, 1 year?

Ms. Verma. All of the contracts that we have at CMS are based on promoting the work of CMS.
Mr. Kennedy. So --

Ms. Verma. When we use contractors we use them for two reasons. One reason would be when we require specialized expertise that we may not have in-house.

Mr. Kennedy. Ma'am, specialized expertise to write speeches, are you aware that for that same cost 2,000 kids could have -- excuse me, 200 kids in CHIP, eligible for CHIP in Kentucky, could have kept their health care?

Ms. Verma. The contracts that we have --

Mr. Kennedy. What is a better use of those healthcare dollars, of U.S. taxpayer dollars, to employ an additional communications person underneath CMS that already has dozens, if not hundreds, or 200 more kids that could get access to health care? What is a better stewardship of those taxpayer dollars?

Ms. Verma. The use of our contracts are to promote the programs that we have in place. We use contractors --

Mr. Kennedy. At the expense of those 200 kids?

Ms. Verma. Those contracts are consistent with what previous administrations have done.

Mr. Kennedy. At the expense of those 200 children.

Ms. Verma. Those contracts that we have in place are consistent with how the agency has used resources in the past and they're focused on promoting the work. One of the things that we want to do is make sure that people understand --
Ms. DeGette. The gentleman's time has expired.

Mr. Kennedy. That is a shame.

Ms. DeGette. The chair recognizes the gentleman from Virginia for 5 minutes.

Mr. Griffith. Thank you very much.

Did you wish to finish your answer?

Ms. Verma. Yes. So what I was trying to say is that the contracts that we have in place are about promoting the work of the agency. One of the things that I wanted to do when we came to CMS is make sure that the American people understand the things that we're doing. We've had a historic number of initiatives, 16 initiatives, and it's important that the American people understand that. We did not have that expertise in-house at the time.

And the other thing that we use contractors are for is when we have something that we cannot do in-house, so that's one reason or we need some short-term help. My job at the agency is to set the vision and set the agenda and it's up to other staff members to determine whether that work can be done in-house or whether we need to hire contractors.

Mr. Griffith. And in relationship to CHIP, wouldn't you agree that the Championing Healthy Kids Act was a major step forward?

Ms. Verma. It absolutely was. I think it's very important
that children have access to healthcare coverage, very important to their development.

Mr. Griffith. And would you be surprised to learn that a number of members of this committee voted no, particularly those on the other side of the aisle?

Ms. Verma. That would be very concerning.

Mr. Griffith. I understand. Also, I find it interesting, just cleaning up some stuff here, that CBO estimates that 2.6 million more people have employer-funded insurance today than before President Trump took office. Were you aware of that?

Ms. Verma. Yes. I think that our agency's success and the success of the administration is clear. Premiums are lower not only in the exchanges but also in Medicare. There are more choices for people in Medicare and in the exchanges, more than what we had when we came into office.

Mr. Griffith. Now, we have heard a lot today about sabotage, and my friend, the gentleman from West Virginia, Mr. McKinley, talked about the fact that sabotage has been used a lot. But I would have to say to my colleagues on the other side of the aisle that when you write a bill such as Obamacare and you put in there, 3,033 times the words "the Secretary" appears and 974 times the words, "the Secretary shall" appear. And off the top of his head, Dr. Burgess indicated there were about 262 times that you if you kept going out, you know, "shall determine," "the
Secretary shall determine," appear, roughly, and we will have to double check that one but that is off the top of his head.

Wouldn't you think it would be unfair to say that the law had been sabotaged when the Congress -- now, remember, that was a bill passed, Obamacare passed specifically and only by Democrats, no Republicans in the House voted for it. So if it was sabotaged, it was sabotaged because they gave too much power to the administrative branch of government and today they find themselves with an administrative branch of government that has a different philosophical outlook and, therefore, if it were in fact sabotaged, it was sabotaged at its initiation in the passage of that bill. Would you agree with me on that?

Ms. Verma. I would agree and the results speaks for themselves. Premiums are lower. When I got into my role, premiums were going up, a hundred percent in some cases, some two hundred percent in some cases. This is for the first time that we've actually seen premiums go down. They went down last year. They're going down again. We've put out over 12 reinsurance waivers and in some cases you've seen double-digit decreases, 30 percent.

So for all the work that we're doing, I don't know how we measure that but to me that looks like success.

Mr. Griffith. Yes, ma'am. And now so let's get to something else I need to talk about. Earlier this year it came
to my attention that CMS planned to include noninvasive ventilators in Medicare's competitive acquisition program for durable medical equipment. In June, Mr. Welch and I led a letter signed by 180 of our colleagues expressing concern about that decision.

I support the goal of ensuring financial responsibility in health care, but I am not convinced that this method is appropriate in every situation. Until we know that access to a critical piece of medical equipment won't be compromised, I don't think we should be making monumental changes to the acquisition process. And I just got your letter -- it arrived late yesterday afternoon -- in response to that letter where you said we are not going to do it on invasive.

But here is the problem I have. I have a rural district as does my friend Mr. Welch. And what happens is, is that if you go to this cost-only issue, in those rural areas you are going to make somebody drive 45 minutes, an hour. I remember talking to one of my suppliers about a case where the lady lived on top of one of the two highest peaks in Virginia, and he took her oxygen up there to her and made sure that she had what she needed for her ventilator supplies, noninvasive. She is not coming down the mountain, particularly not in the wintertime, to get what she needs if now the low-cost supplier is only located in the town. And if it becomes a point where they have to get to Bristol,
you are talking about even more time. But just to get down the
mountain to Marion it is going to take a lot of time. So I would
ask you all to really take a look at that because I am afraid
that in the rural districts our folks are not going to get served.
I yield back.

Ms. DeGette. The gentleman's time has expired. The chair
now recognizes the gentleman from California, Mr. Ruiz, for 5
minutes.

Mr. Ruiz. Thank you. This administration has made clear
from day one that they will not protect people with preexisting
conditions or protect access to affordable health care for
Americans. They continue to repeal the ACA first through
legislation and when that failed through the courts. And in lieu
of complete repeal, they have done everything they can to chip
away at the protections that it provides. Repealing the
protections harms patients but helps insurance companies make
greater profits. It gives them power to deny and delay care for
people who really need it. And as a physician I took an oath
to do no harm, and trying to take affordable coverage away from
millions of Americans flies in the face of that oath. I practiced
medicine before the passage of the Affordable Care Act and I saw
what that meant for patients.

So let me tell you a little bit about what that was like.

In fact, even when I was in medical school, during my medical
school graduation at Harvard Medical School, my whole family, I have a big family and they came from everywhere. And we were in my tiny little apartment and we were getting ready for my ceremony and my little sister curls over in excruciating abdominal and flank pain, excruciating, shaking. And we were so very concerned, but she refused to go to the Emergency Department. It wasn't necessarily because she was going to miss my graduation, she didn't want to be a burden to us for that, but primarily she didn't have health insurance and she couldn't afford it and she was so afraid, so she just endured it. And that is what families do throughout our country, they endure this pain. Well, she was 22. Now, she could have been on her parents' health insurance.

The second story is like a man 55 years old from Palm Springs with HIV positive status. Before the Affordable Care Act, infections after infections, life-threatening, very concerned he wasn't going to live past, you know, 58 or something. And now because of the Medicaid expansion, he is happy. He is living well. He finally can get the care and the medications and everything that he can have and he is living that life that he has always wanted to.

It is like that young mother of two who came into my Emergency Department with the chief symptom of "a lump in my breast." And I am thinking, a lump in your breast? Why are you coming during
the holidays for a lump in your breast? She didn't have any primary care. She didn't have insurance. She knew it was growing, it was the size of a lemon. It was irregular in form, it was painless. Her sister forced her because they knew what they were afraid of. And, sure enough, it was most likely cancer. I was able to connect her with post-Emergency Department care. But because of the Affordable Care Act that preventive mammogram is now covered and that she couldn't afford it and now she potentially had cancer metastasized to her body. That is why we are angry. It is for those patients that we are standing up. It is for the American people who are today scared that we are going to go back to a time where they are going to be denied and delay, that they are going to endure pain, that they are going to potentially lose their life and leave their children behind, that they are going to suffer infections, and that is why are pressing you and this administrations for those questions. Because this administration is encouraging the Supreme Court to strike down the ACA in its entirety, all of it. There is no defense in court to protect people with preexisting condition. There is no defense in court for the young people to stay on their parents' health insurance. There is no defense of the Medicaid expansion. There is no defense of protections for preventive care that help my constituents, my patients, and my family.
There is no defense for the American people in those protections for them. And to make matters worse, you have no plan. You can't produce a document. You can't give us a detail. You are skirting the issues and all we are getting is only spin and talking points. The American people deserve better. I yield back my time.

Ms. DeGette. The gentleman yields back. The chair now recognizes the gentlelady from Indiana, Mrs. Brooks, for 5 minutes.

Mrs. Brooks. Thank you. And thank you, Administrator Verma, for being here today.

Actually, the stories that you have heard from my colleagues, I assume that in your role for the last 3 years, you have mentioned that you have been having roundtable discussions. And that wasn't what I was originally going to ask you, and I do want to save a little time for what I want to talk about with you. But can you share very briefly how you do stay connected with the patients and the people you are trying to serve?

Ms. Verma. Well, I appreciate that. We've done a national listening tour and we talk to people all over the nation.

Mrs. Brooks. People who -- can you share who these people --

Ms. Verma. People who are having trouble --

Mrs. Brooks. Yeah, the type of people you talk to?
Ms. Verma. -- affording Obamacare. And so, in the examples that were used previously, I'm scared for those people too, because if they don't have a subsidy they often cannot afford health insurance under Obamacare. Obamacare structure is so expensive that the middle class can't afford health insurance and that's why we're seeing increases in the number of uninsured because premiums have gone up a hundred percent, two hundred percent.

And while this administration has stabilized the market, premiums are going down, they are still too expensive and if you do not have a subsidy and if you have a preexisting condition, you do not have protections today. And that's why this administration is trying to advance efforts to try to make sure that every American has access to affordable coverage. That is not the case today.

Mrs. Brooks. Thank you. I want to pivot and focus on you talked about the role of technology and innovation in the healthcare system. Medical error is the third leading cause of death in the United States responsible for claiming over 400,000 lives and millions of dollars are wasted on duplicative and unnecessary tests and procedures. We know that patients want their up-to-date medical information at their fingertips.

Congresswoman Clarke, a colleague of mine across the aisle, and I introduced the Mobile Health Record Act and it directs CMS
to do more to promote the use of secure medical records approved
by CMS through the Blue Button 2.0 program. The proposed CMS
Interoperability and Patient Access rule is to be published before
the end of the year requiring Medicare Advantage plans first and
Medicaid plans next, to offer open APIs for their plan enrollees
to access their medical data with their mobile application of
choice.

And you mentioned more and more patients are tech-savvy and
want this type of access, but I am, remain concerned about the
lack of public promotion or awareness of the CMS Blue Button
program and its Medicare-approved apps for the 60 million Medicare
beneficiaries. And, in fact, a recent survey showed that only
three out of a hundred Medicare Advantage members are even
familiar that the Blue Button 2.0 program exists.

Knowing how important this is, what more can be done to reach
new enrollees? It is very complicated to get through your
websites and process to find the Blue Button and yet people want
to have their medical records in their hands. So can you talk
to us about what your plans are to improve access to our own medical
records?

Ms. Verma. I appreciate the question and I agree with you
that we can do more to make sure that people understand what's
available. The issue of patient records, and if you'll indulge
me for a second, I'll tell you a story because I think it sort
of sums up the issue of patient access.

My family was traveling, they were headed home. I was headed back to D.C. when my husband had a cardiac event. He had a major seizure. My daughter called me and handed the phone to the paramedics and they said, ma'am, your husband's not breathing and we need to understand his health history. Is there anything in his health history?

And at that moment --

Mrs. Brooks. How long ago was this?

Ms. Verma. This was about 2 years ago, in 2017. And so, at that time, you know, obviously I'm in a panic, but I did not have that information. My family didn't have that information and my husband was in no condition to tell us about his health history. And I scrambled for about 2 hours in the time that it took me to get to my kids and get to my husband to try to find this information.

In the end, the hospital had to do a number of tests because they couldn't figure out what was wrong. Luckily, he's okay and he survived something that maybe less than one percent of people survive, so he was very lucky. But when I left the hospital, I asked the staff there, can I have a copy of all the tests that you performed, so I had a complete medical record to give back to his doctors in Indiana, and, unfortunately, all they could give me was a CD-ROM.
So after our federal government spent $36 billion on electronic health records, all I got was a CD-ROM, which really only had a record of one test, and so that really spoke to me of the issues. Patients need to have access to their complete medical records so that we can understand the issues that we face.

Mrs. Brooks. Can I interrupt? Are you going to dedicate more people to this and how are you going to fix this?

Ms. Verma. This is one of our main priorities. We have several rules. One is about making sure insurers are providing claims data to patients. We are giving incentive payments to physicians to make sure that they're providing data to their patients. Hospitals are facing penalties.

Ms. DeGette. The gentlelady's time has expired. The chair now recognizes the gentlelady from New Hampshire, Ms. Kuster, for 5 minutes.

Ms. Kuster. Thank you. And thank you, Ms. Verma, for being with us today.

A quick yes or no question before we start. I understand, yesterday, Secretary Azar said that the reason he is not concerned about the court decision ending the ACA overnight is that he is relying upon an appeal to the Supreme Court. Is that your position? Is that why you don't have a plan to tell us today?

Ms. Verma. We have planned for a number of different scenarios.
Ms. Kuster. But are you expecting --

Ms. Verma. I think what the Secretary is speaking to is that this is going to take some time for the courts to resolve, but we have planned for a variety of different scenarios.

Ms. Kuster. Including an appeal to the Supreme Court?

Ms. Verma. Correct.

Ms. Kuster. So, because I am a little confused today by your testimony and particularly by the testimony of our colleagues. I have been in Congress for 7 years. I voted 55 times not to repeal the Affordable Care Act because our colleagues were so persistent about week after week, month after month voting over and over again to repeal the Affordable Care Act in its entirety. And now this administration is in court asking to repeal the Affordable Care Act in its entirety. And yet, you sit here today singing the praises of the Affordable Care Act and how proud you are of your work to bring down the rates, but at the same time you are cutting access for 400,000 children.

That was your testimony this morning.

So I just want to move to a particularly important part for my constituents which is the issue of preexisting conditions.

And you will recall that before the Affordable Care Act, Americans could be denied their health insurance coverage if they had any kind of a preexisting condition. I think about it in my family. I will just start at the beginning of the alphabet,
asthma, allergies, Alzheimer's, cancer, diabetes, the list goes on and on. And, in fact, over 50 percent of Americans have a deniable condition.

In New Hampshire that is 54 percent of our citizens have a deniable condition, and yet your administration, in fact your own actions with the short-term limited duration health plans -- by the way, a classic Washington, D.C. doublespeak, short-term limited duration health plans -- have threatened families with preexisting conditions. And, in fact, you have encouraged states to promote junk plans through their waivers in order to circumvent essential health benefits and protections for preexisting conditions.

I was very proud to lead bipartisan legislation. It passed the House, Protecting Americans with Pre-existing Conditions, last May, and it will ensure that people with preexisting conditions are covered. But let me ask you, do you believe, Ms. Verma, that allowing individuals to once again be discriminated against or have their coverage declined due to preexisting conditions is moving America in the right direction for their health care? Just yes or no.

Ms. Verma. None of the actions that we have taken do anything to undermine the protections for people with preexisting conditions.

Ms. Kuster. Well, encouraging junk plans that do not cover
Americans with preexisting -- we heard the testimony right here. We had families right in front of us and they had no idea. There was no requirement that they be warned of that and instead of 3 months, these were a year and they could be re-upped multiple times. So I think your testimony is not actually truthful to us today and I regret that. According to a 2019 study by the Kaiser Family Foundation, half of Americans as I mentioned have a declinable condition. Did your agency conduct an analysis to evaluate the effects of the implementation of your guidance on these families and their access to affordable health insurance? Yes or no.

Ms. Verma. I'm sorry. Which guidance are you referring to?

Ms. Kuster. The guidance that you provided about the waivers and the junk health plans, did you analyze the impact on American families that had preexisting conditions? Yes or no.

Ms. Verma. So in the issue of the 1332 guidance that we put out for states, I can tell you that states have had an enormously difficult time --
Ms. Kuster. -- analyze what would happen to families with preexisting conditions? Yes or no.

Ms. Verma. The way the guidelines work is we give basically direction to states about how they can develop plans to make health insurance more --

Ms. Kuster. I am asking if your office analyzed the impact of your guidance. Yes or no. This is not difficult.

Ms. Verma. So we have to impact -- we would have to review the proposals. And so for every proposal --

Ms. Kuster. And can you provide that to this committee, your analysis?

Ms. Verma. Every proposal that comes in under 1332 is analyzed around the four guardrails around comprehensive coverage.

Ms. Kuster. And could you provide that analysis to this committee? My time is up. Yes or no.

Ms. Verma. So every single proposal that comes in --

Ms. Kuster. Yes or no, you'll provide that analysis to this committee?

Ms. DeGette. The gentlelady's time has expired.

Ms. Kuster. My time is up.

Ms. DeGette. The chair now recognizes the gentleman from South Carolina, Mr. Duncan, for 5 minutes.

Mr. Duncan. Thank you, Madam Chairman.
Administrator Verma, I will let you finish answering her question if you need to.

Ms. Verma. Sure. So let me start with short-term limited duration plans. These are plans that have been available before Obamacare started and during Obamacare. They used to just be available for 3 months and we extended the period of time. We also made sure and we strengthened these protections, which were not in place under the previous administration, to make sure that people understood what type of plan that they were buying and what the limitations were of these plans.

But there are so many Americans today that cannot afford coverage under Obamacare when rates have gone up a hundred to two hundred percent, and I gave you some examples of a couple in Nebraska. They are 55 years old and the premiums that they would have to pay are anywhere between a third to half of their income. Short-term limited duration plans provide a lifeline. They can provide coverage at rates that are perhaps 60 percent lower than what they could find under Obamacare, so it provides an alternative.

There's many people that are in between jobs that cannot afford Obamacare and this is an alternative. And our administration has done everything that we can to ensure that there are protections in place and that those plans clearly articulate the limitations of what they may or may not cover.
Mr. Duncan. Yeah. Thank you for that. I apologize for how some of my colleagues have treated you today.

Let me say I appreciate the multiple conversations we have had regarding some of the nursing home issues occurring across the Southeast Region. We have touched on topics including inconsistencies and civil monetary penalties, citations given among the regions, and how facilities in Region 4 have been especially hit. We have also touched on the important need for specific guidance to be provided for abuse reporting rules.

Another thing I would appreciate you looking further into is the red consumer alert icon that could be placed next to nursing homes that have been cited for incidents of abuse and the Nursing Home Compare website. I understand this initiative goes into effect today. However, I feel CMS needs to fully solve the CMP and abuse reporting issues, first, before we go negatively labeling facilities online. If facilities in the Southeast Region don't get relief soon, we are going to be in a tight spot.

So can you and your staff please comment or at least commit to revisiting the issue of consumer alert icon being implemented?

Ms. Verma. Well, we've put out a five-part strategy on strengthening oversight, enhancing enforcement, increasing transparency, improving quality, and putting patients over paperwork. One of the things that we've done is we have clarified immediate jeopardy guidelines. And I agree with you that there
has been inconsistency in how CMS and state agencies has
implemented the guidance and so that's why we've created a new
performance standard system so that we can monitor what's going
on in the local level to ensure that we have consistency in how
we are clarifying immediate jeopardy in cases of abuse and
neglect.

In terms of the icon, there's about maybe five percent of
nursing homes that will be impacted by this and it only alerts
those in which we've had cases of abuse and neglect. And, you
know, if there's other types of issues that have come up, they're
sort of, I would say, not high-level areas of abuse and neglect,
in those areas we only use the icon if they have been repeat
offenders.

So this isn't really going to impact very many nursing homes.
There are many nursing homes that provide high-quality care,
but there are some out there and we think it's important to make
sure that the American people have the information that they need
to make the decisions that work best for them.

Mr. Duncan. In the essence of time we will move on. We
will be watching some of the reforms and how they impact the
nursing home facilities.

I want to touch base on one other thing and that is the
exchange program integrity Section 1303 in the Affordable Care
Act. We have asked, we talked yesterday about this. You say
that the ruling finalization is supposed to be in HHS's hands now. Open enrollment period begins November 1st and I think clarification on this is important. We sent a letter July 1, me and many, many of my colleagues signed this, asking for Secretary Azar to approve that.

I want to submit that if we can, to the record, Madam Chair.

And also want to urge my colleagues, I am going to send another letter today if you would like to sign on to that on the 1303 urging fast implementation.

Ms. DeGette. Without objection, the letter will be entered.

[The information follows:]
Mr. Duncan. I would also like to add a letter from some of the care providers that have urged us to take action as well, for the record.

Ms. DeGette. We will review that letter. I haven't seen that letter.

Mr. Duncan. Thank you. It is important that this rule get finalized, and it was proposed November of 2018. That is almost a year later and it still hasn't been. Can you speak to the work CMS has done to help finalize this rule and what the current status is? We know it is in Azar's hands, but if you would like to touch base on that in 10 seconds.

Ms. Verma. We share your commitment to getting that rule finalized and we'll be doing everything that we can to bring that to fruition.

Mr. Duncan. Okay. If any colleagues want to sign on to that letter to Secretary Azar today by close of business you can contact my office. I yield back.

Ms. DeGette. The chair will admit the second letter that the gentleman referenced.

[The information follows:]

**********COMMITTEE INSERT**********
Ms. DeGette. The chair now recognizes the gentlelady from Florida, Ms. Castor, for 5 minutes.

Ms. Castor. Thank you, Madam Chair. And thank you, Administrator Verma, for being here today.

The Trump administration has made numerous policy changes that increase the costs on families across this country, increase health insurance premiums, and erode coverage for preexisting conditions, preexisting conditions like cancer and diabetes.

We had all hoped that this fight was over, but we are going to continue to have to work to make sure that families who have preexisting conditions get their coverage.

You stated earlier in your testimony that the Trump administration policies have stabilized costs. There is no evidence of that. A recent study by the Kaiser Family Foundation estimates that 2019 premiums are 16 percent higher than they otherwise would be due to the Trump administration's actions.

And a report out of your own agency has established that the various sabotage policies of the Affordable Care Act has increased costs on families who are not eligible for tax credits.

And one of the most egregious policies that has increased costs is the expansion of the junk health insurance plans, the short-term limited duration plans, because what has happened, after the Trump administration and the GOP failed to repeal the Affordable Care Act and dramatically cut health services under
Medicaid, they turned to a very insidious plan to cut outreach
and enrollment, weaken the health insurance pool by eliminating
navigators, and then marketing, allowing these junk insurance
plans to roll out, to the detriment of the families we represent.

These junk insurance plans do not have to cover preexisting
conditions. They don't have to cover hospital ER care or
prescriptions drugs. They don't have to cover mental health
services. And when Secretary Azar was here, Madam Administrator,
we asked him, I asked him specifically, are you aware that these
plans can exclude coverage for preexisting conditions or decline
to offer coverage to individuals with preexisting conditions,
yes or no? And he responded, "Yes, that's correct."

Do you disagree with him that these junk insurance plans
don't have to cover preexisting conditions, or you agree with
Secretary Azar?

Ms. Verma. Short-term limited duration plans provide more
flexibility. And under our administration, premiums --

Ms. Castor. Well, by flexibility are you saying, you agree
then they don't have to cover preexisting conditions. That is
-- see, this is very dangerous because we are about to enter into
an open enrollment period, right, the open enrollment under the
Affordable Care Act dates are -- what date?

Ms. Verma. They start November 1st.

Ms. Castor. And run through?
Ms. Verma. They go through December 15th.

Ms. Castor. Okay, so be careful, consumers, families across the country. If you go online and you type in, I am looking, shopping for health insurance sometimes what will come up will be one of these junk insurance plans. The Federal Trade Commission has already had to act and shut down some of these fly-by-night health insurers calling it a bait-and-switch scheme.

So when you are shopping for your health insurance, be careful. A lot of these companies are going to market a plan that says, oh yes, we will cover you. We will cover your preexisting condition, and then they find it is not covered. In fact, the nonpartisan Congressional Budget Office confirmed in a report that short-term plans have large coverage gaps that expose consumers to catastrophic costs especially for folks with preexisting conditions. For example, a woman who enrolled in a short-term plan and was then diagnosed with breast cancer could face between 41,000 and $111,000 in out-of-pocket costs. That is from the CBO and the American Cancer Society Action Network.

Another one of the insidious sabotage efforts has been to our independent navigators across the country. And there is a lot of misinformation coming out that oh, navigators aren't effective. Well, if you go to the Kaiser Family Foundation report and the Government Accountability Office report from the past few months, they said, wow, HHS is pedaling false information.
These navigators are -- brokers are fine, but navigators do not have allegiance to an insurance company, they have an allegiance to the consumer, often help them sort through all of their affordable options. So it is really unwise to eliminate navigators on one hand, market junk plans, cut outreach and enrollment -- all of these things undermine a health insurance pool that helps keep costs down for families.

Ms. DeGette. The gentlelady's time has expired.

Ms. Castor. Thank you very much. I yield back my time.

Ms. DeGette. The chair now recognizes the ranking member of the full committee, Mr. Walden from Oregon, for 5 minutes.

Mr. Walden. Good morning, Madam Chair. And, Ms. Verma, thank you again for being here. We appreciate your leadership at the agency and your sitting through these discussions.

I want to talk about the navigators, because in the CMS report that I believe is from 2016, which is before the Trump administration, for plan year 2017, navigators received $62.5 million in federal grants, they enrolled 81,426 individuals, which, if I understand that right, equates to $767 per person is the math if you divide the total number enrolled versus the total amount spent. Now also, according to CMS from the Obama administration data, 17 navigators enrolled less than a hundred people each at an average cost of $5,000 per enrollee and 78 percent of the navigators failed to achieve their enrollment
goals.

So this is from the CMS information that is from 2016 for plan year 2017, and when did you become administrator?


Mr. Walden. Yeah. So in 2017 then, CMS announced that it would start awarding funding to navigators based on their ability to meet their enrollment goals. That sounds like pretty standard business practice.

Ms. Verma. That's right. We have a duty to taxpayers to make sure that our programs are cost effective.

Mr. Walden. And so as a result, CMS reduced the funding for the program by ten million for 39 organizations in 2018. Why? Why did you do that?

Ms. Verma. We did that because the navigator program was not producing the types of results that we would expect to see. My goal is to make sure that consumers using HealthCare.gov or our call centers have a very smooth experience and we felt like there were more different ways. When a program is new it does require a lot of intensive investment in terms of outreach and enrollment.

Mr. Walden. Sure.

Ms. Verma. But looking at the Affordable Care Act, it had been in place and we were looking, reviewing the types of investments that have been made. We had seen from the previous
administration that they had actually doubled their advertising
budget to a hundred million dollars but actually enrollment went
down, so we knew that those types of things weren't effective.
And the same thing with the navigator program. When we did
the math it just didn't add up when you are spending $5,000 per
person. So what we tried to do is invest in more cost-effective
ways, digital ads, more of those types of things, and I think
our results have been effective. We had a 90 percent customer
satisfaction rate for people that used our call centers.
We haven't seen the dire predictions in terms of enrollment
going down. We've had minor fluctuations, which I think can be
attributable to the Trump economy where things are move -- are
so good that people don't necessarily --
Mr. Walden. Well, let me ask you that. And I am sorry to
interrupt you, but on that very point, aren't -- how many more
people are now covered by private insurance as a result of the
strong economy?
Ms. Verma. Well, because of the strong economy what we're
seeing is that people aren't relying on public programs as much.
We are seeing, however, some of the individuals though that
aren't subsidized that they're having trouble affording health
insurance and that the increase in the number of uninsured is
actually for people that are 300 and 400 percent of the poverty
level.
And so, what that shows us is that they can't afford health insurance premiums because of the way Obamacare is structured, and so people that are subsidized we're seeing their enrollment go up, but it's the unsubsidized population where we're seeing problems. We've seen a 40 percent decrease.

Mr. Walden. So this is kind of the middle class --

Ms. Verma. That's right.

Mr. Walden. -- that is caught right there. Not getting subsidy, can't afford the health insurance they are stuck with, and you are trying to give options and have states involved. My state has come to you and gotten relief from certain federal requirements, right?

Ms. Verma. That's correct. We've been doing reinsurance waivers and I think the short-term limited duration plans and association plans, those are efforts of the administration to give people alternatives because we know the middle class cannot afford expensive Obamacare. So we're trying to provide more choices and let the American people decide what benefit plan is going to work best for them, not a one-size-fits-all government approach which is expensive. We think Americans should make those decisions themselves.

Mr. Walden. When we had a big debate on the floor on some healthcare issues, and a number of my friends on the other side of the aisle had amendments directing the navigators do a whole
bunch of things -- reach out to rural areas -- and I raised the
issue then and I think we followed up with a letter to you recently.

That told me the system is broken with the navigators because
they were having to have amendments directing the navigators to
do all these different things. And so, is that system broken?

Ms. Verma. Yeah. And I also think that, you know, we look
at -- we do open enrollment for the Medicare program every year
and what we do there is we use a system of volunteers to help
individuals.

Mr. Walden. Are their navigators paid from like Medicare
Part D or Medicare?

Ms. Verma. No. We use a system --

Mr. Walden. All right.

Ms. Verma. -- something we called our ship volunteers,
and they do an incredible job of helping seniors through the open
enrollment process. So I think there's better ways and more
cost-effective ways.

Mr. Walden. Thank you. My time has expired. Thank you,
Madam Chair.

Ms. DeGette. Thank you so much. The chair now recognizes
the gentlelady from New York, Ms. Clarke, for 5 minutes.

Ms. Clarke. I thank you, Madam Chair, and I thank our
ranking member.

Administrator Verma, Hubert Humphrey, he was the namesake
of the building that you work in, said, "The moral test of
government is how the government treats those who are in the dawn
of life, the children." This quote is even inscribed on the wall
as you walk through the front door of HHS. On your watch it is
safe to say that this administration has failed that moral test.

This administration inherited historically low uninsured
rates among children, but thanks to this administration's
sabotage and mismanagement of health care those rates have gone
up from 3.6 million uninsured in 2016 to 4.3 million uninsured
children in 2018. You have said you want to preserve Medicaid
for those who truly need it. Are low-income children among those
who truly need Medicaid? This is a yes or no question.

Ms. Verma. As a mom, I have two children. I think having
health insurance for children is extremely important to their
development.

Ms. Clarke. Very well. So the New York Times has reported
yesterday that since 2017 more than a million children have lost
coverage in Medicaid and CHIP. Further, the Census Bureau
reported that on your watch the children's uninsured rate
increased to 5.5 percent, largely because of the deadline in
coverage under Medicaid and CHIP. Administrator Verma,
do you agree with the findings of your administration's own Census
Bureau? Yes or no.

Ms. Verma. There's a couple of -- there's two separate
1982 issues here.

1983 Ms. Clarke. Yes or no. Yes or no. Do you agree? Have you --

1984 Ms. Verma. It's not a yes or no question.

1985 Ms. Clarke. It is a yes or no question. Either you agree with what the Census has presented to you or you don't.

1986 Ms. Verma. I believe that the Census data is accurate.

1987 Ms. Clarke. Do you agree with it? Yes -- it is accurate, so that is a yes. You have previously claimed that the children who lost Medicaid have transitioned into private coverage, but if that were true, we would see an increase in the enrollment in private coverage. However, your own Census Bureau says that that is not the case. That there has been no increase in the number of children covered under private insurance.

1988 Administrator Verma, can you explain why the rates of children enrolled in Medicaid CHIP are declining while private insurance coverage has remained flat?

1989 Ms. Verma. So if we look at the number of uninsured children, which I'm deeply concerned about, the biggest drop is for families that are earning above 400 percent of the poverty level. And so what's happening is, under the Trump economy, the economy is the best that we've had in 50 years, unemployment is down.

1990 Ms. Clarke. I don't want to hear your talking points.
Ms. Verma. There's less people living in poverty.

Ms. Clarke. Reclaiming my time. The New York Times story talked about a little boy in Texas named Elijah whose family didn't know that he had been kicked off Medicaid until he was admitted to intensive care for a respiratory virus. Texas has the highest number of uninsured children in the country and conducts more frequent eligibility checks than any other state. Data shows that of the 50,000 children in Texas kicked off Medicaid, more than half regained their coverage within 12 months which means these children were dropped erroneously.

In Tennessee, tens of thousands of children lost coverage because of late or incomplete paperwork. Until recently, Tennessee used an application that could be up to 47 pages long that one Medicaid expert called "daunting."

Administrator Verma, we all agree that the program integrity is a critical part of any federal program, but would you agree that the program integrity requirement should not be weaponized to kick children off of Medicaid? That is a yes or no.

Ms. Verma. I think it's important that children have coverage, first of all. In terms of program integrity, unfortunately, we're seeing that there are major problems in Medicaid eligibility. We're hearing cases all the time. I can tell you I saw data yesterday which is concerning.

Ms. Clarke. I understand your concern. But you should be
far more concerned about the decline or the increase in the numbers
of children who are uninsured. You talked about being a parent
and what you want for your children. What about low-income
children across this nation? That is your responsibility. So
you can say you want to preserve Medicaid for those who truly
need it, but on your watch over a million children have lost
Medicaid and CHIP coverage and the children's uninsured rate has
reversed years of gains. The numbers don't lie and are clearly
going in the wrong direction. You have failed the most vulnerable
amongst us. You have failed the American people.

With that, Madam Chair, I yield back.

Ms. DeGette. The chair now recognizes the gentleman from
New York, Mr. Tonko, for 5 minutes.

Mr. Tonko. Thank you, Madam Chair.

Administrator Verma, CMS has promoted and expanded the
availability of short-term limited duration insurance plans that
are not required to comply with the comprehensive consumer
protections of the Affordable Care Act. These junk plans
undermine protections for people with preexisting conditions,
increase costs, and leave American families with less financial
protection and more exposure to fraud.

Now I want to follow up on Representative Castor's
questioning. Administrator Verma, isn't it true that these plans
are allowed to exclude coverage for preexisting conditions?
Ms. Verma. Short-term limited duration plans provide --
Mr. Tonko. Yes or no. Yes or no.
Ms. Verma. -- an alternative. There's a --
Mr. Tonko. Yes or --
Ms. Verma. It depends on the plan.
Mr. Tonko. Yes or no.
Ms. Verma. It depends on the plan.
Mr. Tonko. Isn't it true that these plans are allowed to exclude coverage, are allowed to exclude coverage? Yes or no.
Ms. Verma. Short-term limited duration plans have more flexibilities than --
Mr. Tonko. I am asking for a yes or no. I have 5 minutes, so I want to get --
Ms. Verma. It depends on the plan. There are different types of short-term limited duration plans.
Mr. Tonko. I am asking if these plans are allowed to exclude coverage. That is a yes or no question.
Ms. Verma. Short-term limited duration plans have the flexibility around benefit design.
Mr. Tonko. So it is a yes.
Ms. Verma. But it depends on how that plan is structured.
Mr. Tonko. But they are allowed to exclude coverage?
Ms. Verma. Not all of the plans will do that. It depends on the plan.
Mr. Tonko. Are they allowed to?

Ms. Verma. And what we have done is to ensure --

Mr. Tonko. You are not answering the question, ma'am.

Ms. Verma. -- that there are the appropriate protections in place for consumers so they understand the type of coverage they are buying.

Mr. Tonko. Ma'am, I mean you are eating up the clock. I am asking if they are allowed to exclude coverage for preexisting conditions.

Ms. Verma. They have flexibility around benefit design.

Mr. Tonko. So that is -- I believe that is a yes answer.

Administrator Verma, isn't it true also that people on these plans can be charged higher premiums without limit based on their health status, gender, age, and other factors? Yes or no.

Ms. Verma. The CBO said that the short-term limited duration plans could be 60 percent lower than the Affordable Care Act plans.

Mr. Tonko. Yes or no, can they be charged higher premiums without limit based on their health status, gender, age, and factors?

Ms. Verma. They have the flexibility. They do not have to comply --

Mr. Tonko. They have the flexibility so that is a yes.

Ms. Verma. -- with the Obamacare plans.
Mr. Tonko. Thank --

Ms. Verma. But that's why they're priced lower.

Mr. Tonko. I don't want to use any more time.

In addition to excluding coverage of preexisting conditions, charging people more based on their health status, I am concerned by the failure of these plans to cover basic health care services.

Administrator Verma, isn't it true that junk plans can refuse to cover essential health benefits like hospitalization, maternity care, prescription drugs, mental health care, and preventive care? Yes or no.

Ms. Verma. You know, I was talking to a family the other day that they lost --

Mr. Tonko. Well, yes or no. It is okay that you had that --

Ms. Verma. -- their health insurance. They lost their job.

Mr. Tonko. Ma'am. Ma'am, yes or no. It is my time. Is it true that these can refuse, these plans can refuse to cover those essential benefits?

Ms. Verma. There's a variety of different plans that are offered under short-term limited duration and it depends on the plan.

Mr. Tonko. You are not answering the question.

Ms. Verma. It depends on the plan.
Mr. Tonko. It depends on the plan, but can -- again, the
question is can they refuse to cover essential health benefits
like those I mentioned?

Ms. Verma. They have flexibility on benefit design.

Mr. Tonko. So that is a yes. They have flexibility. Even
if some of these plans might cover some essential health benefits,
I am concerned that what might happen should people get sick while
they have a junk plan.

Administrator Verma, isn't it true that these plans can
impose lifetime and annual limits on coverage and are not subject
to cost sharing limits?

Ms. Verma. If there were more affordable options available
under Obamacare, people wouldn't have to make compromises. But
unfortunately, premiums have gone up --

Mr. Tonko. I don't want -- don't filibuster on me.

Ms. Verma. -- so much that there's no alternative.

Mr. Tonko. Please. Please. I am asking for a yes or no.

Isn't it true that these plans can impose lifetime and annual
limits on coverage?

Ms. Verma. Yes, they can.

Mr. Tonko. Okay. Thank you for the yes. These plans seem
to have very little utility if you need health care or don't want
to be one sickness away from bankruptcy. That is exactly why
the ACA was passed. It was to make sure that people had
comprehensive coverage and were not one illness away from
bankruptcy.

So, Administrator Verma, I am curious. What are people with
these junk plans supposed to do when they need vital healthcare
services that are not covered by these junk plans?

Ms. Verma. Well, what are they supposed to do when they
have to spend half of their income on the Obamacare premiums and
then another ten to twelve thousand dollars on the high
deductibles? They have no alternative. And what our
administration is trying to do is to provide more choices where
there aren't any. And so when people are forced to pay half of
their income or a third of their income on a premium plus a
deductible, they can't afford health insurance and short-term
limited duration plans may give them a different option. It's
better than having no insurance at all.

And in absence of no solution by Congress to address --

Mr. Tonko. I am going to reclaim my time.

Ms. Verma. -- unaffordable premiums, there is at least
something for people.

Mr. Tonko. Well, I believe that the statistics with one
in three people being able to afford something with the subsidies
that we provide are an encouraging statistic. And with that I
yield back.

Ms. Verma. And many people don't get subsidies.
Mr. Tonko. And I would just ask that you put children first.

And with that I yield back.

Ms. DeGette. The gentleman's time has expired. The chair now recognizes the gentlelady from Washington State, Mrs. McMorris Rodgers, for 5 minutes.

Mrs. McMorris Rodgers. Thank you, Madam Chair. I would like to begin just by giving the administrator a chance to answer anything that you didn't get to answer in the last questions since you were being cut off repeatedly.

Ms. Verma. Thank you. I appreciate that. You know, first of all, Obamacare has become affordable -- unaffordable for so many families, for the middle class they can't afford the premiums and if they're not getting a subsidy, they have no alternative.

Short-term limited duration plans provide an alternative. I was just talking to a family where, you know, the husband lost his job. They have two kids in high school. And they couldn't afford -- they couldn't afford premiums under Obamacare and so they looked at a short-term limited duration plan. It met their coverage needs. They reviewed the benefits and felt like it was going to work for their family and so they were able to buy this plan.

You know, these plans can be 60 percent lower than what's on the exchanges and so it gave them an alternative. You know, they may not need it for a long period of time, but it's important
that we have alternatives. In absence of a solution, we're trying
to do something for the American people for the middle-class
Americans that can't afford Obamacare.

Mrs. McMorris Rodgers. I want to say thank you. I want
to say thank you for your leadership. I want to say thank you
for your commitment to making sure that we keep the promise,
especially to those on Medicare, our seniors that are depending
upon Medicare, for those on Medicaid, some of the most vulnerable
in our country. I just want to say thanks for the work that you
are doing.

I also applaud you for the work you are doing to ensure that
we continue to lead the world in innovation and thinking of how
we ensure that we have a healthcare system that is going to provide
access and quality at an affordable price for everyone. And I
think the flexibility is so important. I think that offering
a variety of plans is so important to meet an individual's or
a family's need, particular needs. Certainly, Medicare and
Medicaid are critical safety nets and we must keep, fulfill the
promise that we have made to those that are depending upon Medicare
and Medicaid.

I am committed also to making sure that those with
preexisting conditions have the confidence and the certainty that
they will always have quality, access to quality and affordable
health care. I have a son with special needs with disabilities
and I remember during the debate on Obamacare that I was concerned about the impact that it was going to have on those with disabilities within Medicaid. According to the Kaiser Family Foundation, they have reported that more than 450,000 individuals with developmental disabilities are on a waiting list today for Medicaid in this country -- 450,000 individuals with disabilities.

When I was, during the debate when I was, when I said I am concerned about people with disabilities being put on a waiting list for Medicaid, I was laughed at. Today in Washington State, 15,000 individuals with disabilities are on a waiting list. This is Washington State that expanded Medicaid to the furthest degree possible. We have hundreds of thousands of people with disabilities that are waiting for care. I co-chair the Rural Health Coalition. I have visited hospitals and healthcare facilities all throughout my district in Eastern Washington. It is heartbreaking when I hear from providers and hospitals that are having trouble keeping their doors open because of the low reimbursement rates and the high populations of Medicare and Medicaid.

So Washington State is at the highest level, 130 percent of federal poverty level are covered under Medicaid. The income threshold is even higher for children at 210 percent of the federal poverty level. We need to make sure that we are protecting
current beneficiaries because they need to have that certainty.  
I wanted to ask you, could you just talk to me about CMS and what you are doing to track those that are on waiting lists and how do we ensure that the populations, some of the most vulnerable in our communities are actually getting the care that we have promised to them?

Ms. Verma. Well, I share your commitment to the vulnerable populations in the Medicaid program. Many of these individuals have no place to turn and Medicare is a vital safety net that is so critical to improving their lives, the quality of care, and their day-to-day lives. One of the things that we're very concerned about is program integrity within the Medicaid program. We're seeing some alarming data that is showing that states aren't necessarily putting the right people on the program and that we have some high cases and problematic eligibility systems that are putting people on the program that don't belong.

And so, we'll be taking action to make sure that we can ensure that the people on the program actually belong on the program, because if we don't do that we're failing taxpayers and people that deserve to be on the program.

Ms. DeGette. The gentlelady's time has expired. The chair now recognizes the gentlelady from Delaware, Ms. Blunt Rochester, for 5 minutes.

Ms. Blunt Rochester. Thank you, Madam Chairwoman.
And thank you, Administrator Verma, for joining us today.

Today's hearing is critically important because CMS is tasked with overseeing the implementation of the Affordable Care Act, the landmark law that allowed thousands of Delawareans as well as millions of Americans to be protected and not be denied coverage based on a preexisting condition or removed from their parents' health plan at the age of 26, just to name a few. It is one of the significant reasons why I came to Congress was to protect this because I know it gave hope to so many people, particularly people with preexisting conditions.

And, unfortunately, Delaware's enrollment in the exchanges began dropping in 2016. And that is not a surprise when you factor in the administration's decisions to number one, shorten significantly the enrollment period; number two, cut the navigator program by 84 percent causing many people to be confused and not have the help and support that they needed to navigate which a sometimes incredibly difficult system for anybody, private sector or public sector; and three, cut outreach funds by a whopping 90 percent for a program that doesn't have the longevity of a Medicare or the name recognition. With less time to apply and fewer resources to do it, you can understand why people believe that these actions are deliberate attempts to unilaterally repeal the ACA.

Administrator Verma, after cutting the federal funding to
facilitate enrollment in HealthCare.gov, you were quoted as saying, "This decision reflects CMS's commitment to put federal dollars for the federally-facilitated exchanges to their most cost-effective use in order to better support consumers through the enrollment process."

I would like to focus on two parts of your statement. One, supporting consumers during the enrollment process and, secondly, the cost effectiveness. According to a former senior advisor at CMS, Joshua Peck, who previously oversaw the ACA marketing program, the outreach and marketing programs that have been dramatically scaled back were working and they were cost effective.

I have been informed that there is data on how federal dollars should be effectively spent in order to reach Americans who need health insurance. Specifically, a July 2018 general Government Accountability Office report on HHS outreach and enrollment efforts in the individual marketplace cites an HHS study on the most effective forms of advertising for new and returning enrollees.

In March, I along with 29 of my colleagues wrote from this committee, reached out to you to ask for this study because we wanted to really fully understand and get to the bottom of what ACA marketplace outreach strategies were actually working.

After a follow-up, because I didn't receive a letter after that
one, we wrote another letter. I received a letter back which, unfortunately, did not give us a direct answer, you know, and I would like to submit -- I would ask unanimous consent to submit the three pieces of correspondence into the record.

Ms. DeGette. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********
Ms. Blunt Rochester. Administrator Verma, my colleagues and I just wanted to understand how CMS can most effectively help our constituents enroll in ACA-compliant health coverage. And this one really is a yes or no question. Will you commit to releasing any and all documents, studies, relevant data created from 2014 onward related to marketing and outreach efforts for the Affordable Care Act so that we on the committee and particularly in our oversight role can have the information and understand that rationale? Yes or no.

Ms. Verma. All document requests are handled by Health and Human Services and so I would refer your request to the Department.

Ms. Blunt Rochester. So the letter that we originally sent was actually sent to the Department. And it would be great to also have your commitment, I mean, I am assuming you had to have made the decision so therefore you either had information or you didn't. You, I mean you made the decision so it would be really great to have that information so that we could make these decisions.

Again, would you support the turning over of that information?

Ms. Verma. All document requests are handled by the Department of Health and Human Services and I would refer your request to them.
10 seconds I am going to just say, for many years I got to serve in public service just like you, Deputy Secretary of Health and Social Services, State Personnel Director. It is important that people have confidence and faith in these institutions and the way we answer questions exhibits that confidence and faith.

Just answer the questions. Just work with us, because we all want to see people have health care.

Ms. DeGette. The gentlelady's time has expired.

Ms. Verma. And if I have the time -- I would happy to answer your questions.

Ms. DeGette. The chair now recognizes the gentleman from Indiana, Mr. Bucshon, for 5 minutes.

Mr. Bucshon. First of all, thank you, Administrator Verma, for being here today and thank you for the great work that you are doing at CMS, a difficult agency to lead as I would imagine.

First off, I want to thank you for your recent proposal to reform Stark Law. As a long-term advocate for reforming the Stark Law, I am pleased that CMS has proposed real reform to the law.

The Stark Law is a dated regulatory structure designed for a fee-for-service payment model that has inhibited the value-based care and coordinated care arrangements that many physicians are eager to take advantage of in order to provide better and more efficient care for their patients. As we rapidly move to a value-based care payment models, your proposal to modernize Stark
Law will remove legal barriers that currently prevent physicians from entering into coordinated care and innovative payment models, which I believe can lead to better outcomes for patients and keep costs down.

So I would like to bring up the DME fee-setting provisions of the proposed rule by CMS that was proposed in July, and there are some concerns as you know that the proposed rule will place authority in the hands of CMS staff to set Medicare rates for medical devices in ways that number one, will expand disparities between private payor and Medicare reimbursement and, number two, inhibit the availability of innovative medical devices for Medicare beneficiaries.

In particular, do you think that a developer of a breakthrough medical device with fairly robust sales in a non-Medicare market could review the regulations and then calculate with reasonable certainty the fee that would might be set by Medicare?

Ms. Verma. You know, one of the things that we're trying to do around innovation is provide more transparency for innovations so people understand what they're going to face in terms of coverage decisions, coding decisions, and also reimbursements. So we have tried to -- we've actually proposed some regulations that would give more flexibility so that we can look at the private market and bring in what they may expect to
be reimbursed in the private market as part of our decision making.

Mr. Bucshon. Thank you. I very much appreciate that. And so, do you think that in this space that the Medicare fee will be roughly equivalent to the non-Medicare price?

Ms. Verma. It depends on the particular product. Our goal with durable medical equipment is to make sure that our beneficiaries have access to the equipment that they need and make sure that we have a competitive environment.

Mr. Bucshon. Thank you very much. So I appreciate your consideration on these issues as you work towards finalizing that rule.

Another one is a little bit in the weeds but is important. It is the issue as it relates to Medicare beneficiaries who are on Coumadin therapy for atrial fibrillation and other medical problems that require anticoagulation, for example, a heart valve replacement. As you know, weekly blood tests are required to keep these patients in the safe treatment range.

And the concern here is, is that this year's proposed physician payment rule includes a 20 percent reduction in INR, the International Normalized Ratio, which is a test of anticoagulation. That is being reduced for 20 percent and is being reduced for the third year in a row. And so, I would like to ask if we could hit the pause button and really reconsider that. Freezing the reimbursement paired with work over the next
year to figure out what is a sustainable path forward will help ensure that these vulnerable Medicare beneficiaries can receive the care they need. So I hope that we can take a look at that and revisit that.

And then, finally, I wanted to thank you for your letter that your office sent in response to the bipartisan letter that I sent on September 27th with 24 of my colleagues regarding the CY20 Physician Fee Schedule proposed rule. My colleagues and I have concerns with the agency's proposal not to apply a payment adjustment to the evaluation and management or E&M code component of global surgical codes even though the agency is proposing to update the E&M code values for standalone office visits. And as the agency works to finalize the rule, I appreciate your ongoing input and collaboration on that issue.

I have 48 seconds left. Do you have anything else that you feel like you haven't been able to say during the hearing that you might want to tell the American people about your work?

Ms. Verma. Well, I would appreciate the opportunity to be able to answer some of the questions that have been posed before, but we haven't had time. One of the things that I do want to talk about are the numbers on, the number of people on Medicaid and the declines there as well as what we're seeing on the uninsured. When we look at the Medicaid program it is natural to see fluctuations in enrollment. As the economy does better
we can expect to see lower enrollment. We've seen that in the Clinton administration. There's an urban study report on this as well.

And so, because we are in a booming Trump economy with the lower unemployment, less people on poverty, we are going to see that impact in the Medicaid program. That being said, our administration is committed to addressing children and making sure all kids have access to coverage.

Mr. Bucshon. Thank you very much and I will be submitting some other questions for the record. I yield back.

Ms. DeGette. The chair now recognizes the gentleman from California, Mr. Cardenas, for 5 minutes.

Mr. Cardenas. Thank you very much, Madam Chairwoman. I appreciate this opportunity to have an open and public discussion about such an important program to millions and millions of Americans.

One of the fundamental gains under the Affordable Care Act was the historic increase in coverage thanks to Medicaid expansion. Approximately 12 million people gained coverage for essential healthcare services thanks to this expansion and it continues to be one of the most important payors for health care in this country. Studies have made clear that Medicaid expansion has greatly benefited Americans who gained coverage.

Researchers from the Census Bureau, NIH, UCLA, and the
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University of Michigan recently found, and I quote, "Medicaid expansions substantially reduced mortality rates among those who stood to benefit the most." They estimated that due the state's Medicaid expansion in states that there were 19,000 fewer American deaths in the first 4 years alone. And the failure of other states to not expand Medicaid resulted in an estimated over 15,000 additional American deaths over the same period.

Administrator Verma, are you aware of that particular research?

Ms. Verma. I'm aware of it.

Mr. Cardenas. Okay, thank you. Other studies also show gains in access to quality and affordable care as well as positive health outcomes. And in the midst of the opioid crisis, Medicaid expansion has increased access to medication-assisted treatment for opioid addiction.

My question to you, Administrator Verma, is, is it true that substance use disorder treatment is a top healthcare priority for HHS?

Ms. Verma. I believe it is, yes.

Mr. Cardenas. Okay. That is good to hear. In fact, HHS has stated that its number one strategy to combat the opioid crisis is "access, better prevention, treatment, and recovery services."

And as we know, Medicaid has been integral for increasing access to those services in expansion states. The American Medical
Association has reported, and I quote, Medicaid is on the front lines and often provides more comprehensive care for substance use disorders than the commercial insurance market does. There may be opportunities to extend Medicaid successes to commercial coverage. Expanding Medicaid would help even more patients.

So, Administrator Verma, do you agree with the AMA that Medicaid is critical for providing comprehensive care for substance disorder to Americans and that expanding Medicaid would help more American people who are suffering from addiction?

Ms. Verma. Thank you. A couple things. One, on Medicaid programs, CMS has approved 26 state Medicaid 1115 demonstrations to expand.

Mr. Cardenas. How many states in the union?

Ms. Verma. There's 50 states in the union, 26 states.

Mr. Cardenas. Okay, thank you. So just over half.

Ms. Verma. But those are the ones that have applied, and if they've applied we've approved them. So we have tried to ensure that people with substance use disorder have a full array of options available to them and more places to receive treatment.

Mr. Cardenas. So the states that have applied and are providing that service, are they doing better than the states that are not applying in this category?

Ms. Verma. These waivers, we just started granting them probably late 2017 and so we're still evaluating those waivers.
Mr. Cardenas. When do you anticipate having evaluations that you could report to Congress?

Ms. Verma. We'll be happy to share any information that we can with you.

Mr. Cardenas. About when? Is it 2019, 2020, 2030?

Ms. Verma. You know, it depends on when it comes in. These are five-year waivers.

Mr. Cardenas. Okay, five-year.

Ms. Verma. And so it would take us at least that and it depends on when they started their waiver.

Mr. Cardenas. Okay. Thank you so much.

As we know, the Trump administration is rooting for the ACA's demise by asking the court to strike down the entire law. But if that happens, Medicaid expansion would be reversed. Therefore, 12 million American people would lose coverage literally overnight.

Administrator Verma, if the administration gets its way in the Texas v. United States lawsuit, what will happen to those 12 million vulnerable people who suddenly find themselves without coverage?

Ms. Verma. Well, we're rooting for all Americans to have coverage and under the Affordable Care Act, the middle class can't afford Obamacare's coverage.

Mr. Cardenas. I asked you specifically about that lawsuit
and what would happen to those 12 million Americans.

Ms. Verma. And we've been very clear, the President's been very clear he wants to make sure that people with preexisting conditions would have protections and we want to make sure that all Americans would have access to affordable coverage.

Mr. Cardenas. Okay, thank you. Reclaiming my time. That is not the answer to the question I specifically asked. I would like to state for the record that the Trump administration and Administrator Verma are paying lip service to the caring about American people with these issues, but it is clear that not taking the steps to encourage the best thing a state can do to immediately improve the lives of millions of American residents of those states that it expands -- that it should be expanding Medicaid.

I am out of time, Madam Chair. I yield back.

Ms. DeGette. The gentleman yields back. The chair now recognizes the gentleman from Montana, Mr. Gianforte, for 5 minutes.

Mr. Gianforte. Thank you, Madam Chair. And thank you, Administrator Verma, for being here today to testify in front of our committee.

Last year, Congress removed Medicare reimbursement restrictions in five areas including telestroke services. Do you think telehealth would be useful and effective in other critical care scenarios especially for rural hospitals like I
have in my district that may not have specialists in these small communities?

Ms. Verma. Absolutely. And I think that's one of the things that we're trying to focus on in the Medicare program and part of the reason why I have some concerns when you hear about proposals to put everybody into the Medicare program.

Unfortunately, the Medicare program often is very slow to respond to new technology. That being said, our administration has focused on telehealth services. We've expanded the number of telehealth services that are available in rural communities and we've also provided remote communication technology to the entire program so our beneficiaries can easily access care.

Mr. Gianforte. Okay, I want to dig into this a little more. The federal government is among the most prolific users of telehealth and virtual care technologies including the VA, DOD, IHS, NASA. Unfortunately, just one-quarter of one percent of Medicare fee-for-service beneficiaries used telehealth in 2016.

Meanwhile, the government has funds, grants, projects through HRSA, SAMHSA, FCC, and others. We know that some grants may be duplicative across HHS operating divisions and it is often difficult for healthcare providers and patients to understand how they can better access telehealth services.

With limited resources available for telehealth adoption, it is important that we spend all these funds wisely. Can you
help us understand how these different entities across the federal government coordinate policy development, federal funding opportunities, and best practices as it relates to telehealth?

Ms. Verma. Sure. One of the things that we have going on at Health and Human Services is the Secretary has convened a Rural Health Committee. And so we have, he's bringing together all of the agencies under HHS to focus specifically on rural health and as part of those discussions we're talking about how we can expand telehealth services to make sure not only people in rural communities but even urban communities can access those services.

Mr. Gianforte. Okay. And do you believe there is opportunities to exist to improve coordination and efficiencies further?

Ms. Verma. Absolutely.

Mr. Gianforte. Okay. Are you aware of any national telehealth strategy and, if not, should one exist?

Ms. Verma. I think there's been some focused effort on this in rural communities to make sure that, you know, a lot of the problem is even if telehealth services are available they may not have broadband access and so the administration has focused on that as well. You know, telehealth is a great example of innovative technology that can really go a long way to improve access and to improve health care and outcomes and so would love to continue to work with you on that issue.
Mr. Gianforte. Well, it is a real area of attention for us given I represent the state of Montana. We have a lot of space and not many practitioners. We don't have specialists. Telehealth is one way to bring those to these rural communities so they can maintain the viability of our critical access hospitals and others. So I appreciate all that CMS has done to increase access to telehealth services. The federal government has a commitment to keep to our seniors and ensure they have access to high-quality, affordable health care. Congress should focus on leveraging both federal funds and lessons learned so that those who need access most have it, particularly folks in rural areas. We should prioritize efforts to expand telehealth access and fully realize the potential it has to provide services to all our seniors with access to reliable, quality health care.

I have a minute left. Is there anything else you would like to tell the American people that hasn't been addressed today?

Ms. Verma. I would like to focus on some of our efforts around rural health because I think it's an important area. We've been concerned about the hundred hospitals that have closed, rural hospitals. We're also concerned that 40 percent of rural hospitals are operating at a negative margin. This is why we've taken action with the wage index to increase reimbursement to hospitals in rural areas and we're also working on something,
a new model for rural communities to basically think about how they can redesign their system.

I think those decisions need to be made at the local level, can't be made in Washington, but it's an opportunity for them to rethink the structure and to move in more value-based care.

So we're excited to continue our work and our commitment to rural communities across America.

Mr. Gianforte. Again, I want to thank you for your work at CMS and thank you for being here today. And with that I yield back.

Ms. Verma. Thank you.

Ms. DeGette. The gentleman yields back. The chair now recognizes the gentleman from Illinois, Mr. Rush, for 5 minutes.

Mr. Rush. I want to thank you, Madam Chair. And welcome, Administrator Verma.

Administrator Verma, last month I sent you a letter asking, to me, a very important question. Why are there so many dialysis centers in black neighborhoods? In the poor part of my district it seems that there is a dialysis center on each and every corner.

And I want to thank you for responding to my letter and I am cautiously optimistic regarding CMS's aggressive goals to reduce the disproportionate rates of kidney disease in lower income and minority communities.

Madam Chair, I ask unanimous consent to offer my letter to
CMS and to offer their response into the record.

Ms. DeGette. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********
Mr. Rush. Administrator Verma, will you describe in detail how the goals you outline in your response to me will ensure minority communities in particular that they will have access to the care and education on treatment options that they may require if they are on dialysis?

Ms. Verma. Well, thank you for your question. This is an important area. The President has actually put out an executive order around kidney disease and the goal of that is multifaceted. First of all, we want to improve the quality of care. We want to make sure that people that are living with kidney disease have options about their care. The first thing that we want to do is make sure that the transplants, that the ability to have a transplant to cure their disease is available. And we know that there's a lot of regulations that get in the way of having more organs be available and so the President has asked us to take action on that issue.

The second thing we want to do is make sure that we're paying doctors for the quality and the outcomes that they achieve. And one of the things that we want to focus on is giving people living with kidney disease more options so that they don't necessarily have to go into a dialysis treatment center and they can have more home-based dialysis.

Mr. Rush. Ms. Verma, I want to know about the dialysis centers and those patients who are on dialysis, not those patients
who are looking for organ transplants. And that is really good, but please center your answers on the issue of the dialysis center epidemic in lower and minority communities throughout the nation, certainly in my district.

Ms. Verma. Well, I think that's what this executive order focuses on. We want to improve the quality of care. We want to make sure that people have options. That they're not forced to just go to a dialysis center, that they can even receive that care at home.

Mr. Rush. So you don't have an answer to my question?

Ms. Verma. Well, I think our executive order, writ large, focuses on it on kidney care.

Mr. Rush. Well, let me ask you another question then. I am concerned about hospitals closing in my district and in similarly situated districts across the nation, all right. What do you have, any data on closures of hospitals in lower and minority income communities across the nation?

Ms. Verma. I'm sorry. The question is you want to understand the impact on --

Mr. Rush. I want to know do you have any data on the number of hospitals that have been closed in my district and lower income and minority districts across the nation within the last 5 years?

Ms. Verma. I don't have that data with me today, but I can commit to you that we can help your office and provide any data...
Mr. Rush. Do you know why there is an increase in the number of hospitals that are closing in lower and minority income communities?

Ms. Verma. I have not studied that issue, but I'd be happy to work with my team and get you that information.

Mr. Rush. Can you come up with any idea about how to prevent hospitals from closing in minority and low-income communities across the nation if, in fact, the data reveals that we have such an epidemic?

Ms. Verma. Well, we want to make sure that people all across the nation have access. I think we've looked at the issue in rural areas --

Mr. Rush. I yield back.

Ms. Verma. -- but happy to work with you on that.

Ms. DeGette. The gentleman yields back. The chair now recognizes Mr. Carter from Georgia for 5 minutes.

Mr. Carter. Thank you very much, Madam Chair. And, Administrator Verma, thank you for being here. We appreciate it very much. Is there anything you need to respond to before I get -- you are okay? Okay.

I want to thank you. I have been working with you now for close to 2-1/2 years and I appreciate your work. I think you understand what we are trying to do and I think we are on board.
I want to especially tell you how much I appreciate the proposed rule changes earlier this year concerning rebates with PBMs and especially with DIR fees. And whereas, I know you have to temper your remarks, but I don't, I was devastated that they did not -- that the administration blocked those rules and that we weren't able to get them through and I hope that you will continue to work toward that.

I, for one, believe that we need to do away with PBMs and I certainly believe we need to do away with DIR fees. Both of them need to be eliminated. But one thing that I don't think needs to be eliminated is the 340B program. I do think it serves a useful purpose. However, I do think it needs to be updated and I think that we need to tighten up that program. There are flaws in that program and it can be better than what it is now if we simply make some changes to it.

We did a study in the last Congress about the 340B program and made some recommendations and one of the things that we cited was duplicate discounts. The discounts that are going to the recipient, the covered entity receives a rebate for the drug that is dispensed to the patient and the Medicaid agency, and it can be both the state Medicaid drug rebate plan or the Medicare managed care plan.

And I just wanted to ask you, whereas I know HRSA has primary jurisdiction over the 340B program, CMS has jurisdiction over
the Medicaid program, what are we doing about that? Can you help me?

Ms. Verma. Sure. And I also do want to address the DIR fees. What I will say is we're very concerned about small pharmacies and we want to make sure that our policies ensure a competitive marketplace, and I can tell you that the agency continues to work on that issue. We're particularly concerned about some of the quality metrics that may be impossible for some of these pharmacies to comply, so we're going to continue to do what we can under the law.

Mr. Carter. And, of course, as you well know we are trying to address it legislatively as well and I want to thank my colleagues on the other side of the aisle for assisting in that as well.

Ms. Verma. Thank you. And then in regards to the 340B program, as you know that is the subject of litigation so I won't get into that, but we are concerned about the double discounts. At the end of the day, some of the proposals that we made would result in our seniors paying less and we're concerned about that.

I also would add that the President's budget in terms of the 340B project or our proposal would say that if we made any changes to the 340B program that any savings could be directed back to the safety net institutions.

And so, I would ask that you take a look at that because
I think that would be helpful in reforming the program, ensuring that beneficiaries are paying less when they get their medications but also ensuring that we support safety net institutions.

Mr. Carter. Absolutely. And I don't mean to be redundant, but again as I said earlier, I am not opposed to the program. It just needs, we need to upgrade the program and we need to make it even better and we can make it even better.

Okay, and then let's shift over to your oversight of hospital accrediting organizations because I know that is your responsibility as well. And it is my understanding that you have a new pilot program out there that is dealing with the "increase the agency's oversight of organizations involved in accrediting and inspecting most hospitals?"

Ms. Verma. I think, one -- we do have, we had an RFI out on this. One of the things that we've had some concerns about is that organizations that are reviewing safety and quality at hospitals we put out an RFI because we've also heard some concerns that these organizations are also receiving consulting dollars from those same entities, so we're taking a look at that. We want to make sure that the American public can count on the accreditation and that they have the information that they need about the hospital at their fingertips.

Mr. Carter. Obviously that is a conflict of interest if they are doing the consulting and the accrediting. Is the pilot
program in place or you just have an RFI for it?

Ms. Verma. We -- so there's two different issues. One is around the accreditation issue and conflicts of interest. The other issue that we have in place is just looking at, we have a pilot program to do joint review so that we can have our oversight of the accrediting organizations and that we basically do the review of the hospitals at the same time so that we're not duplicating that. We're going to see how that goes.

Mr. Carter. Great. And again, I want to thank you for all your work and especially for your work on the DIR fees, because as you say particularly for small pharmacies, which we need in this country, this is devastating for them. So, thank you and I yield back.

Ms. Verma. Thank you.

Ms. DeGette. The gentleman yields back.

I want to thank our witness for her participation in today's hearing and I want to remind members that pursuant to committee rules they have 10 business days to submit additional questions for the record to be answered by the witness who has appeared before the subcommittee. Administrator Verma, I would ask that you agree to respond promptly to any such questions should you receive them. And with that the subcommittee is adjourned.

Ms. Verma. Thank you.

[Whereupon, at 12:31 p.m., the subcommittee was adjourned.]