COLE STATEMENT – MEMBER DAY

In the area of permitting reform, I would urge the Committee to avoid expanding federal agency authority over electricity issues in a manner that would override or render state and tribal authority meaningless regarding electric generation and transmission designed to protect the state and tribe's electric consumers. Empowering federal agencies to allocate costs to a state's electric customers in derogation of the state, and regional authorities who have been entrusted with that responsibility, or allowing federal agencies to condemn private property to facilitate interstate transmission lines that offer little if any local benefit, is the decidedly wrong approach, not only from a cooperative federalism perspective but most certainly not judicious given the concerns held by the public with regard to affordability of their energy supplies. Those decisions are better made by state authorities closest to the citizens of a state and having an obligation to protect those citizens rather than unelected bureaucrats in Washington DC.

Representing a heavily rural district, I am familiar with the challenges of accessing rural health care and the persistent rural health workforce shortage. It is widely recognized that medical training in underserved communities increases the likelihood that physicians will remain in those communities to practice. That is why I recently introduced H.R. 5428, the *Medical Student Education Authorization Act of 2025*. This legislation formally authorizes the MSE program, which provides grants to public institutions of higher education to expand or support graduate medical education and focuses these resources to institutions in states with the most severe primary care shortages. Since the program's inception, nearly $337 million in

grants has been invested in the next generation of rural providers. With bipartisan, bicameral, and industry support, I would greatly appreciate your consideration of H.R. 5428 in any upcoming hearings or markups considering rural health or health workforce legislation.

One program that is particularly important to many rural hospitals and health clinics in my district is the 340B Drug Pricing Program. Due to recent changes in the 340B reimbursement model, combined with revenue losses from the IRA Medicare Drug Price Negotiation Program and other challenges facing rural providers currently, providers in my district are facing difficult decisions about whether to close critical services or discontinue coverage of certain medications. Rural providers with smaller patient populations lack the cash flow to purchase drugs at wholesale prices up front, even with rebates. For example, a rural community health center in my district estimates they will need an additional $7 million to purchase the same medications that cost roughly $230,000 after discounts in 2024. While I recognize the rapid expansion and reported abuses of the program by large healthcare systems and other bad actors, any future reforms should consider the unique challenges faced by rural hospitals and health centers which have proved themselves to be good stewards of the program and should remain grounded in the program's original intent to stretch federal resources in underserved communities and provide comprehensive services to low-income and uninsured patients.